

St. Mary's County Government
Benefits Guide

2026 - 2027



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Reminders for the 2026-2027 Plan Year

All employees are encouraged to log in to the bswift Benefits Platform to review their current benefit elections, add or remove coverage and update beneficiary designations for the new plan year. See page 5 of the guide for details or go to SMCG.bswift.com to start your enrollment.

Incentive Payment for Declining Medical Coverage

The County will continue to offer the incentive payment for declining medical coverage. You must enroll each plan year to receive the incentive payment. For each plan year (July 1 - June 30) in which an eligible employee does not participate in St. Mary's County Government group medical coverage (health and prescription) either as an employee, dependent or retiree, the employee will be eligible to receive an incentive payment. A signed waiver opting out of County coverage must be completed and submitted to HR each plan year to be eligible for the payment.

Incentive Payment*	24 Pays	Annual
Full-Time	\$40	\$960
RPT 30 - 39	\$30	\$720
RPT 20 - 29	\$25	\$600
Variable hour 30+ per week	\$25	\$600

**The incentive payment is taxable income to you. If you opt-out of coverage, you cannot enroll until the next open enrollment unless you have a Qualifying Life Event (QLE).*

This benefit 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 St. Mary's County Government.

Dental

The calendar year maximum on the dental plan is \$1,500. The orthodontia lifetime maximum is \$1,000 and coverage for night guards is available.

Flexible Spending Accounts

You are required to make annual elections to participate. In 2026 - 2027, you may contribute:

- Healthcare FSA: Up to \$3,400 for the year
- Dependent Care FSA: Up to \$7,500 per household for the year

Please note, June 30, 2027, is the deadline to utilize funds in your FSA account. You will have 60 days from June 30, 2027, to submit claims for expenses incurred between July 1, 2026, and June 30, 2027. Up to \$680 of unspent funds in the FSA health account can be rolled over into the new plan year.

Voluntary Benefits: from The Standard (offered on a post-tax basis)

If you haven't already, enroll yourself and your dependents in Accident Insurance, Critical Illness and Hospital Indemnity Insurance through The Standard effective July 1, 2026. These plans offer extra protection from the expected and unexpected.

Enhanced Wellness Coverage

Enhanced Wellness coverage includes one additional eye exam and two additional dental exams for members with diabetes, hypertension and/or pregnancy (up to 6 months post-delivery) with no additional cost.

Welcome to St. Mary's County Government Benefits

St. Mary's County Government takes pride in offering a comprehensive and competitive benefits package to our employees. Through our benefits partners, the County offers a program that gives you the flexibility and options to meet your unique needs.

2026-2027 Open Enrollment

- **Open Enrollment**
Open Enrollment is May 5 -19, 2026.
- **Use the bswift Portal to Make your Elections**
You must login to the bswift benefits portal to enroll or make benefit changes. (See page 5 for more details).
- **Coverage Begins July 1, 2026**
The benefit year is from July 1, 2026 – June 30, 2027 plan year.
- **Review your Options**
Take a look at your current elections to ensure that you are enrolled in the plans that meet your needs and you are covering eligible family members who need coverage. No changes can be made after Open Enrollment unless you have a Qualifying Life Event.
- **Review and update your beneficiaries and personal information**
- **Get Support from Specialists**
Bolton Decision Support Specialists are trained specifically on County benefits and can answer questions and assist with your enrollment. Schedule an appointment at <https://go.oncehub.com/smcg>.

Schedule an Appointment



In Person

Decision Support Specialists will be available in-person throughout open enrollment to assist you with enrolling and answering your questions at the following locations:

HR Office, 23115 Leonard Hall Dr., 3rd Fl.

Public Works, 44829 St. Andrews Church Rd., Highway Assembly Rm.

Sheriff's Office, 23150 Leonard Hall Dr.

Emergency Services, 23090 Leonard Hall Dr.

Detention & Rehab. Center, 41880 Baldrige St.

By Phone

May 5 - May 19
11:00am - 8:00pm EDT

At the beginning of the call, you will be asked to verify your username and temporary password (last 4 digits of your SSN) to confirm your identity. Your username is your first initial + full last name + year of birth.

To schedule an in-person or phone appointment, go to

<https://go.oncehub.com/smcg>

IMPORTANT

Your current benefit elections will automatically pass over to the new plan year except for FSA and the incentive payment for declining medical coverage. The choices you make during Open Enrollment or upon hire are in effect for the remainder of the Plan year. Once you enroll, you must wait until the next Open Enrollment period to make changes to your benefits unless you have a Qualifying Life Event (QLE) as defined by the IRS.

How to Enroll

If you have a question, 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. You may also contact the County's Benefits Team at 301-475-4200 ext. 1100 or email at benefits@stmaryscountymd.gov for assistance.

All benefit elections/changes must be submitted online through bswift. The system allows you to access your benefits information and enroll online.

