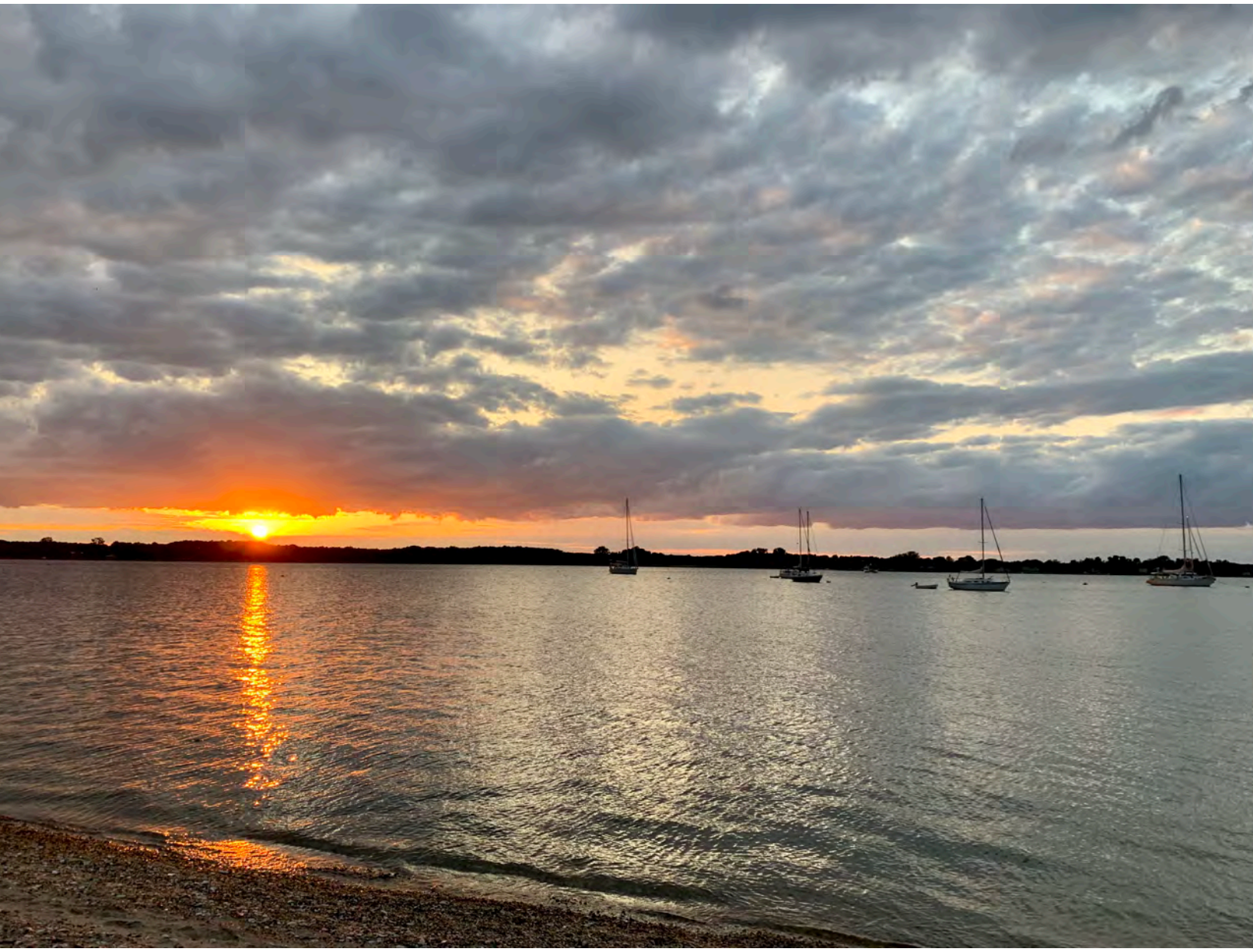
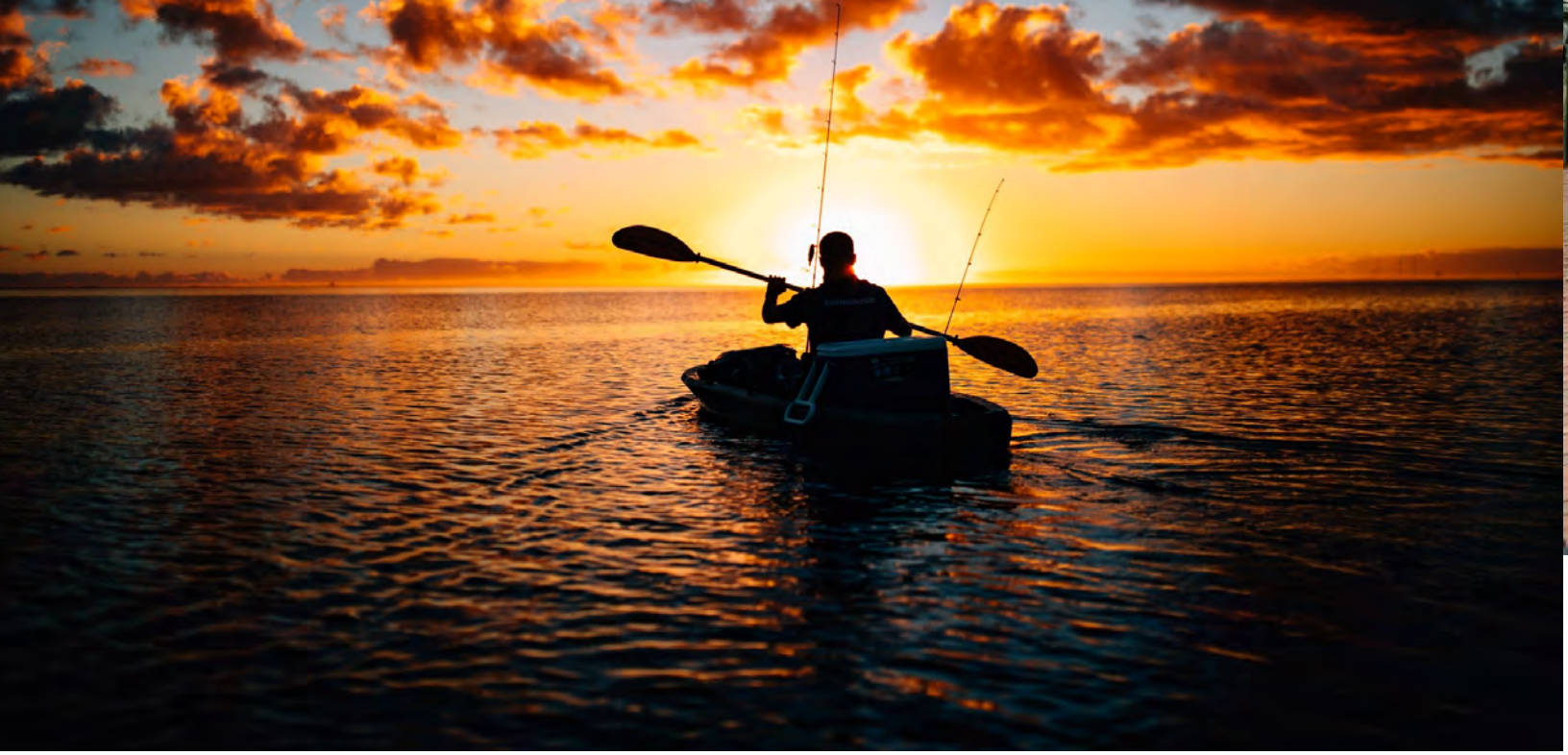


2020-2021

BENEFITS OVERVIEW GUIDE

Talbot County Public Schools

Building lives, creating futures



CONTENTS

Welcome to Your Talbot County Public Schools (TCPS) Benefits

TCPS takes pride in offering a comprehensive and competitive benefits package to our employees. TCPS, 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.

2020 Open Enrollment

- Open Enrollment is Tuesday, May 26 through Friday, June 5, 2020.
- We have an online enrollment platform, PlanSource, that all current employees will use for Open Enrollment (see page 5 for more details).
- All benefits run on a September 1, 2020 – August 31, 2021 plan year.
- Benefit changes must be submitted through PlanSource and will be effective for the September 1, 2020 - August 31, 2021 plan year.
- Due to the Social Distancing guidelines in place in MD, Decision Support Specialists will only be available over the phone to assist you with your enrollment. Please see more details on enrollment options under "How to Enroll" on page 5.
- While this is not an active enrollment year, you must enroll annually in the Flexible Spending Account plans and the YMCA programs to participate.
    - On March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The Act includes a provision that allows all over-the-counter products to be qualified as medical expenses. Menstruation care products have also been added as an additional over-the-counter category.
- TCPS is pleased to offer a variety of Supplemental Benefit plans, including Short-Term and Long-Term Disability, Whole Life with Long-Term Care, Critical Illness, and Accident. Please review the full benefits of each of these plans in this benefit guide.
- TCPS continues to evaluate ways to improve the quality of your health care and keep our health plans competitively priced, while controlling costs for you and TCPS. We encourage staff to become and remain engaged in these efforts by being educated on the plans and using them wisely. Be sure to participate in Employee Wellness programs and activities, and partner with your physician to get appropriate preventative screenings. Also, consider programs like mail order pharmacy and generic prescriptions to lower your copays and overall plan costs.

