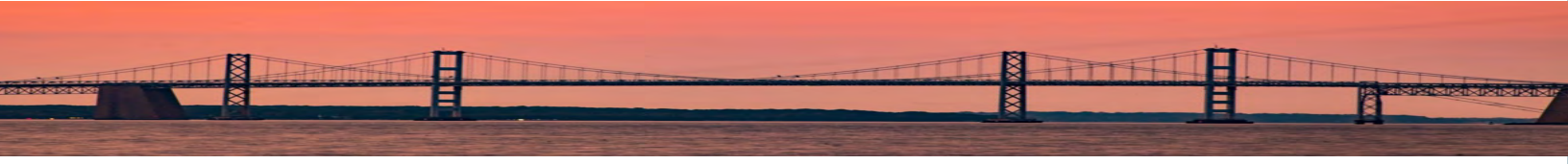
Queen Anne's County
HUMAN RESOURCES

WHERE SHORE LIVING **BEGINS**

2025-2026
BENEFITS OVERVIEW GUIDE



Welcome to Your Queen Anne's County Government Benefits

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

New Hire Benefit Highlights

- **EPO Marathon Health Center Plan:** Offers the lowest payroll deductions and there is no deductible to meet. All benefits-eligible employees may enroll. Annual physicals for employee and spouse (if covered) must be completed at the Marathon Health Center.
- **Whole Life with Long-Term Care from Unum:** "Guaranteed issue" (GI) for employees — no health questions for most plans and policies include Long-Term Care benefits.
  During future open enrollments, if already enrolled in coverage, you may increase up to the $100,000 GI amount without answering health questions. If not enrolled, you will be required to answer health questions before coverage is approved.
- **Short-Term Disability:** no extended Benefit Waiting Period for enrollees during their new hire enrollment. After your new hire enrollment periods ends, if you would like to elect coverage during a future open enrollment, there is a 60-day extended Benefit Waiting Period before benefits begin if the disability is due to disease, pregnancy, or mental disorder. More details on page 23.
- **Long-Term Disability:** Guaranteed issue" for employees — no health questions to answer. If you choose to enroll in a later enrollment, you will be required to complete an Evidence of Insurability (EOI) form.
- **PrudentRx Copay Assistance:** Program enrollment is automatic when you are prescribed a covered specialty medication. Qualifying drugs are covered at no copay to the member.

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

Enrollment Assistance

QAC has partnered with Bolton to administer our Benefits Enrollment System (bswift). If you have a question or need your password reset, or are having technical issues, please send an email to service@boltonusa.com outlining your request and the Service team will assist you.

Online Enrollment Instructions

bswift allows you to access your benefits information and enroll online. Go to qacg.bswift.com to enroll or access the site through the County Intranet via Single Sign On.

Step 1: Sign in to bswift

Username: Your username is first initial of first name + full last name + year of birth. For example: If your name is Jane Anderson and you were born in 1970, your username would be janderson1970.
Password: The last four numbers of your Social Security number (SSN). You will be required to reset your password upon your initial login: all passwords must have a minimum of eight characters, one of which must be a number and one a letter.

Step 2: Get Started

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

Next you will review your **Family Information**. Eligible dependents can be added on this page.

Step 2 (cont'd) You must agree that both your Personal and Family Information is correct before you can proceed, then click Continue.

Step 3: Begin Your Enrollment and Enroll

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

Your elections from FY25 have been copied to FY26 except for your Flexible Spending Account plan elections. The total benefit cost, per pay period, will appear on the right side of the enrollment screen.

Step 4: Confirm Enrollment Selections

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

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

Enrollment Reminders

- Beneficiary designations for Life Insurance and certain Voluntary Plans will be stored in bswift. Make sure to review or update this information as you go through enrollment to ensure you have current beneficiaries in place.
- If you are adding a spouse and/or children onto your health insurance, you must upload or submit dependent documentation to Human Resources by August 8, 2025. A marriage certificate is required for a spouse and a birth certificate for each child being newly enrolled along with Social Security cards. A copy of the Social Security card will be required for any new dependent.

Benefits Eligibility

Employee Eligibility

All County employees, as defined by QAC, are benefits eligible (full-time and percentage part-time). Employees have the option of the PPO, EPO and BCA plans to choose from.

Dependent Eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse, dependent children and disabled adult child. The dependent eligibility documentation requirements are outlined on the bswift platform. See page 7 for additional details.

When to Enroll

NEW HIRE ELIGIBILITY*	QUALIFYING LIFE EVENTS	OPEN ENROLLMENT
As a newly hired benefits-eligible employee, you are offered an initial enrollment period to elect benefits. Elections made as a new hire will stay in effect for the entire plan year and cannot be changed until the next plan year during Open Enrollment or within 30 calendar days following a qualifying life event.	Certain events in your life (i.e., marriage, divorce, gain or loss of coverage due to a job change, etc.) allow you to make changes to your benefit plan(s). If you experience a qualifying life event during the plan year, you must make the changes online (HR is able to assist you) **within 30 calendar days** following the qualifying life event date, even if the supporting documentation is not yet available.	You must log in to bswift during Open Enrollment to make any **coverage changes** for the following year. Open Enrollment is offered annually to give you the opportunity to change, elect or cancel benefits. It is usually in the summer of each year.
EFFECTIVE DATE	**EFFECTIVE DATE**	**EFFECTIVE DATE**
First (1st) day of the month following your hire date.	First (1st) day of the month following the qualifying life event date. Some exceptions apply—for example, when adding a newborn within 30 calendar days of birth, benefit changes are effective on the birth date.	Open Enrollment elections will become effective September 1 of the next plan year.

*We request that all benefits-eligible employees log in to bswift to elect or decline benefits.

How & When to Enroll

This chart outlines how you enroll and the deadline for enrollment for each benefit.