It is important to take time to review the plan options available to you prior to making your selections. Consider each benefit and the associated costs carefully and choose the benefits package that will meet your and your family's needs throughout the year.

This benefits guide describes the highlights of our benefits in non-technical language. Our specific rights to benefits under the plan are governed solely, and in every respect, by the official 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 document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules as decided by TCPS.

Benefits Eligibility

Employee Eligibility

All regular employees, as defined by TCPS, are benefits eligible. Beginning **September 1, 2012**, new guidelines determined the appropriate level of hourly support services employee benefits.

Employees hired before **September 1, 2012,** continue to receive their current level of benefits, provided they work the same number of hours. If they work fewer hours, they will be governed by the new level of benefits.

- A Part-time employee is a person who works more than 4 hours, but less than 5 hours per day or less than 25 hours per week. This employee is entitled to half-time benefits.
- A Full-time support services employee is a person who works 5 or more hours per day or 25 or more hours per week. This employee is entitled to full-time benefits.

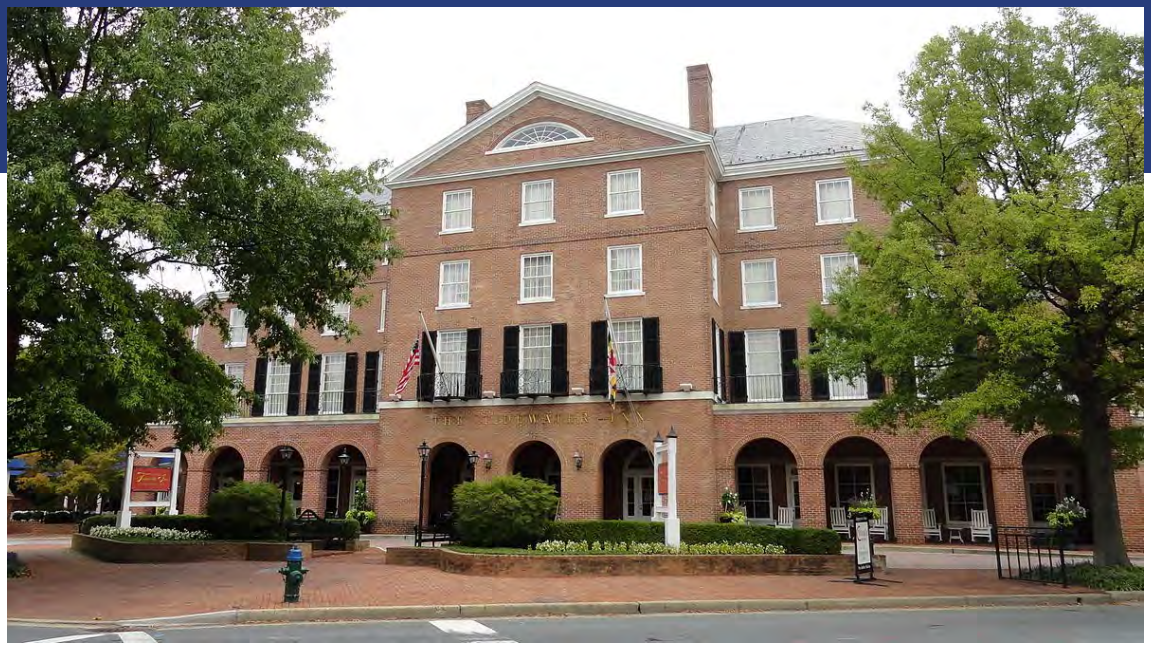
Dependent Eligibility

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. Refer to the Dependent Eligibility Documentation Requirements on PlanSource for more details. You will be required to verify your dependents on PlanSource as part of the new enrollment process. For any new dependents, you will be required to provide the appropriate documentation before they will be added to coverage. Grandchildren are not eligible dependents under this plan.

When to Enroll

Open Enrollment: You can enroll during the annual Open Enrollment period. This year Open Enrollment will run from May 26 through June 5, 2020. Coverage for all benefits will be effective on September 1, 2020.

New Hire: You must enroll within 30 days of your eligibility/hire date. If you don't enroll for coverage within 30 days of your eligibility date, you won't receive health coverage during the plan year, unless you have a qualifying life event (see Making Changes on page 5 for details). Coverage begins on the 1st of the month following your date of hire.



How to Enroll

TCPS has partnered with Stratovize to administer our Benefits Enrollment System (PlanSource) and conduct our Open Enrollment. You may self-enroll on PlanSource by following the Online Enrollment Instructions below. If you would like assistance with making your elections and completing your enrollment on PlanSource, you may schedule a phone call with a Stratovize Decision Support Specialist by following the instruction to the right.

If you don't need enrollment assistance but have a question or need your password reset, or are having technical issues, please send an email to **service@stratovize.com** outlining your request and a Customer Service Representative will assist you.

Online Enrollment Instructions

PlanSource allows you to access your benefits information and enroll online. Go to https://benefits.plansource.com to enroll.

Step 1: Sign in to PlanSource

Username: Your username is the first initial of your first name, up to the first six characters of your last name, and the last four of your Social Security Number (SSN). For example: If your name is Jane Anderson and the last four digits of your SSN are 1234, your username would be janders1234.

Password: Your birthdate in YYYYMMDD format. For example: If your birthdate is August 14, 1962, your password would be 19620814. At your initial login, you will be prompted to change your password.

Step 2: Launch Enrollment

Click on "Get Started" to begin. You will review your profile and family information next. When complete, select "Next: Shop for Benefits."

Step 3: Enroll

On the benefits dashboard you will see available options in the middle of your screen. Your elections from 2019 have been copied to 2020 except for Health FSA, Dependent Care FSA and YMCA. Benefits requiring an election will be marked as "Shop Plans" or "Review and Confirm". Benefits marked "Change Plan" or "View Summary" have been copied from the current year and can be changed if you wish.

The total benefit cost, per pay period, will appear in the upper right side of the enrollment screen in your Shopping Cart. Click on "Shop Plans" to review the options for each benefit. Select "Update Cart" after each election has been made until you each the final page called "Current Benefit Elections."

Step 4: Confirm Enrollment Selections

If beneficiaries are missing for any benefits for which they are required, you will be prompted to add them before you can check out.

Decision Support Specialists will be available to assist you over the phone with your enrollment from 8:00 am to 8:00 pm Monday through Friday from May 26 through June 5.

All calls will be scheduled for 30 minutes and you will be contacted at the appointed time based on the phone number you provide in the online meeting scheduler. Enter 'TCPS' as your School District when making an appointment.

At the beginning of the call, to verify your identity, you will need to provide your username and password as outlined below in: **Step 1: Sign in to PlanSource**

If you are adding any dependents or making any beneficiary changes, please gather that information in advance of the call.

Click here to schedule a call with a Decision Support Specialist or go to **https://go.oncehub.com/ESMEC**

Enrollment Reminders

- While this is not an active enrollment year, you must enroll annually in the Flexible Spending Account plans and the YMCA programs to participate.
- Beneficiary designations for all life insurance plans will be stored in PlanSource. Please make sure to update this information as you go through the enrollment process to ensure you have current beneficiaries in place.

Making Changes

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

You have 30 days to make changes to your coverage.

Step 4 (contd) Once you have added/updated your beneficiaries, you will click "Review and Checkout" to proceed to the next page where you will review your elections. Click "Checkout" to complete your enrollment. Changes will NOT be submitted unless you click "Checkout." You will have the option to generate a confirmation statement once your enrollment is complete. Remember, you can return at any time through the end of the enrollment period to review or make additional changes.

Your Cost for Health Coverage

Your per PAYCHECK payroll deductions for medical, pharmacy, vision, and dental coverage are shown in the tables below. Premiums from the tables below are deducted from 24 and 20 paychecks, respectively. Actual payroll amounts may vary slightly.

Medical, Pharmacy and Dental Premiums (Full-time Employees)

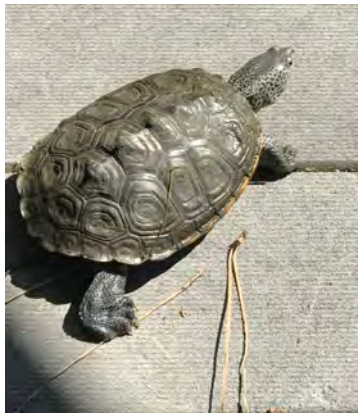
Exclusive Provider Option (EPO)				
	24 Pays/Year		20 Pays/Year	
Coverage Level	Board	Employee	Board	Employee
Individual	$280.10	$49.43	$336.12	$59.32
Parent/Child	$551.83	$97.38	$662.19	$116.86
Husband/Wife	$674.00	$118.94	$808.79	$142.73
Family	$767.19	$135.39	$920.63	$162.46

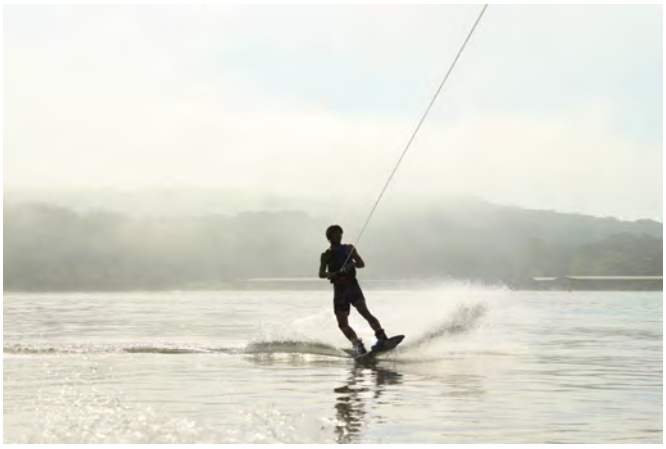
Preferred Provider Option (PPO)				
	24 Pays/Year		20 Pays/Year	
Coverage Level	Board	Employee	Board	Employee
Individual	$294.26	$73.57	$353.11	$88.28
Parent/Child	$570.61	$142.65	$684.73	$171.18
Husband/Wife	$700.15	$175.04	$840.18	$210.05
Family	$803.56	$200.89	$964.27	$241.07

* For Regular Part-time employees, there is a 50/50 split per paycheck.

Vision Premiums (All Employees)

Blue Vision Plus		
Coverage Level	Board	Employee
Individual	$3.46	$0.00
Parent/Child	$5.05	$0.00
Husband/Wife	$6.68	$0.00
Family	$8.76	$0.00





Medical Coverage (includes pharmacy, dental, and vision)

You have a choice between two medical options: a Preferred Provider Option (PPO) and an Exclusive Provider Option (EPO). Both 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 benefits you receive will be based upon the network status of the provider as well as the plan you are enrolled in.

An EPO is essentially a PPO Plan that does not provide coverage if you visit an out-of-network provider. If you do incur costs with an out-of-network provider, you will be responsible for 100% of the cost. In-network benefits are provided when you use Preferred Providers or In-network Providers.

PPO covers care provided both inside and outside the plan's provider network. You will pay more out of your own pocket when you use practitioners who do not belong to the Preferred Provider Network. You will be required to pay a deductible and a greater portion of the cost of medical treatment. You may also need to file the claim.

When reviewing your benefit, 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—TCPS 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.

Plan Features	EPO Medical Plan		PPO Medical Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible Individual/Family	None	No coverage	None	$200/$600
Annual Out-of-Pocket Maximum* Individual/Family	$1,200/$3,600	No coverage	$800/$2,400	
Prescription Annual Out-of-Pocket Maximum* Individual/Family	$5,400/$9,600	No coverage	$5,400/$9,600	
Lifetime Maximum	Unlimited	No coverage	Unlimited	
Copayments for Certain Services				
Office Visit	$20 per visit	No coverage	$20 per visit	You are responsible for deductible & coinsurance for services by participating providers**
Hospital Facility	$40 per visit		$40 per visit	
Practitioner (at hospital)	$30 per visit		$30 per visit	
Well Care				
Adult Routine Physical Exam	100% of the "AB"	No coverage	100% of the "AB"	80% of "AB" after deductible
Routine GYN Exam				
Well Child Visits (guidelines apply)				NO deductible for Well Child Visits
Type of Service				
Hospital Inpatient Pre-admission review/ approval required	100% of "AB"	No coverage	100% of "AB"	80% of "AB" after deductible
Outpatient Diagnostic—Lab	100% of "AB" after $20 copay	No coverage	100% of "AB" after $20 copay	Paid in-network benefit**

* Plan has a separate max for medical and drug expenses, which accumulate independently.
** Non-participating providers can bill you up to total charges.
"AB" = Allowed Benefit

Plan Features	EPO Medical Plan		PPO Medical Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Radiation Therapy, Chemotherapy & Renal Dialysis • Facility Billed • Practitioner in Facility • Practitioner in Office	$40 member copay $30 member copay $20 member copay	No coverage	100% of "AB" after $40 member copay $30 member copay $20 member copay	80% of "AB" after deductible
Chiropractic Services (unlimited visits)	100% of "AB" after $20 copay	No coverage	100% of "AB" after $20 copay	80% of "AB" after deductible
Inpatient Mental Health	100% of "AB"	No coverage	100% of "AB"	80% of "AB" after deductible
Prescription Drugs: Retail (up to a 34-day supply)				
Generic	$7 copay	No coverage	$7 copay	
Preferred Brand	$24 copay	No coverage	$24 copay	
Non-Preferred Brand	$24 copay	No coverage	$24 copay	
Prescription Drugs: Mail Order (up to 34-day supply)				
Generic	$7 copay	No coverage	$7 copay	
Preferred Brand	$24 copay	No coverage	$24 copay	
Non-Preferred Brand	$24 copay	No coverage	$24 copay	
Maintenance Drugs: Retail Pharmacy (up to 100-day supply)				
Generic	$14 copay	No coverage	$14 copay	
Preferred Brand	$48 copay	No coverage	$48 copay	
Non-Preferred Brand	$48 copay	No coverage	$48 copay	

"AB" = Allowed Benefit

This is only a brief summary of the plans. For more details, including limitations and exclusions, please see PlanSource Benefit Library for a Summary Plan Description.

Pharmacy Coverage

Some prescription drugs require Prior Authorizations. Prior Authorization ensures you achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call to begin the prior authorization process. For the most up-to-date prior authorization list, visit Express Scripts at www.express-scripts.com.

Prescription Drug Copay: Brand Name vs. Generic Equivalent

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

Mail Service Pharmacy Helps Save You Money

The Mail Service Pharmacy offers a convenient way to fill prescriptions with fast, accurate home delivery. Plus, it's an easy way to save on your maintenance medications. Once you register at www.express-scripts.com, 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 Express Scripts Pharmacy Services at 855-778-1435 or by completing the Mail Service Pharmacy Order Form.

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 www.carefirst.com.

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

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

Healthy Vision—Take Good Care of Your Eyes

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: $45 allowance
**Davis Vision Collection Contacts: $40 copay

Finding an In-Network Provider

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

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.

Accident Insurance

- Every 10 minutes, over 750 Americans suffer an injury severe enough to seek medical assistance.[1]
- Most injuries are not work-related and therefore not covered by worker's compensation.[1]

Unum Accident Insurance is designed to help you meet your out-of-pocket expenses and extra bills resulting from an accidental injury. Coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Click here to watch a short video on *how* Accident Insurance benefits you and your family.

Examples of covered injuries include:

Broken Bones	up to $7,500
Burns	up to $10,000
Torn Ligaments	up to $1,200
Lacerations	up to $600
Eye Injuries	$300
Concussion	$150

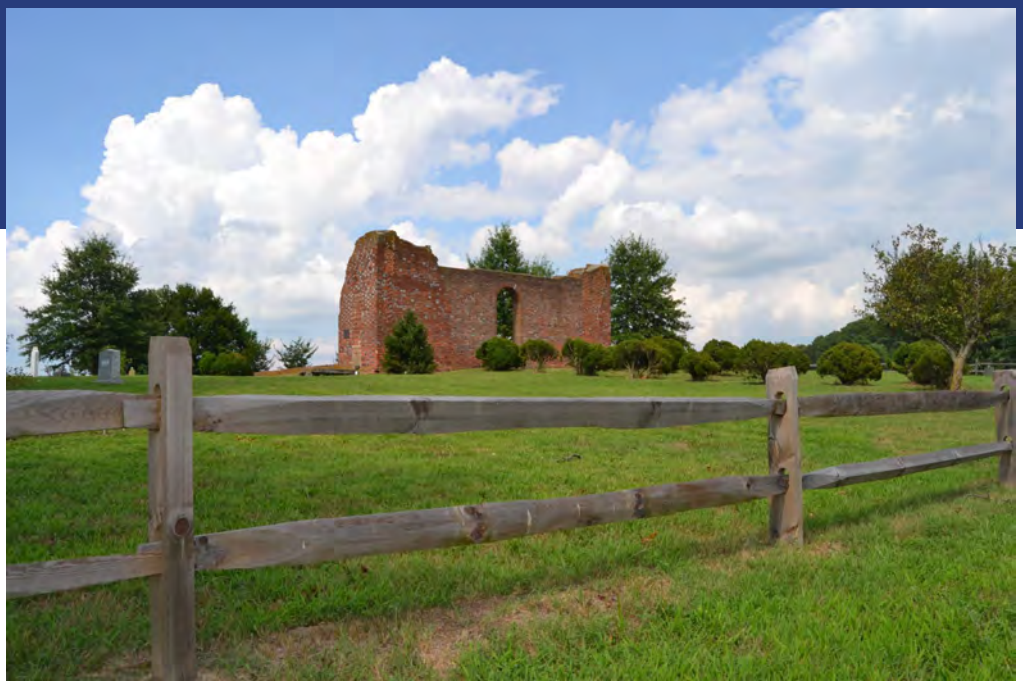
Some covered expenses include:

Emergency Room Treatment	$50
Outpatient Surgery Facility	$300
Physician's Follow-up Visits	$150
Hospital Admission	$1,000, $1,500 (ICU)
Hospital Confinement	$200/day
Physical Therapy	$25 x 10 visit

Additional benefits included:

- Sickness Hospital Confinement Benefit—Pays a daily benefit if an insured employee, spouse, or child is hospitalized for a covered illness.
- Wellness Benefit—Pays $100 per calendar year per insured individual if a covered health screening test is performed.