BENEFIT	HOW TO ENROLL			DEADLINE TO ENROLL	
	ONLINE	PAPER	AUTO ENROLLED	WITHIN 7 CALENDAR DAYS OF NEW HIRE DATE OR WITHIN 30 DAYS OF A QUALIFYING LIFE EVENT	NO DEADLINE
Health (Medical, Rx, Dental, Vision)	X			X	
Flexible Spending Account (FSA) & Dependent Care Flexible Spending Account (FSA)	X			X	
Employee Assistance Program (EAP) \Work-Life Services			X	N/A	N/A
Accident	X			X	
Hospital Indemnity	X			X	
Critical Illness	X			X	
Basic Life Insurance and AD&D	X			N/A	N/A
Whole Life Insurance*	X			X	
Short-Term Disability	X			X	
Long-Term Disability*	X			X	
Identity Theft Protection	X			X	
457(b) Plan	X				X
401(a) Plan			X		X
MD State Retirement		X		N/A	N/A

*Evidence of Insurability/medical underwriting is required for enrollment after new hire eligibility period.

Making Changes To Your Benefits

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

The following are examples of a qualifying life event:

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

Life event changes must be made within 30 days of the qualifying event.

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

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

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

Cut Costs, Not Care: Explore the New Marathon Health Center EPO Plan

A smarter, more affordable way to stay covered

Say hello to the new Exclusive Provider Option (EPO) Marathon Health Center Plan, designed to give you access to trusted care through the CareFirst network, with no deductible and cost-effective copays. This plan keeps things simple and budget-friendly by covering only in-network providers, helping you save without sacrificing quality.

Click here to find affordable, in-network providers!

See how the new plan compares...

	EPO Marathon Plan	Blue Choice Advantage
Payroll deduction *(per paycheck)*		
Employee	$58.80	$61.90
Employee + Child	$106.88	$112.54
Employee + Spouse	$152.38	$160.45
Family	$159.69	$167.95
Deductible		✓
Free primary care visit at Marathon Health Center	✓	✓
Annual physical must be received at Marathon Health Center	✓	
All care must be received in-network	✓	

Marathon Health Center — Convenient, Affordable, Medical Care

The Marathon Health Center provides personalized, low-cost (no-cost for medical plan members) care in a welcoming and supportive setting. Available to all employees and located at 2977 4-H Park Road, Ste. 202, Centreville, MD 21617.

Services include:

- Annual physical exams
- Health screenings
- Mental health support
- No-cost on-site lab work
- School and sports physicals
- Medications
- Sick and urgent care

Click here to schedule an appointment!

Your Cost for Health Coverage

Your PER PAYCHECK payroll deductions for medical, dental, vision and pharmacy coverages are shown in the tables below. Premiums are deducted pretax from 24 paychecks, September 2025 through August 2026. Actual payroll amounts below are for full-time employees only and may vary slightly. Part-time employees can view their rates by logging on to bswift (see page 4 for instructions) or calling Human Resources.

Medical, Dental, Vision, and Pharmacy Premiums

Exclusive Provider Option (EPO) Marathon Health Center Plan

Coverage Level	Full-Time	
	Employee	County
Employee	$58.80	$333.17
Employee + Child	$106.88	$605.65
Employee + Spouse	$152.38	$863.50
Family	$159.69	$904.91

Blue Choice Advantage (BCA) 85/15

Coverage Level	Full-Time	
	Employee	County
Employee	$61.90	$350.74
Employee + Child	$112.54	$637.75
Employee + Spouse	$160.45	$909.24
Family	$167.95	$951.72

Medical and Pharmacy Drug Coverage

QAC offers two medical plan choices through CareFirst BlueCross BlueShield which give you access to a quality network of practitioners and hospitals in Maryland, along with access to a national network. CareFirst does not require a referral, so you may receive services from any provider. However, the benefit you receive will be based upon the network status of the provider as well as the plan in which you are enrolled. All medical plans include dental, vision and prescription drug coverages at the same level of coverage elected for medical.

Exclusive Provider Option (EPO) does not provide coverage if you visit an out-of-network provider. If you do incur costs with an out-of-network provider, you will be responsible for 100% of the costs. In-network benefits are provided when you use Preferred Providers or In-Network Providers.

To enroll in the **EPO Marathon Health Center Plan**, **annual physicals must be completed** for both employee and spouse, if covered, at the Marathon Health Center, and Primary Care visits for non-Marathon providers are $50 per visit. Pediatric care visit copays for non-Marathon providers remain $20 per visit.

Blue Choice Advantage (BCA) costs less than the EPO and provides out-of-network coverage. This plan does require the deductible to be met before the plan contributes to most services. Preventive care is covered 100%, like other plans.

There is a $50 waiver credit per pay (24 pay periods) for full-time employees who waive medical coverage due to coverage through their spouse or other source.

Plan Features	BCA Medical Plan		EPO Marathon Health Center Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network ^
Calendar Year Deductible Individual/Family	$100/$200	$500/$1,000	None	No Coverage
Annual Calendar Year Out-of-Pocket Maximum* Individual/Family**	$2,000/$4,000	$3,000/$6,000	$1,600/$4,800	No Coverage
Lifetime Maximum	Unlimited	Unlimited	Unlimited	No Coverage
Copayments for Certain Services				
Office Visit	Deductible + $20 Copay	40% Coinsurance Subject to Deductible	$0 - Marathon provider $50 - Non-Marathon provider	No Coverage
Specialist Visit	Deductible + $40 Copay	40% Coinsurance Subject to Deductible	$40 Copay	No Coverage
Inpatient Admission	Deductible + 10% of Allowed Benefit	Deductible + 40% of Allowed Benefit	$100 per day $300 max per admission	No Coverage

Note: Non-participating providers may bill you the difference between the CareFirst allowed benefit and the provider's total charge.
^Annual physicals must be completed for both employee and spouse, if covered, at the Marathon Health Center.
*Plan has a separate maximum for medical and drug expenses, which accumulate independently.
**For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.