To view the Schedule of Benefits for a full list of covered injuries and expenses *or* to view the list of Health Screening Tests to earn the wellness benefit, see the PlanSource Document Library.



[1] National Safety Council, Injury Facts (2015)

Critical Illness Insurance

- Men have a 1 in 2 lifetime risk of developing some form of cancer. For women, the risk is 1 in 3.[2]
- On average, an American suffers a stroke every 40 seconds.[1]
- Every 25 seconds, an American will suffer a coronary event.[1]
- 60% of all bankruptcies are directly tied to medical conditions like critical illnesses.[1]

Critical Illness insurance can help relieve the financial impact of a sudden, life-threatening illness. Coverage helps pay expenses not covered by medical insurance including deductibles, copays, child care, loss of income, travel expenses, and more.

The Critical Illness plan provides:

- Premiums that are locked in at the age when you purchase the coverage—they don't increase as you age
- Guaranteed Issue coverage of up to $30,000 for the employee and $15,000 for the spouse
- Coverage for children automatically at 25% of the employee's elected amount
- No lifetime maximum payout
- Coverage for Advanced Multiple Sclerosis and Advanced Parkinson's Disease
- $100 Wellness benefit per insured per calendar year
- No Evidence of Insurability requirement when you enroll in any coverage amount this year or for any increase in future years up to the $30,000 maximum coverage—that means no health questions required to be answered. Plus, the rate at which you purchased your initial policy will be the rate used for the additional coverage.
- Reoccurrence benefit which can pay an additional 50% of the coverage amount for a subsequent diagnosis of the same critical illness (must be 12 months treatment-free between diagnoses)
- Pre-existing condition limitations have been waived. What does this mean? The insurance carrier, The Standard would not complete any investigation into the claim related to a pre-existing condition. If the claim meets the carrier's definition of a covered critical illness, then the carrier would pay the claim. However, the plan requires that the initial diagnosis of the critical illness be made while covered under the group policy.

For Example

John Doe purchases a Critical Illness plan with a 9/1/20 effective date. He started taking medication to treat high cholesterol and high blood pressure in July 2019. On 10/10/20, John had a heart attack. No investigation related to any pre-existing condition would be done and John's claim would be paid.

John Doe purchases a critical illness plan with a 9/1/20 effective date and the pre-existing condition exclusion is waived. He was diagnosed with cancer three months prior to the effective date. John submits a claim. The claim would be denied because the initial diagnosis of the cancer occurred prior to John being covered under the group policy.

[1] 2011 Heart and Stroke Update, Heart Association of America

[2]2011 Cancer Facts and Figures, American Cancer Society

Critical Illness insurance pays a lump sum cash benefit upon diagnosis of a covered critical illness. Covered illnesses include the following.

Cancer	**Stroke**	**Advanced Alzheimer's Disease*** **
Carcinoma in Situ*	**Coma**	**Advanced Multiple Sclerosis**
End-stage Renal (Kidney) Failure	**Paralysis—2 or more limbs**	**Advanced Parkinson's Disease**
Major Organ Failure**	**Loss of Hearing, Sight, or Speech**	**Amyotrophic Lateral Sclerosis**
Myocardial Infarcation (Heart Attack)	**Occupational Hepatitis**	**Benign Brain Tumor**
Severe Coronary Artery Disease with Recommendation of Bypass*	**Occupational HIV**	**Bone Marrow Transplant**

21 childhood diseases—Anal Atresia, Anencephaly, Biliary Atresia, Cerebral Palsy, Cleft Lip or Cleft Palate, Club Foot, Coarctation of the Aorta, Cystic Fibrosis, Diaphragmatic Hernia, Down Syndrome, Gastroschisis, Hirschsprung's Disease, Hypoplastic Left Heart Syndrome, Infantile Hypertrophic Pyloric Stenosis, Muscular Dystrophy, Omphalocele, Patent Ductus Arteriosus, Spina Bifida Cystica with Myelomeningocele, Tetralogy of Fallot, Transposition of the Great Arteries.

*Carcinoma in Situ and Severe Coronary Artery Disease with Recommendation of Bypass are paid at 25% of the coverage amount. All other critical illnesses are paid at 100% of the coverage amount.

**Major Organ Failure means an initial diagnosis of irreversible failure of the heart, liver, lung, small intestine, or pancreas as a result of a disease and for which a transplantation of the organ(s) or tissue from a suitable human donor is required.

***Advanced Alzheimer's Disease means a diagnosis of Alzheimer's Disease that has advanced to a permanent clinical loss of the ability to do all the following: remember, reason, perceive, understand, express, and give ideas.

Click here to watch a short video on *how* Critical Illness Insurance benefits you and your family.

Flexible Spending Accounts (FSAs)

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

FSA Contributions

When you elect an FSA, you contribute a portion of your salary to pay for health care 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 2020 plan year, you may contribute a minimum of $100 or up to a maximum of $2,750 to your HC FSA.**

Dependent Care Flexible Spending Account (DC FSA)

The Dependent Care Flexible Spending Account can be used to pay day care 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.

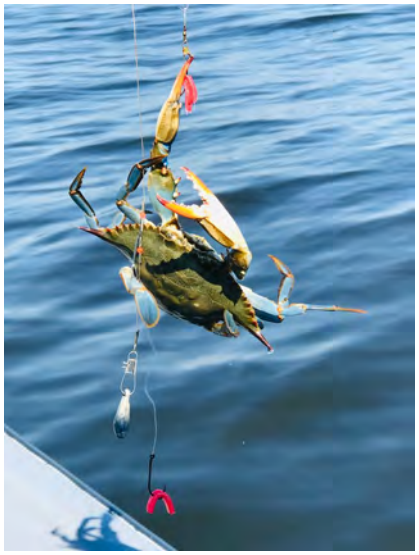
Dependent care expenses must be incurred to enable you (and your spouse if married) to work or look for work. Work may include actively looking for work but does not include unpaid volunteer work, or volunteer work for a nominal salary. Your spouse is considered to have worked if he or she is a full-time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

Expenses you pay for dependent care while you are off work due to illness are not eligible for reimbursement.

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

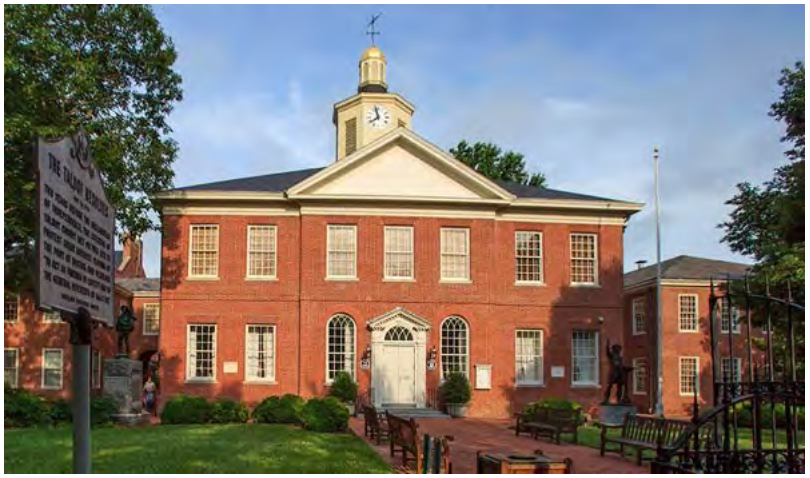
The maximum annual amount that you may contribute to the DC FSA is:

$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 plan year end may carry over up to $500 into the next plan year without changing the amount they can contribute.
- You must submit all eligible expenses no later than 90 days after the end of the plan year.
- If your employment ends during the year, you will have 90 days from your date of termination in which to submit claims for reimbursement for claims incurred prior to your date of termination.

FSA—Get Connected!

visit: https://www.mywealthcareonline.com/fba

- **Click new user**
- **Create your account**
- **Employee ID = 4-digit pin or SSN**
- **Employer ID = your FSA card number (FBATALB)**

Important!