Plan Features	BCA Medical Plan		EPO Marathon Health Center Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Room	Deductible + $150 Copay	Deductible + $150 Copay	$150 Copay waived if admitted	No Coverage
Urgent Care	$50 Copay	$50 Copay	$50 Copay	No Coverage
Preventive Care, Screenings, Immunizations	No Member Liability	40% Coinsurance Subject to Deductible	No Member Liability	No Coverage
Diagnostic Test (X-ray, bloodwork)	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	$20 Copay	No Coverage
Physician/Surgeon Fee Outpatient	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	$30 Copay	No Coverage
Mental/Behavioral Health Inpatient Services	10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	$100 per day $300 max per admission	No Coverage
Prescription Drugs				
Prescription Annual Calendar Year Out-of-Pocket Maximum*	$5,100/$10,200		$5,100/$10,200	No Coverage
Retail	**(34-day supply)**		**(34-day supply)**	
Generic	$10 Copay		$10 Copay	No Coverage
Preferred Brand	$35 Copay		$35 Copay	No Coverage
Non-Preferred Brand	$50 Copay		$50 Copay	No Coverage
Mail Order	**(90-day supply)**		**(100-day supply)**	
Generic	$16 Copay		$16 Copay	No Coverage
Preferred Brand	$60 Copay		$60 Copay	No Coverage
Non-Preferred Brand	$90 Copay		$90 Copay	No Coverage
Maintenance Drugs	**(90-day supply)**		**(100-day supply)**	
Generic	$16 Copay		$16 Copay	No Coverage
Preferred Brand	$60 Copay		$60 Copay	No Coverage
Non-Preferred Brand	$90 Copay		$90 Copay	No Coverage

*Plan has a separate maximum for medical and drug expenses, which accumulate independently.

Medical Coverage Feature
CloseKnit: The Virtual Care Option

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

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

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

Pharmacy Coverage

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

Prescription Drug Copay: Brand Name vs. Generic Equivalent

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

Mail Service Is a Convenient Way to Get Your Prescriptions

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

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

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

Helps Save You Money: For two (2) copays through the mail service pharmacy, you will receive one (1) three-month supply of medication, saving money from having to fill three (3) one-month supplies at retail.

Dental Coverage

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

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

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

Dental Clinics

Going to the dentist just got easier! Queen Anne's County is excited to bring mobile dentistry to employees. These on-site clinics provide your routine cleaning offered by a CareFirst provider, Jet Dental! Watch for more information about the dental clinics from the Human Resources Department.

Vision Coverage

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

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

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

New in 2025-2026

1. New $50 Visionworks Bonus! Use your current frame allowance plus an extra $50 toward designer frames — exclusively at Visionworks.
2. Members no longer need to remember when they last utilized their benefits,

Finding an In-Network Provider

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

Vision Clinics

We're excited provide on-site Vision Clinics throughout the year to County employees and family members with our health insurance. Whether you need an updated prescription, a routine eye exam, or you're just curious if those late-night screen binges are affecting your eyes — this is your chance to get checked out by professionals without ever leaving the office. Watch for more information about from the Human Resources Department.

Mail Order Replacement Contact Lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses: easy, convenient purchasing online, and quick shipping direct to your door.

Warby Parker

Warby Parker has been an in-network retailer for CareFirst BlueCross BlueShield offering designer-quality prescription glasses (starting at $95), contacts, vision care exams, and vision tests. Warby Parker offers users the option to try up to five frames for free for five full days. You can shop for their eyewear online at warbyparker.com.

Hearing Aids Discount

Members have access to the largest hearing care provider network in the country and substantial savings on top-tier manufacturer brand devices and related professional services through the EPIC Hearing Service Plan. The EPIC network is comprised of professional audiologists and ENT physicians and represents the largest accredited network of its kind in the nation, with provider locations in all 50 states. Contact **EPIC** at 844-246-0544 or go to epichearing.com for more information.

Passport to Wellness

The Wellness Committee encourages full-time employees to participate in the Passport to Wellness and supports our efforts to enhance wellness throughout the County to:

- Improve and maintain your health, which is essential to enjoying a long life
- Reduce healthcare costs so that these dollars can be used for other purposes such as salaries, benefits and County services
- Increase the use of your preventive services: if you can identify an issue early on, it is much easier to correct with a higher success rate (remember there are no copays for preventive screenings)
- Have fun with your co-workers competing in events and you can earn $250!

CareFirst offers a variety of Wellness Programs; listed below are a few that may interest you and your family. These are free to you and any dependents enrolled in the health plan. To learn more, log in to My Account at carefirst.com/myaccount or call 877-260-3253.

CareFirst WellBeing Program

To get started, visit carefirst.com/wellbeing. Enter your CareFirst My Account username and password and complete the one-time registration to experience the customized CareFirst WellBeing program. Once you register, you can access your well-being resources from the web or download the CareFirst WellBeing app from the App Store or Google Play.

One-on-One Health Coaching

Members have access to personal health coaching. You may also receive a call inviting you to participate. Lifestyle coaching can assist with tobacco cessation, weight management, physical activity, stress management, and healthy eating. Disease management coaching is available for asthma, diabetes, coronary artery disease, congestive heart failure, COPD, chronic low back pain, osteoarthritis, atrial fibrillation, irritable bowel syndrome, and fibromyalgia. We encourage you to take advantage of this voluntary and confidential phone-based program that can help you achieve your best possible health by calling 877-515-2615.

Noom – Weight Management and Diabetes Prevention

Ready to join the millions of Americans already using NOOM? Now you can join NOOM at no cost as a CareFirst member. CareFirst is focused on whole health and aims to meet the needs of our members in all aspects of their lives. That's why we've made NOOM available through our well-being program. NOOM is designed to help you achieve and maintain a healthy weight. It can also help lower your risk for chronic conditions like diabetes. What makes NOOM different? Its approach. NOOM's personalized, psychology-based techniques will help you better understand your relationship with food. You'll be more mindful of habits and gain the knowledge and support needed to make lasting change. Ready to get started? Log in or sign up for CareFirst WellBeing. Once logged in, select You followed by Benefits. Next, click Health & Fitness and then NOOM.