Don't forget to review and update your beneficiary information as situations may change.

Log in to PlanSource to make changes.

Life and AD&D Coverage—Prepare for the Unthinkable

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

TCPS provides The Standard Basic Term Life insurance and Accidental Death & Dismemberment (AD&D) insurance to all benefit eligible employees. The coverage is automatic and the premiums are 100% employer paid.

Class 2: All employees hired before September 1, 2012 and all full-time employees hired on or after September 1, 2012.

Class 3: All part-time employees that work 4 or more hours per day, but less than 5 hours per day, hired after September 1, 2012.

An Accelerated Benefit is included: A member diagnosed with a Terminal Illness may withdraw up to 90% of their Life benefit to a maximum of $500,000 (when Basic Life and any Additional Life are combined), if their life expectancy is 12 months or less. Sick time must be used before utilizing your Long-Term Disability Benefit.

	Class 2	Class 3
Benefit Schedule	**1x Annual Earnings rounded to the nearest $1,000**	**50% of Annual Earnings rounded to the nearest $1,000**
Maximum Benefit	$100,000	$50,000
Guarantee Issue	Full Benefit	Full Benefit
AD&D Benefit	Matches Life Benefit	Matches Life Benefit
Employer Contribution	100%	100%

Supplemental Employee Term Life Insurance

You can purchase additional Term Life Insurance coverage for yourself and your family. Consider the cost of funeral expenses, legal expenses, and general living expenses for your surviving family members when choosing an appropriate amount of additional coverage.

	Employee	Spouse	Child
Benefit Schedule	Increments of $10,000	Increments of $5,000	Flat $10,000
Maximum Benefit	$500,000	$250,000	n/a
Minimum Benefit	$10,000	$5,000	n/a
Guarantee Issue (new hires only)	$200,000	$50,000	Full Benefit
Age Reduction Schedule	To 75% at age 70 To 66.67% at age 75	To 75% at age 70 To 66.67% at age 75	n/a
Employer Contribution	0%	0%	0%

- Members may enroll for the first time or elect an increase up to one increment ($10,000) without proof of good health during the Employer's designated Annual Enrollment Period. Keep in mind, Basic Term Life and Supplemental Life cannot exceed 6x your annual earnings.
- An Accelerated Benefit is included. Terminally ill members may withdraw up to 90% of their Life benefit to a maximum of $500,000 (when Basic Life and any Additional Life are combined), if their life expectancy is 12 months or less.

Whole Life Insurance with Long-Term Care

Whole Life Insurance can pay money to your family if you die. It can help them with basic living expenses, final arrangements, tuition, and more. Plan features include:

- True permanent life that combines Life Insurance, Long-Term Care Insurance, and a Savings Account all in one policy.
- For those age 50 and under as of 9/1/2020—an option to select a "Paid up at Age 70" plan design, in which if you make your monthly premium payments up to age 70 no premium payments are required after you turn 70 years old.
- Guaranteed 4.5% interest rate on the Cash Value Balance.
- You are able to select coverage for your spouse even if you do not elect coverage for yourself. You can elect coverage of up $50,000 for your spouse.

Click here to watch a short video on *how* Whole Life Insurance with Long-Term Care benefits you and your family.

The following example shows a 45-year-old employee who purchases a $20,000 Non-Smoker policy. The "Paid up at Age 70" plan may also be referenced to as the "Payments Stop at Age 70" plan by Unum. As well, the "Paid up at Age 120" plan may be referenced to as the "Payments Continue after Age 70" plan. The following chart shows an example of two enrollment scenarios.

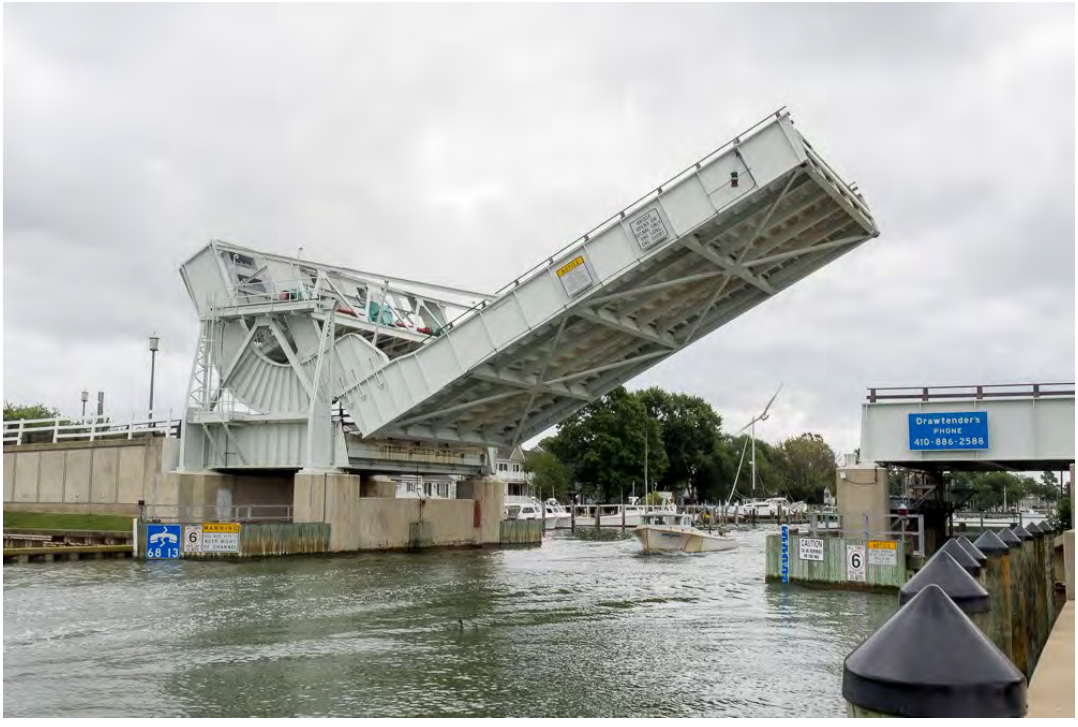
Carrier:	Unum	Unum
Plan	Paid up at 70	Paid up at 120
Age when purchased	45	45
Smoker status	Non-Smoker	Non-Smoker
Amount of coverage purchased	$20,000	$20,000
Monthly premium	$48.88	$38.04
Total premium paid up to age 70 (300 payments)	$14,664	$11, 412
Guaranteed Cash Value at age 70	$9,836	$7,042
Net premium paid (total premium minus cash value)	$4,828	$4,370
Average monthly premium paid (net premium/300 payments)	$16.09	$14.57

While the monthly premium is $48.88 and $38.04, respectively, for the two options, once you consider the Cash Value that has built up in the policy over time, the net monthly premium paid for the Life Policy and the Long-Term Care coverage is considerably less. Plus, the Cash Value continues to earn a guaranteed 4.5% annual interest rate, and you can take loans out against the Cash Value if needed. For the Paid up at Age 70 policy, no further premium payments would be required.

Please schedule an appointment with a Decision Support Specialist or send an email to service@stratovize.com if you have additional questions on the Whole Life Insurance plan or need assistance enrolling.

The Whole Life Insurance plan also includes the following benefits:

- Policy is portable; you can take this policy with you upon transition of employment or retirement at no additional cost.
- Premiums will never increase from the day you purchase the policy.
- Available Child Term Life Rider.
- Living Benefit Rider—automatically included at no extra premium on all policies purchased prior to the age of 66. This feature allows the policy owner to request up to 100% of the death benefit (to a maximum of $150,000) if the insured is diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout reduces the death benefit.
- Long-Term Care Rider—automatically included in this plan, it provides the benefits if a physician certifies the insured is functionally impaired and requires long-term care provided through nursing home care, assisted living facility, home health care, or adult day care. (This coverage is not available for issue ages over 70.)
    - This provides a monthly benefit for nursing home care or assisted living facility of the lesser of 6% (benefit percent may vary by state) of the policy face amount or $3,000.
    - This provides a monthly benefit for Home Health Care or adult day care equal to the lesser of 4% of the policy death benefit, the actual monthly costs for Home Health Care, or $1,500.
    - Benefits for long-term care will begin after the 90-day elimination period, subject to any pre-existing condition limitations defined in the rider. At this time, rider premiums will be waived.
    - Each benefit payment reduces the policy values by a proportional amount and is considered an early payout of the death benefit. The maximum benefit is equal to 100% of the death benefit, less any policy debt.
    - This is tax-qualified, which means that any benefits you receive will not be taxed.
- Option to Select: Restoration Rider—continues the benefits payable under the long-term care rider after all monthly benefit amounts under the base rider have been exhausted
    - Therefore, if you elect this Rider and have selected a $50,000 Whole Life Policy and you have exhausted the $50,000 Long-Term Care Benefits under the Long-Term Care Rider, this will provide a one-time restoration of your Death Benefit back to the original policy amount.
    - Not available on the "Payments Stop at Age 70" plan.
    - Issue ages are 15-60.



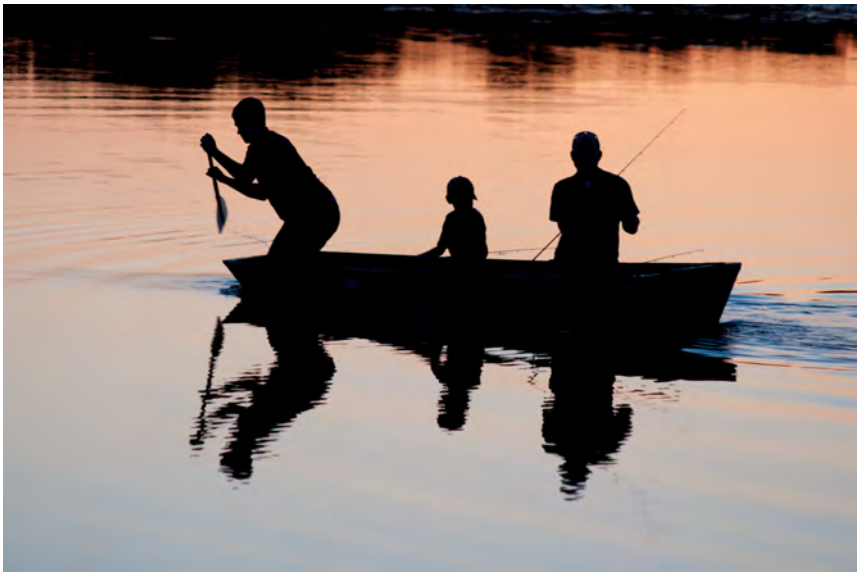
Short-Term Disability Insurance

TCPS recognizes an injury or illness could strike at any time and leave you unable to work. To protect you and your family financially in the event of a non-work-related injury or illness, TCPS offers a voluntary Short-Term Disability option that will coordinate coverage with the current voluntary Long-Term Disability plan offered through The Standard.

Highlights of the Short-Term Disability Plan:

- Pays a benefit of 60% of weekly pay up to a maximum weekly benefit of $1,750.00.
- Benefits are paid on a weekly, instead of a monthly, basis.
- There is a 30-day benefit waiting period for disability due to sickness or injury before benefits are payable. (Per the guidelines of the TCPS plan, you must first use any vacation or sick time available before receiving any benefits under the Short-Term Disability plan.)
- Pays a benefit for up to a maximum of up to 180 days.
- Benefit is Non-Taxable, so it is covering much more than 60% of your normal weekly pay.
- For employees enrolling in the Short-Term Disability plan for the first time during this 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. 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 for disabilities that begin during the first 12 months you are covered. After 12 months, the usual 30-day Benefit Waiting Period based on the plan you elected will again apply.
    - Example, if an employee who enrolls as a late entrant during Annual Enrollment effective 9/1/20 has a claim related to a disability related to disease, pregnancy, or a mental disorder beginning on 12/1/20, then there will be a 60-day Benefit Waiting Period before Short-Term Disability benefits will begin. If this member has a claim beginning on 9/2/2021, the Extended Benefit Waiting Period would not apply.
- New Hires: Pre-existing conditions are waived so if the qualified disability begins after your coverage begins, you are covered.
    - If the qualified disability begins after your coverage begins, you are covered. This includes coverage for pregnancy if the disability begins after coverage goes into effect.
- Coverage is offered on a Guaranteed Issue basis so there are no medical questions to answer.

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



Long-Term Disability Insurance

TCPS offers a Long-Term Disability plan with a 180-day benefit waiting period. The 180 days represent the time from which you first become disabled to the date you are eligible to begin receiving your disability benefits. Long-Term Disability is meant to provide protection for more significant disabilities. EOI is required for those not previously enrolled in the plan.

Highlights of the Long-Term Disability plan include:

- Pays a benefit of 60% of monthly pay up to a maximum monthly benefit of $8,000.
- Benefits paid monthly.
- Has a 180-day benefit waiting period for disability due to sickness or injury. (Per the guidelines of the TCPS plan, you must first use any vacation or sick time available before receiving any benefits under the Long-Term Disability plan.)
- Benefit is Non-Taxable, so it is covering much more than 60% of your normal monthly pay.

Pre-existing limitation provisions do apply to the Long-Term Disability plan. A pre-existing condition is defined as a mental or physical condition whether or not diagnosed or misdiagnosed:

- For which you've done or for which a reasonably prudent person would've done any of the following:
  - Consulted a physician or other licensed medical professional;
  - Received medical treatment, services, or advice;
  - Undergone diagnostic procedures, including self-administered procedures; and/or
  - Taken prescribed drugs or medications;
- Which, as a result of any medical examination, including routine examination, was discovered or suspected at any time during the 90-day period just before your insurance becomes effective.

You are not covered for a disability caused or contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition unless, on the date you become disabled, you:

- Have been continuously insured under the Group Policy for 12 months; and
- Have been Actively at Work for at least one full day after the end of that 12 months.

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

Maximum Benefit Period

If you become disabled before age 62, LTD benefits may continue during disability until you reach age 65, 3 years 6 months, or to Social Security Normal Retirement Age (SSNRA), whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins:

Age at Disability	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Additional Benefits-Because You Deserve More

2020-2021 School Year

Retirement

Eligible employees have seven percent (7%) of their annual salary deducted from their paycheck for retirement contributions. Retirement benefits may be received when sum of age and eligibility service equals 90 or at age 65 with 10 years eligibility service. After 10 years of service, employees are vested and benefits will not be lost. After one year of service, the State Retirement Agency matches an employee's salary for a life insurance plan.

Education Subsidies

The Board agrees to reimburse all unit members for twelve (12) credit hours earned per year **if approved prior to course registration.**

Teachers - The first (6) credits will be reimbursed at the rate of the then current Salisbury University per graduate credit cost. Additional credits will be reimbursed at the rate of two hundred and fifty dollars ($250) per credit.

Support Staff - The first nine (9) credits will be reimbursed at the rate of then current Salisbury University per graduate credit cost. Additional credits will be reimbursed at the rate of two hundred fifty dollars (250) per credit. A grade of A or B must be received and documented for reimbursement (In no case, however, shall a unit member be reimbursed for more than the actual tuition cost per credit hour.) Unit members working toward teaching degrees will be reimbursed at the current Salisbury University per graduate credit rate for (12) credit hours, and members working towards a teaching degree will be paid their regular salary during which time they are completing their required student teaching hours. A substitute will be hired to take their place during the student teacher period of time.

Sick Leave

Eligible employees are entitled to annual sick leave as follows: 13 days for ten-month employees; 14 days for 11-month employees; and 15 days for 12-month employees. Employees are entitled to an unlimited accumulation of sick leave. These days may be used at retirement to add to length of service. Two days (certified staff) or three days (support staff) of sick leave may be used each work year for personal leave that cannot be conducted outside of normal duty hours or on a non-duty day . Two days will be allotted without giving a reason. Each request must be submitted within 48 hours in advance. Such leave will be taken in increments of at least one half day. Employees who have not used any sick or personal leave during the Fiscal Year shall receive two additional sick days at the end of the Fiscal Year.

Family Illness

Eight days of sick leave may be used for illness of a family member (child, grandchild, spouse, parent, in-laws, brother, sister, grandparent), and/or other person(s) living regularly in the household.

Bereavement

Each employee is entitled to the following bereavement leave, including the day of the funeral, memorial service, or interment:

- Five work days following the death of a child, parent, brother, sister, spouse, grandparent, grandchild, in-laws, or member of the immediate household.
- One work day following the death of an aunt, uncle, niece, or nephew.

If an employee has personal leave available, they may, at their option, use up to two days in addition and in conjunction with the above, as long as the leave form is submitted upon return to duty.