SmartDollar™

When it comes to managing your finances and preparing for your financial future, it may be difficult to know if you're on the right track. Take control with SmartDollar. SmartDollar is a free online financial well-being program available through your CareFirst WellBeing program. Whether you want to stop living paycheck to paycheck, get out of debt, save for retirement, or send a child to college, SmartDollar can help. There's no cost to participate, so get started today!

Additional CareFirst WellBeing Platform Features

- RealAge Health Assessment — Determine the physical age of your body compared to your calendar age. You'll discover the lifestyle behaviors helping you stay younger or making you age faster and receive insightful recommendations based on your results.
- Personalized health timeline — Receive content and programs tailored to you.
- Challenges — Stay motivated by joining a challenge to make achieving your health goals more entertaining.
- Inspirations — Break free from stress, unwind at the end of the day or ease into a restful night of sleep with meditation, streaming music and videos.

Marathon Health Center

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

Services

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

Hours

Sun.	Closed
Mon.	10 a.m. - 6 p.m.
Tue.	7 a.m. - 5 p.m.
Wed.	10 a.m. - 6 p.m.
Thu.	7 a.m. - 5 p.m.
Fri.	8 a.m. - 12 p.m.
Sat.	Closed

Marathon Health

2977 4-H Park Road, Ste. 202
Centreville, MD 21617
410-989-9859

Hello Heart

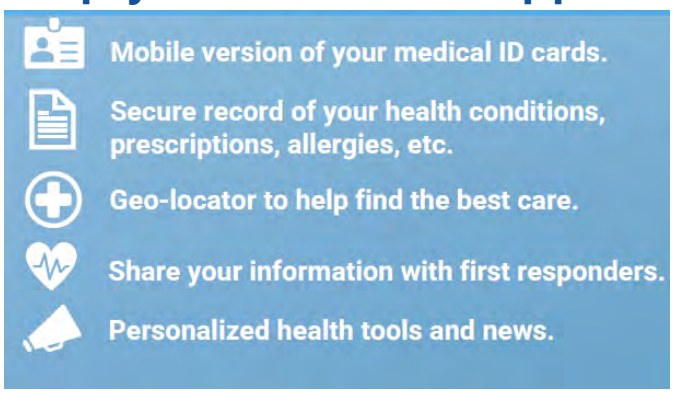
Hello Heart is available to CareFirst members and can be accessed through the Marathon Health Center. Hello Heart puts you in control of your heart health. Track blood pressure and cholesterol readings in one place and get personalized insights on how to improve your health. The easy-to-use app makes it fun to stay on track.

How will Hello Heart help me?

- No more guessing. Your **free** Hello Heart monitor pairs with your phone and automatically sends blood pressure readings to the app, so you can easily track trends over time.
- Get instant health readings, with clear explanations so you know what they mean. Want to share your health data and reports with your doctor? No problem.
- Hello Heart is all about **YOU**. Personalized insights, heart health tips, and easy-to-understand graphs so you can see how your daily choices may be impacting your heart health.
- Does that extra five minutes of walking really make a difference? It might. With Hello Heart, you can see how activity, weight, and medications may impact your readings.
- Enjoy your own privacy. The Hello Heart app is designed with technical and organizational controls to keep your data safe. You can share your info if you want, or not. Either way, you can use the app to access your health data whenever you need it.

For more information, please visit the local Marathon Health Center.

Simply Better Mobile App



Download the app today!
App code: QAC

sb health
simply better health

Accarent Health

What Is Accarent Health?

The Accarent Health program makes receiving exceptional care for complex medical procedures and treatments at the best hospitals in the country accessible and simple.

Why Choose Accarent?

Accarent Health provides access to over 230 specialized surgical procedures and treatments for adult and pediatric members, from a network of the highest-rated providers in the country, with no out-of-pocket cost to the patient. Accarent also offers dedicated case management, concierge benefits, and travel assistance.

How It Works:

Contact Accarent: When specialized medical care is needed, contact Accarent to speak with a personal case manager to learn more about your benefits through Accarent Health's Centers of Excellence program.

Choose Your Center of Excellence: Choose one of Accarent's highly rated academic medical centers or accredited providers to receive care.

Receive Care: Accarent's nurse case management team will assist you through the entire care episode and continue to support you for 30-120 days post-discharge to ensure satisfaction and a smooth transition to a local provider for follow-up care.

Interested in learning more or ready to discuss your options? Call **866-771-0697** or email **casemanagement@accarenthealth.com**.

Cancer Navigator

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

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

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

Accident Insurance (The Standard)

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

Accidents happen all the time. Whether you're working around the house or your child has an accident at soccer practice, accidents can be painful and costly. Even with medical insurance, there may be out-of-pocket expenses that you'll have to pay. Wouldn't it be nice to have money to offset those unexpected bills?

Did you know that:

- The accident plan pays cash directly to you to be used however you choose.
- This is a 24-hour policy, that covers on- and off-the-job injuries.
- You can cover yourself, your spouse, and your children.
- This policy pays an additional 25% benefit if your child (ages 18 and under) is injured while playing organized sports.
- Line of Duty Benefit provides an additional 100% of the accidental death, accidental dismemberment benefit, or accidental impairment benefit for public safety officers (police officers, firefighters, corrections officers, judicial officers, and officially recognized or designated volunteer firefighters).
- Includes a $50 Health Maintenance Screening benefit.

Benefits are payable for:

- Fractures, dislocations, cuts, and burns
- Emergency, urgent, and follow-up care
- Accidental death and dismemberment
- X-rays, MRI, CAT scans, and other tests
- Concussions, eye Injuries, and tendon, ligament, and disc repair

Example of how accident insurance works:

Lacrosse Match

It was going so well! Then, two girls collided. It didn't look too serious, but Olivia was limping badly and simply couldn't finish the game. A trip to the Emergency Room and bad news — a torn ACL meant surgery and rehab. Her season was cut short, but they would have plenty of help with the costs of treatment and recovery.