Annual (Vacation)

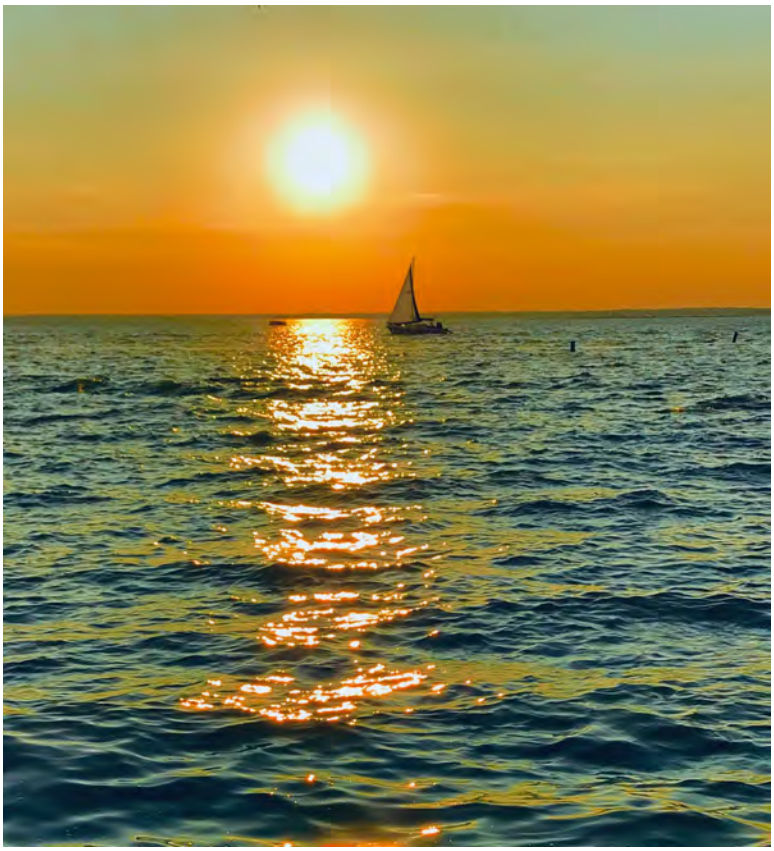
Twelve-month employees who work a 244-day work year may earn up to 20 vacation days per year. Refer to your handbook for a calculation of annual leave.

YMCA Participation

All full-time employees have the opportunity to participate in the YMCA through semi-monthly deductions from their paycheck. Enrollments after the end of the Open Enrollment period, June 5, 2020, will not qualify for the payroll deduction and will be handled directly by the YMCA. If you enroll in the YMCA program your enrollment is locked in for the full 12-month period. TCPS reserves the right to change the rates noted below if the YMCA changes their rates.

Membership Type	Annual	Subsidy	Your Total	# of Pay Periods	Deduction per Pay Period
1 Adult	$648	$120	$528	20	$26.40
1 Adult/1 Child	$720	$120	$600	20	$30.00
1 Adult/2+ Child.	$792	$120	$672	20	$33.60
1 Senior*	$552	$120	$432	20	$21.60
1 Senior/1 Child	$624	$120	$504	20	$25.20
1 Senior/2+ Child.	$696	$120	$576	20	$28.80
1 Teen	$408	$120	$288	20	$14.40
2 Adults	$840	$120	$720	20	$36.00
2 Adults/1 Child	$912	$120	$792	20	$39.60
2 Adults/2+ Child.	$984	$120	$864	20	$43.20
2 Seniors	$684	$120	$564	20	$28.20
2 Seniors/1 Child	$756	$120	$636	20	$31.80
2 Seniors/2+ Child.	$828	$120	$708	20	$35.40

* Seniors are persons 62+ years old



403(b) and 457(b) Plans-Planning for Your Future

403(b) Retirement Plan

When is the best time to start saving for retirement? Now. The sooner you begin planning for your retirement, the better! TCPS offers a 403(b) retirement plan designed for employees of public schools that allows participants to set aside additional money for retirement. Participation is voluntary. Personal pre-tax and/or post-tax contributions are added to your account conveniently through payroll deductions up to annual IRS limits. You decide how much to contribute and how to invest your contributions. The TCPS 403(b) plan offers investment choices with our approved vendors listed on the Contacts page.

403(b) Eligibility

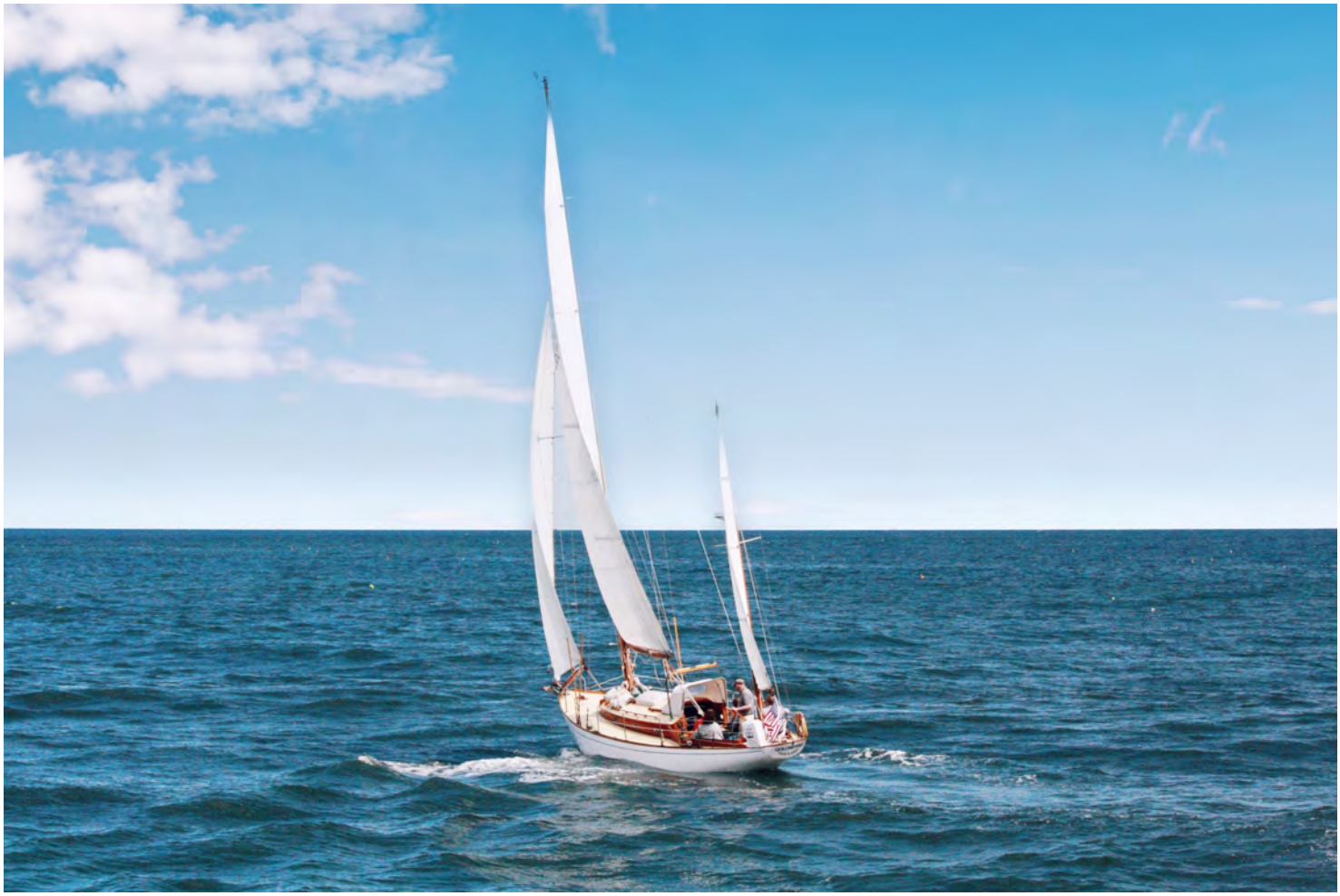
You are eligible to participate in the TCPS 403(b) plan at any time. You can increase, decrease, or discontinue personal contributions at any time. Contributions are 100% vested.

457(b) Retirement Plan

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

How a 457(b) Works

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



Educational Systems Federal Credit Union

1-800-356-6660

www.esfcu.org

Site Visit

Talbot County Education Center

First Monday each month

2:00 – 4:30 p.m.

Employee Assistance Program

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

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

The EAP Can Help with Many Issues Including:

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

Program Benefits Include:

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

For information about the EAP services, contact Business Health Services or see your Human Resources representative.

Business Health Services

1-800-327-2251

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

Questions?

Your Benefits Contacts

Benefit Plans	Contact	Phone	Website or email
PlanSource Online Enrollment	Stratovize	844-850-3380	service@stratovize.com
Medical	CareFirst	877-691-5856	www.carefirst.com
Carefirst District Office	CareFirst	410-742-3274	salisbury.do@carefirst.com
Prescription Claims Retail	Express Scripts Pharmacy	855-778-1435	www.express-scripts.com
Prescription Mail Order	Express Scripts Pharmacy	855-778-1435	www.express-scripts.com
Dental	CareFirst	866-891-2802	www.carefirst.com
Vision	Davis Vision	800-783-5602	www.carefirst.com
The Standard Critical Illness	Stratovize	844-850-3380	service@stratovize.com
Unum Accident	Stratovize	844-850-3380	service@stratovize.com
Basic & Supplemental Term Life Insurance	The Standard	800-348-3226	www.standard.com/group-life-add
Unum Whole Life Insurance with Long Term Care	Stratovize	844-850-3380	service@stratovize.com
Short-Term and Long-Term Disability	The Standard	800-348-3226	www.standard.com/group-life-add
Flexible Spending Account	Flexible Benefits Administrators	800-437-3539	www.mywealthcareonline.com/fba
403(b)	Ameriprise	443-837-1062	www.ameriprisefinancial.com
403(b)	Horace Mann	410-749-9100	www.horacemann.com
403(b)	VOYA	410-829-4714	www.voya.com
403(b)	MetLife	302-270-2632	www.metlife.com
403(b)	AIG Retirement Services	410-991-5022	www.AIG.com/RetirementServices
403(b) Roth	Horace Mann	410-749-9100	www.horacemann.com
403(b) Roth	VOYA	410-829-4714	www.voya.com
403(b) Roth	AIG Retirement Services	410-991-5022	www.AIG.com/RetirementServices
457(b)	TIAA-CREF	800-842-2776	www.tiaa.org/public/index
FSA	Flexible Benefit Administrators	800-437-3539	www.flex-admin.com
Federal Credit Union	Customer Service	800-356-6660	
United Fund	Barbara Lane	410-822-1957	