Emergency Room	$150
MRI	$200
ACL Repair	$750
Surgical Facility (outpatient)	$150
Rehabilitation Facility (outpatient – five visits)	$500
Subtotal	$1,750
25% Youth Organized Sports Benefit	$437.50
Benefits Paid	$2,187.50

Affordable Rates Per Pay:

Deductions are taken post-tax

Employee	Employee & Spouse	Employee & Child(ren)	Family
$4.84	$7.69	$9.14	$14.32

Click here or scan the QR code to watch a short video on how Accident Insurance benefits you and your family.

Hospital Indemnity Insurance (Transamerica)

A trip to the hospital can be costly.

Some trips to the hospital are planned, like having a baby or a scheduled procedure, but sometimes they are totally unexpected. And hospital stays are expensive: The average cost of a three-day hospital stay is around $30,000[1]. Hospital Indemnity coverage could help to pay for expenses of a hospitalization as brief as 20 hours.

Plan Features

Daily In-Hospital Indemnity Benefit

Pays $100 each day an insured person is confined to a hospital but not an emergency room, outpatient stay, or stay in an observation unit as the result of a covered accident or sickness. (Maximum 31 days per confinement.)

Hospital Confinement Indemnity Benefit Rider

Pays $1,500 for the first 24-hour period that an insured person is confined to a hospital but not an emergency room, outpatient stay or stay in an observation unit as the result of a covered accident or sickness. This benefit is limited to one payment per calendar year.

Critical Illness Indemnity Benefit Rider

Pays $5,000 to the insured employee (25% of employee benefit to dependents) if diagnosed with a critical illness (invasive cancer, heart attack, stroke, end stage renal failure or major organ failure). A subsequent benefit is payable when the insured is diagnosed with a different critical illness 60 or more days after the first diagnosis.

Outpatient Surgical Indemnity Benefit Rider

Pays $100 if an insured person undergoes outpatient surgery as the result of a covered accident or sickness. This benefit is limited to one payment per calendar year.

Skilled Nursing Indemnity Benefit Rider

Pays $100 each day an insured person is confined to a skilled nursing facility due to a covered accident or sickness. (Maximum 60 days per confinement/120 days per lifetime.)

Hospital Indemnity rates:

(not based on age or smoker status, deductions are taken post-tax)

Employee	Employee & Spouse	Employee & Child(ren)	Family
$13.06	$26.38	$18.71	$29.87

[1]Protection from high medical costs, healthcare.gov (2021)

Critical Illness Insurance (The Standard)

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

You may have medical insurance, but that doesn't mean you're covered for all of the expenses resulting from a serious illness that you probably haven't budgeted for — things like copays, loss of income, childcare, and travel expenses. Do you have enough in savings to cover the expenses from a Critical Illness?

Do you know:

- The policy pays you a lump sum benefit upon diagnosis.
- No health questions to enroll.
- You can elect up to $30,000 of coverage on yourself and your spouse (rates are based on your age and tobacco status).
- Your children under age 26 are automatically covered at 50% of your benefit amount.
- Includes a $100 Health Maintenance Screening benefit per calendar year per insured.

Example of how critical illness insurance works:

Robin learned that she had breast cancer, and upon her diagnosis, the policy paid a lump sum benefit of $10,000. Relieved of the financial worry, she could focus on getting well. The extra money would come in handy, and Robin could decide how she wanted to spend it. Medical expenses, alternative treatments, or that trip that she always dreamed of.

Age Range at Issue	Rates per Pay
18-29	$2.00
30-39	$3.05
40-49	$5.20
50-59	$8.25
60-69	$13.50
70-99	$23.25

Keep in Mind:

- Covered Conditions
  - Heart attack, stroke, cancer, paralysis, advanced MS, ALS
  - Major organ failure, end-stage renal failure, coma
  - Advanced Alzheimer's, bone marrow transplant, more
- 21 additional covered children's diseases
- Pays a 100% additional occurrence benefit if you are diagnosed with another covered condition after the first one
- Pays a 100% re-occurrence benefit if you have the same diagnosis at least 6 months after the initial diagnosis and have been treatment free
- Future purchases are based on your age when you buy your first Critical Illness policy — consider a starter policy to lock in your rate this year
- Deductions are taken post-tax

Click here or scan the QR code to watch a short video on how Critical Illness Insurance benefits you and your family.

Prepare for the Unthinkable

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

QAC provides Lincoln Term Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance to all full-time benefit-eligible employees. The coverage is automatic and the premiums are 100% employer paid.

Eligibility	Class 1 Less than 5 Yrs. of Service	Class 2 5 Yrs. to Less than 10 Yrs. of Service	Class 3 10 Yrs. to Less than 20 Yrs. of Service	Class 4 20+ Yrs. of Service
Coverage Effective Date	Date of Hire			
Benefit Schedule	1x Annual Earnings	1.25x Annual Earnings	1.5x Annual Earnings	1.75x Annual Earnings
Maximum Benefit	$350,000			
Minimum Benefit	$10,000			
AD&D Benefit	Matches Life Benefit			
Age Reduction Schedule	50% at Age 70			
Employer Contribution	100%			

Accelerated Benefit Provision: An active employee can elect a payment of up to 90% of his/her Basic Term Life Insurance if life expectancy is 12 months or less.

Whole Life Insurance with Long-Term Care (Unum)

An innovative plan that provides Life Insurance with built-in Long-Term Care benefits.

Just starting out? Growing your family? Thinking about retirement? This policy can be an important part of your overall financial wellness. It provides a life insurance benefit and could be used to pay for long-term care expenses. It eliminates the possibility of paying for coverage you may never use. That's why these hybrid policies have become so popular.

Did you know that:

- Most people outlive their employer-paid life insurance and need coverage for retirement.
- Qualification is easy; there are no exams, tests, or lengthy applications.
- You can lock in rates that will not increase with age.
- Coverage for yourself, your spouse, or both of you is affordable.
- Inexpensive coverage for kids is available too!

Here's how it works:

- You can choose the benefit amount that you want: as little as $10,000, up to $200,000. This is referred to as the face amount or death benefit.
- There is a second part of the policy, the cash value, that builds over time. It gives you many options that your group term benefit does not provide.
- The cash value earns a minimum of 3.75% interest annually.
- If you leave employment or retire, you can take the policy with you – the cost will not increase and the benefits will not decrease.
- You can borrow from the policy once it has developed a cash value.

Educate Yourself about the Need for Long-Term Care

If you are like most people, you know a relative, neighbor, or friend who needed Long-Term Care (LTC). LTC is for people who are challenged to take care of themselves; eating, dressing, bathing. Studies show that seven in 10 Americans over the age of 65 will need it at some point.[1] That's why the Unum plan automatically includes LTC benefits.

An Example:

Carol worked in the county government for 30 years. After several years of retirement, her health declined – so she entered an Assisted Living facility. It was not inexpensive, $3,000 a month, but she had planned ahead. The Unum policy would cover $1,800 of the cost – not the entire expense, but a good portion. And after the policy paid $30,000 of her LTC expenses, since she had elected the Restoration Rider* at enrollment, she still had the initial benefit to cover final expenses, and a little more.

$1,800 LTC benefit paid for 16.67 months	$30,000
Face amount of life insurance remaining	$30,000
Total value of whole life policy benefits	$60,000

*The Restoration Rider is an option available at the time of policy purchase only on the "Payments continue after age 70" plan. The rider replaces up to 100% of the face amount if the policy is used for LTC benefits. This rider is only available for issue ages of 15 to 60.

Please note:

- LTC benefits are available with the loss of two or more "activities of daily living" (ADLs).
- The ADLs are bathing, dressing, eating, continence, toileting, transferring, and severe cognitive impairment.
- LTC benefits are payable after receiving 90 days of qualifying care.
- The monthly benefits:
  - 4% for Home Health Care and Adult Day Care (25 months)
  - 6% for LTC and Assisted Living facilities (16.67 months)
- If you take a loan against your policy, any debt will be deducted:
  - From the Death Benefit otherwise payable at death
  - Upon payment or application of the Surrender Value

The easiest way to learn more about this unique benefit is to send an email to **service@boltonusa.com**.

[1] Long Term Care Planning - What is Long Term Care?, LTC Insurance Consultants (2021)

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts allow you to set aside pre-tax dollars for healthcare and/or dependent care expenses.

You must enroll each year in order to participate in an FSA.

FSA Contributions

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

Healthcare Flexible Spending Account (HC FSA)

FSA funds may only be used to pay for "out-of-pocket" medical, dental, vision and prescription drug expenses at any time without federal tax liability or penalty. **For the 2025 plan year, you may contribute up to $3,300 to your HC FSA.**

Dependent Care Flexible Spending Account (DC FSA)

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

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

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

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

- **$5,000 if single, or married, filing jointly**
- **$2,500 if married, filing separately**

Important Rules:

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

- Rollover Provision—Participants in HC FSA plans with unused funds at year end may carry over up to **$660** into the next year without changing the amount they can contribute.
- You must submit all eligible expenses no later than 90 days after the end of the plan year.
- If your employment ends during the year, you will have 90 days from your date of termination in which to submit claims for reimbursement for claims incurred prior to your date of termination.

FSA—Get Connected!

Visit: fba.wealthcareportal.com

- **Click new user**
- **Create your account**
- **Employee ID = SSN**
- **Employer ID = your FSA card number (FBAQACG)**

Important FSA Dates

- FSA Plan Year: 9/1/2025 to 8/31/2026
- Last Day to Incur Claims for Healthcare FSA: 8/31/2026
- Last Day to Incur Claims for the Dependent Care FSA: 11/15/2026
- Last day to Submit Claims for 2025/2026 election: 11/29/2026
- Up to $660 of unused HC FSA funds may roll forward into the new plan year.
    - Any unused HC FSA funds over this amount will be forfeited.
    - The roll-forward HC FSA funds may not be reflected in your HC FSA account until November 30 of each year

Protect Your Income!

Short-Term Disability (The Standard)

QAC recognizes an injury or illness could strike at any time and leave you unable to work. To protect you and your family financially, we offer voluntary Short-Term Disability (STD) insurance through The Standard.

Please see the two STD plan options offered in the chart below.

	Voluntary STD 29-Day Benefit Waiting Period	Voluntary STD 6-Day Benefit Waiting Period
Benefit Schedule	Pays 60% of regular weekly income	Pays 60% of regular weekly income
Maximum Weekly Benefit	$1,000	$1,000
Minimum Weekly Benefit	$15	$15
Benefit Waiting Period — Accident	29 Days	6 Days
Benefit Waiting Period — Sickness	29 Days	6 Days
Maximum Benefit Period	90 Days	90 Days
Guarantee Issue Amount	Full Benefit	Full Benefit
Employer Contribution	0%	0%
Taxability of Benefits	Non-Taxable	Non-Taxable
Partial/Residual Disability	Included	Included
Temporary Recovery	90 Days	90 Days
Maternity	Covered the same as any other illness	Covered the same as any other illness

- **Your STD benefit plus any sick time you use cannot exceed 100% of your Predisability Earnings (your income prior to becoming disabled). For more information please refer to the Certificate of Coverage in the Library.**
- For late enrollees of the Short-Term disability plan (employees not currently enrolled in the Short-Term Disability plan), there is a 60-day extended Benefit Waiting Period before benefits begin if the disability is due to disease, pregnancy, or mental disorder.
    - Benefit payments begin after the Benefit Waiting Period is met.
    - The extended Benefit Waiting Period does not apply to disabilities resulting from an accidental injury.
    - The extended Benefit Waiting Period only applies to disabilities that begin during the first 12 months you are covered.
- After 12 months, the usual Benefit Waiting Period based on the plan you elected will again apply.

For additional information on why the Short-Term Disability plan may be right for you, click here or scan the QR code to watch the video provided by The Standard.

Long-Term Disability

Some injuries or illnesses take longer to recover from. If you were unable to work for an extended period of time or unable to return to work permanently, Long-Term Disability coverage provides the money to help you get through.

Please see the two LTD plan options offered in the chart below.