Annual Notices

Medicare Part D-Creditable Coverage

Important Notice from TCPS 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 TCPS 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. TCPS has determined that the prescription drug coverage offered by the TCPS 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 TCPS and enroll in Medicare prescription drug coverage, you may enroll back into the TCPS 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 TCPS 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 TCPS 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 19 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 the Human Resources Department at 410-822-0330. **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 TCPS 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 www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

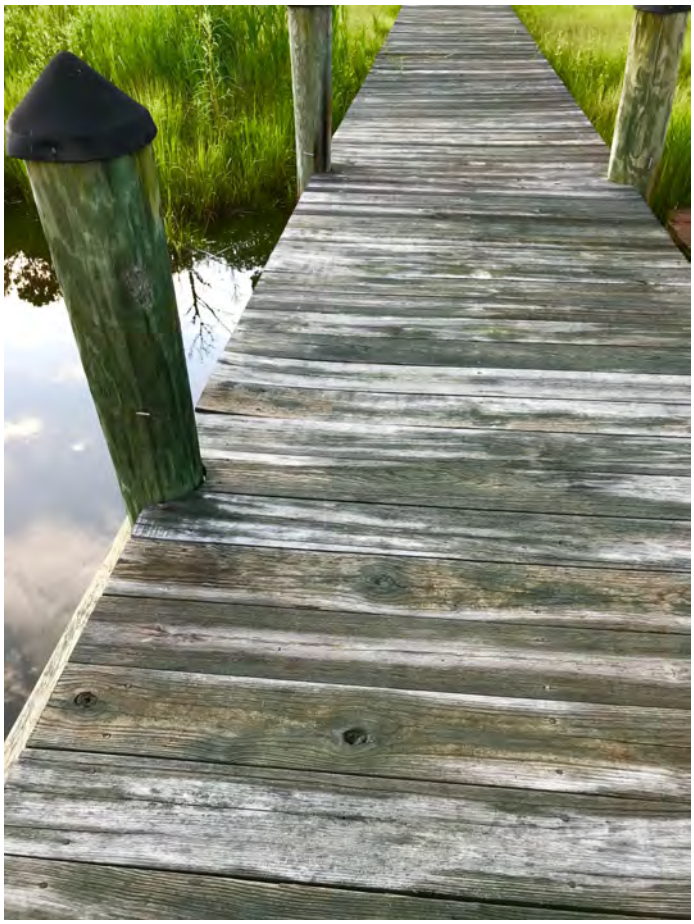
If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

HIPAA Notice of Availability of Privacy Practices

The TCPS 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 TCPS 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.

TCPS:
410-822-0330



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.

TCPS
410-822-0330

*Refer to the COVID-19 DOL FAQ for Participants and Beneficiaries in the Benefit Document Library for information on deadline extensions to file for benefits. This information is also available by following these links:

COVID-19 FAQs for Participants and Beneficiaries
COVID-19 deadline extensions to file for benefit

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.

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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. The list of states is also available on the full CHIP Notice in the Benefit Document Library.

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 **www.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.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

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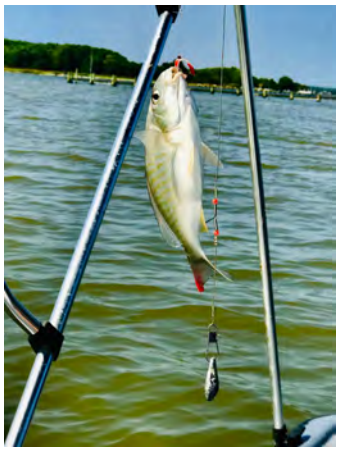
Coordination of Benefits (COB)

All TCPS 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.



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.
Annual Maximum	The most the plan will pay in a calendar year for covered medical or dental expenses. Prescription expenses are not included in the Medical Annual Maximum.
Basic Life Insurance	The group term life insurance provided at no cost to full-time and part-time employees working at least 20 hours per week.
Beneficiary	A person(s) or an entity (such as an association or organization) that you name to receive your life and AD&D insurance benefits if you die while covered; or to receive your vested account balances in your Retirement and Savings Program if you should die.
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.
Co-payment (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.
Covered Service	A medical or dental service covered by your medical or dental 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, the dependent flexible spending plan, and health savings account. 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.
ERISA	ERISA stands for "Employee Retirement Income Security Act of 1974." This federal statute regulates the majority of private pension and welfare group benefit plans in the United States.
Flexible Spending Account	Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars for unreimbursed medical, prescription, vision, and dental expenses, and dependent care costs.

Formulary	Also known as "Prescription Drug List." A list of drugs approved by a particular insurance carrier.
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.
Guaranteed Issue Maximum	The maximum amount of life insurance you may purchase without providing medical evidence. In order to receive the guarantee issue maximum amount, the insurance must be purchased when you are first eligible (within 30 days of your date of hire or date of eligibility, or when a new plan is first offered).
Health Savings Account (HSA)	A tax-advantaged savings account that allows you to set aside pre-tax dollars to pay for eligible healthcare expenses as defined by Section 213(d) of the tax code. Also known as HSA. An HSA may only be established in conjunction with an eligible high deductible medical plan.
HMO	An HMO, or Health Maintenance Organization, is a group of doctors and hospitals who provide health care to members at a fixed, predetermined price. With an HMO plan, members are required to select a Primary Care Physician who coordinates care.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.
LTD	Long-Term Disability Insurance. This type of insurance provides a percentage of your income if you become totally disabled.
Medical Evidence of Insurability	If you do not purchase life insurance, short-term disability insurance, long-term disability insurance, or 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-Formulary	A drug not included on the list of approved drugs of an insurance carrier.
Non-Preferred Provider	A provider who does not have any agreement with your insurance plan to accept copays or reduced fees for services rendered.
Non-Reimbursed Expenses	Services you have paid for, and that are not reimbursable by your insurance company; for example, copays, deductibles, charges in excess of the reasonable and customary or the allowed benefit, or other charges not covered by your insurance company.
Open Access Plus (OAP)	A type of Point of Service (POS) plan in which members do not have to pick a Primary Care Physician. Members are free to see any physician in or out of network without a referral from a primary physician.
Open Enrollment	See "Annual Benefits Election Period."
Optional Life	Additional life insurance coverage on your life or the life of your dependents beyond the basic coverage.
Out-of-Network Benefits	Benefits that are paid at a lower level when you use out-of-network providers.
Out-of-Pocket Maximum	The most you will pay in a calendar year before the plan pays 100% of covered medical expenses, not including prescription drug co-payments.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for TCPS this is from September 1 to August 31 of the following year.
Plan of Treatment	A plan written by your provider that shows your diagnosis and needed treatment. This Plan of Treatment must be approved by your insurance company in order for your claim to be considered for payment.

Point of Service (POS)

A type of managed care plan that allows members to choose, at the point where care begins, to receive services from a participating or nonparticipating network provider, usually with a financial disincentive for going outside the network. Members must choose a Primary Care Physician within the network. Referrals are required to visit a specialist.

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 .

Precertification

Your insurance company may require your physician to obtain approval before services are rendered in order for the insurance company to pay for the services.

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 Drug List

Also known as "Formulary." A list of drugs approved by a particular insurance carrier.

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.

PPACA

Patient Protection and Affordable Care Act of 2010. Sometimes referred to as the Affordable Care Act, or ACA.

Primary Care Physician (PCP)

In an HMO plan, you must choose a network doctor from a directory of providers, as your Primary Care Physician (PCP). You visit this doctor every time you need health care. In an HMO, your PCP must give you a written referral to see a specialist, or to receive treatment in an emergency room or hospital. If you do not get a referral, the services will not be paid by your insurance company.

Provider

A person or facility who provides medical or dental services to you or your dependents. This can include doctors, hospitals, labs, and other ancillary services, and health care providers.

Qualifying Event

An occurrence that entitles a person to select or change benefits outside of a defined "Open Enrollment" period. Events could include but are not limited to termination of employment, death of a covered person, marriage, divorce, birth, adoption, Medicare eligibility, a dependent child's loss of dependent status, or commencement of or return from an unpaid leave of absence.

R&C

Reasonable and Customary, or R&C, is an expense that is normally charged by similar physicians or dentists for like services in the same geographic area.