	Voluntary LTD 40% Benefit	Voluntary LTD 60% Benefit
Benefit Schedule	Pays 40% of regular monthly income	Pays 60% of regular monthly income
Maximum Monthly Benefit	$6,000	$6,000
Minimum Monthly Benefit	$100	$100
Benefit Waiting Period	90 Days	90 Days
Maximum Benefit Period	To age 70	To age 70
Guarantee Issue Amount*	Full Benefit	Full Benefit
Employer Contribution	0%	0%
Taxability of Benefits	Non-taxable	Non-taxable
Own Occupation Period	24 Months	24 Months
Partial/Residual Disability	Included	Included
Pre-existing Condition Period	3/12	3/12
Mental & Nervous Limitation	24 Months	24 Months
Substance Abuse Limitation	24 Months	24 Months
Other Limited Conditions	24 Months	24 Months
Return to Work Incentive	12 Months	12 Months
Employee Assistance Program	Included: 3 Face-to-Face	Included: 3 Face-to-Face

*Evidence of Insurability is required for those already enrolled in the 40% benefit who elect to move to the 60% benefit.

- **Rehabilitation Plan Benefit:** Is included, which increases the LTD benefit amount by 10% of predisability earnings, not to exceed the maximum benefit, when member is participating in an approved rehabilitation plan. This benefit will also assist in paying for approved expenses incurred by a disabled member as part of an approved rehabilitation plan.

- **Survivors Benefit:** Pays a lump sum equal to three times the non-integrated LTD benefit.

Norton LifeLock

Identity theft occurs every 22 seconds in the U.S., with a median financial loss of $500. Everyday things like online shopping, banking and even browsing can expose your personal information and make you more vulnerable to cybercriminals. Think about protecting your identity, personal information, and connected devices from the threats that you face in digitally connected homes, workplaces and when using public Wi-Fi. Norton LifeLock can make you safer in today's connected world with comprehensive identity theft protection and a whole lot more:

The Benefit Essentials plan provides:

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

You Pay Per Paycheck:

Individual	Family
$4.00	$7.99

Additional Benefits

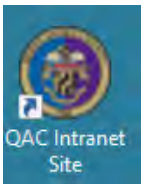
Employee Access Portal

The Employee Access Portal is a gateway to information for employees. Through this portal employees have access to view leave time, pay stubs, direct deposit and W-2s. Employees can make changes to their address, telephone number, and emergency contact. There are informational notices posted along with helpful resources.

SCAN ME

County Intranet

The County Intranet is available on County computer systems by clicking on the QAC Intranet Site icon. On the Intranet, employees will find policies, forms, the employee handbook and job descriptions. There are links to valuable resources such as the Employee Access Portal, bswift, health benefits, IT Support, and many more.



Everbridge

Everbridge is a communication system used by the county to quickly send important messages to employees. It delivers messages through several channels, including voice calls, text messages, and emails. This multi-channel approach ensures that even if one method isn't available, the message can still reach you through another. Everbridge is used for both routine and urgent notifications. Routine messages might include updates about upcoming employee events, while urgent messages could involve weather-related emergencies, office closures, or other serious incidents. In the event of a major emergency, Everbridge may be the first way you hear about it, so it's important to understand how it works.

State Employees' Credit Union (SECU)

SECU offers checking and savings accounts, share drafts, new and used car loans, home mortgage loans, and many other services. For more information, please go to **secumd.org**.

Educational Assistance

Full-time employees have the option of seeking educational development. The County supports education by providing reimbursement for courses related to the employee's position, up to $4,500 annually for undergraduate courses and up to $5,500 annually for graduate courses, for employees who successfully complete the probationary period. To find out more, please contact Human Resources at **410-758-4406**.

Blood Bank

Employees may participate in the group Blood Bank plan offered through the Blood Bank of Delmarva. If you are interested in membership, please go to **DelmarvaBlood.org**, or call **888-825-6638**.

Facebook Wellness Page

QAC Employee Wellness Initiative Group Facebook Page is a private FB Group designed especially for County employees. It is a place where you can find an assortment of health and wellness information to support your journey to wellness. It is available to you and your family members. To access the FB Group, click on this link **facebook.com/groups/qacemployeewellness/** and then click the blue button on the right that says "Join Group". You will then be prompted to answer a few questions, so we know who you are.

Worker's Compensation

All employees are covered by Worker's Compensation for injuries or illnesses occurring while performing normal work duties. For more information, refer to the Work-Related Injury or Illness Policy.

YMCA

We are offering no joining fee and 20% membership discount for Queen Anne's County Government Employees. Proof of County employment must be provided.

Additional Benefits *continued*

Vacation Leave

Full-time employees earn vacation time based on years of service as outlined below. Vacation leave is prorated for part-time employees.

- The first five full years of service: 96 hours a year (eight per month)
- Between six and 10 years of service: 120 hours a year (10 per month)
- Between 11 and 20 years of service: 160 hours a year (13.36 per month)
- After 20 years of service: 200 hours a year (16.64 per month)

Employees accrue vacation time in accordance with this schedule from date of hire and may begin using this time following three months of employment.

Sick Leave

Full-time employees earn 10 hours of sick leave for each full calendar month of employment. Sick leave is prorated for part-time employees. Sick leave can be accumulated toward employee's retirement in that every 22 days of sick leave is counted as one month of service toward retirement. The County allows transfers of sick leave from other Maryland government agencies with one year of full-time employment.

Personal Leave

Annually in January, full-time employees receive 40 hours of personal leave to use during the calendar year. For employees hired mid-year, the personal hours are prorated. Personal leave is prorated for part-time employees.

Holidays

Full-time employees receive 13 paid holidays annually plus an additional holiday in an election year. Holidays are prorated for part-time employees. The recognized holidays are:

- New Year's Day
- Dr. Martin Luther King, Jr. Day
- President's Day
- Good Friday
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Columbus Day
- Election Day (when applicable)
- Veteran's Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day

Additional Benefits *continued*

Employee Assistance Program (EAP)

We recognize you may experience issues that affect your quality of life at home and at work. The Employee Assistance Program (EAP) is available to full-time employees and your household family members 24 hours a day, seven days a week by calling Business Health Services at **800-327-2251**, or going online at **bhsonline.com** (User ID is ESMEC).

The EAP Can Help with Many Issues Including:

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

Program Benefits Include:

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

Benefits are free, voluntary, and confidential. For more information about the EAP services, contact Business Health Services or see your Human Resources Representative.

Retirement Plans—Planning Your Future

Pension Plan

QAC is a proud member of the Maryland State Employees' Retirement System. Full-time employees are enrolled in the plan and contribute 7% of base salary on a pre-tax basis. Likewise, the County contributes to the retirement system. Employees hired on or after July 1, 2011, are vested after 10 years of service with full retirement benefits.

The Law Enforcement Officers' Pension System (LEOPS) is offered to sworn personnel working for the Queen Anne's County Office of the Sheriff and Eligible Emergency Services Providers. The employee contribution is 7% for the LEOPS plan. Service retirement is age 50 or 25 years of eligibility service at any age.

The Correctional Officers' Retirement System (CORS) is offered to Correctional Officer personnel at the Queen Anne's County Department of Corrections. The employee contribution is 5% for the CORS plan. Service retirement is age 55 with at least 10 years of service credit or 20 years of service credit regardless of age.

Deferred Compensation

To enhance retirement savings, employees have the option of participating in a deferred compensation program, also called a 457 plan. A 457 plan allows employees to set aside funds on a pre-tax basis. Voya is QAC's 457 plan provider. The County also provides a match to a 401(a) to employees actively participating in the 457 plan. The match has a 5-year vesting schedule and the amount is determined annually by the County Commissioners.

Questions?

Your Benefits Contacts

Benefit	Contact	Phone	Website or Email
General Benefit Questions	Human Resources	410-758-4406	qachr@qac.org
bswift Online Enrollment	Bolton	844-850-3380	service@boltonusa.com
Medical & Dental	CareFirst	877-691-5856	carefirst.com
Prescription Claims Retail & Mail Order	CareFirst Pharmacy	800-241-3371	carefirst.com/rx
Vision	Davis Vision	800-783-5602	carefirst.com
The Standard Accident	The Standard	800-634-1743	standard.com
Transamerica Hospital Indemnity	Transamerica	888-763-7474	transamericabenefits.com
The Standard Critical Illness	The Standard	800-634-1743	standard.com
Unum Whole Life Insurance with Long Term Care	Unum	800-635-5597	unum.com/employees
Disability Insurance	Bolton	844-850-3380	service@boltonusa.com
Flexible Spending Account	Flexible Benefits Administrators	800-437-3539	fba.wealthcareportal.com
Identity Management Services	Bolton	844-850-3380	service@boltonusa.com
County Life Insurance	Lincoln Financial Group	800-423-2765	lincolnfinancial.com
Employee Assistance Program	Business Health Services	800-327-2251	bhsonline.com
Pension Plan	Maryland State Employees' Retirement System	800-492-5909	sra.maryland.gov
Deferred Compensation	Voya	410-507-5273	robin.gibbons@voyafa.com
Accarent	Accarent	866-771-0697	accarenthealth.com
Cancer Navigator	Cancer Navigator	410-988-3797	
Marathon Health Center	Front Desk	410-989-9859	clients.marathon.health/qachealth

Annual Notices

Medicare Part D - Creditable Coverage

Important Notice From QAC About Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For further information contact Human Resources Department at 410-758-4406. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through QAC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

HIPAA Notice of Availability of Privacy Practices

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

HIPAA Notice of Special Enrollment

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

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

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

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

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

Waiver of Coverage

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

To request special enrollment or obtain more information, contact Human Resources.

Women's Health & Cancer Rights Act (WHCRA)

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

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit[1].

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

How Can I Get More Information?

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

PART B: Information About Health Coverage Offered by Your Employer

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

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the Department of Labor website, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Coordination of Benefits (COB)

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

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

Model Wellness Program Disclosure

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

General Glossary of Terms

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

Flexible Spending Account (FSA)	Flexible Spending Account (FSA) allows you to set aside pre-tax dollars for unreimbursed medical, prescription, vision, and dental expenses, and dependent care costs.
Generic Drug	A drug that may be sold under more than one name, by more than one company.
Guaranteed Issue	A provision that allows you to purchase insurance coverage regardless of the health of you and/or your spouse.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.
Medical Evidence of Insurability	If you do not purchase life insurance, long-term disability insurance, or Whole Life with long-term care insurance when it is first offered, or within 30 days of your date of eligibility, you must complete a health questionnaire in order to be approved for the plan, thus providing evidence that you are insurable. The insurance company will review your health information and determine whether or not they will provide coverage to you. The insurance company may take several months to determine whether or not they will provide you with coverage.
Non-Preferred Provider	A provider who does not have any agreement with your insurance plan to accept copays or reduced fees for services rendered.
Open Enrollment	See "Annual Benefits Election."
Out-of-Network Benefits	Benefits that are paid at a lower level when you use out-of-network providers.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for QAC this is from September 1 to August 31 of the following year.
Pre-Existing Condition	Any condition for which the patient has already received medical advice or treatment prior to the effective date of a new insurance plan. Benefits for this condition may not be paid for the first 12 months of coverage. See specific plan details of the benefit plan for more information.
Preferred Provider	A provider who has contracted with your insurance company to be paid directly for covered services, and who will accept the allowed benefit as a payment in full. Also referred to as a participating provider, or an in-network provider.
Prescription Drugs	Allergy serums, biologicals, prescription drugs, and injectable insulin that are approved by your Insurance company, or that by law must be dispensed with a prescription.
Qualifying Event	An occurrence that entitles a person to select or change benefits outside of a defined "Open Enrollment" period. Events could include but are not limited to termination of employment, death of a covered person, marriage, divorce, birth, adoption, Medicare eligibility, a dependent child's loss of dependent status, or commencement of or return from an unpaid leave of absence (see page 7 for more details)

Notes:


Queen Anne's County
HUMAN RESOURCES
WHERE SHORE LIVING BEGINS