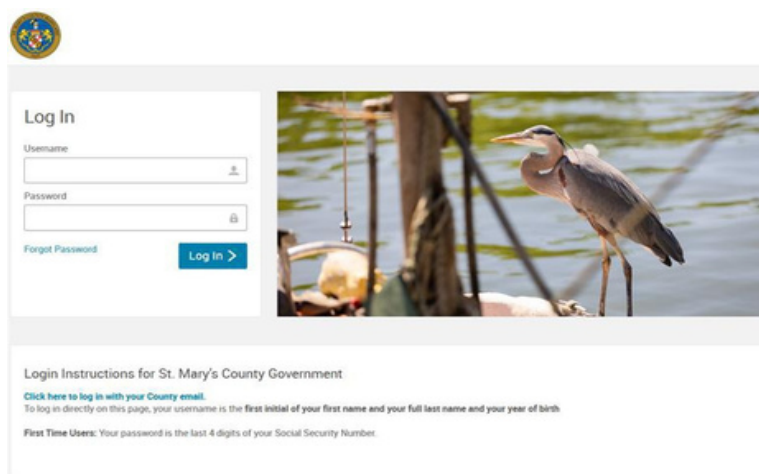
➤ Option 1: Employee Portal Home Page

- Login to the employee portal, <https://apps.stmarysmd.com/Employee>.
- Select bswift under "Applications."
- Login to bswift with your SMCG network username and password.



➤ Option 2: Log-in through bswift directly at <https://smcg.bswift.com>.

- Your username is your first initial + full last name + year of birth.
- Your password will be reset for Open Enrollment.
- Your temporary password is the last four numbers of your Social Security number (SSN).



Still Need Help Logging In?

- Email: service@boltonusa.com
- Email: Benefits@stmaryscountymd.gov
- Call the Benefits Team 301-475-4200 ext. 1100

Qualifying Life Event

Making Changes

The choices you make during Open Enrollment are in effect for the remainder of the Plan year. Once you enroll, you must wait until the next Open Enrollment period to make changes to your benefits unless you have a qualifying life event as defined by the IRS. You must make enrollment changes within 30 days of the date of the qualifying event. If you miss that deadline, you may not change your current benefits until the next Plan year.

Lifestyle Change/Event	Documentation Required
Marriage	Marriage Certificate & Social Security cards
Divorce	Divorce Decree
Birth or Adoption	Birth Certificate or Adoption papers & Social Security cards
Change in employment status from part-time to 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
Group Health Plan (example: aging off parent's plan)	Documentation from plan or issuer regarding change in eligibility (with effective date)

Benefits Eligibility

Employee Eligibility

Benefit eligible employees are all full-time and regular part-time employees as well as temporary employees working at least 30 hours per week. Hourly employee eligibility will be determined utilizing an initial measurement and an annual look back period. Those averaging 30 or more hours per week during the look back period will be eligible to elect benefits for the Plan year beginning July 1.

Available benefits include: Medical & Prescription, Dental, Vision, FSA Health & Dependent Care, 457(b), Critical Illness, Hospital Indemnity, Accident Insurance, Whole Life Insurance, EAP, Identity Protection, and Marathon Health Center. Please reference the hourly benefit guide in the bswift library for more details.

Dependent Eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse, dependent children, including stepchildren, and disabled adult children. Refer to the Dependent Eligibility Documentation Requirements on bswift for more details. For any new dependents, you will be required to upload documentation as evidence of your relationship status, e.g., marriage license, birth certificate, etc. Any change in dependent status requires you to administer a life event in the benefits portal to remove or to add the dependent.

Premium Contributions

The County's Group Health Insurance Program requires you to pay a portion of the premium. A Section 125 plan allows you to elect to make these payments pre-tax rather than on a post-tax basis. Therefore, as an employee, you will not owe Federal Income Tax or FICA Tax on the premium amounts. You walk away with more dollars in your paycheck.

You cannot change your election during the Plan year without an IRS-approved Qualifying Life Event. You may change your election during the next Open Enrollment, which will take effect on July 1 of the next Plan year.

Medical Coverage

You have a choice between two CareFirst medical plan options: BlueChoice HMO Open Access Plan and BlueChoice Advantage (full-time and regular part-time employees). Eligible hourly employees (averaging 30+ hours per week) may participate in the BlueChoice HMO Open Access Plan. Both medical plans give you access to a quality network of practitioners and hospitals.

The BlueChoice Advantage plan allows you to access any CareFirst provider anywhere in the United States at in-network rates. You also have the flexibility to use out-of-network providers, but you will have higher out-of-pocket costs. 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.

You're never alone. If you or someone you know is in crisis, dial 988 or contact the CareFirst support line at 800-245-7013.

The BlueChoice HMO Open Access plan provides comprehensive coverage when you use CareFirst participating HMO providers. If you do incur costs with an out-of-network provider, you will be responsible for 100% of the cost unless it's an emergency as defined by the Plan documents

Understanding your Options for Care

Seeking advice: 24-Hour Nurse Advice Line

- General questions about health issues on where to go for care
- Registered nurses are available 24/7 by phone at 800-535-9700

Want care quickly: CloseKnit Virtual Care

- Treatment for minor illnesses and injuries as well as therapy, psychiatry, diet and nutrition and breast feeding support
- Board-certified doctors available by smart phone, tablet or computer

Need care soon: Primary Care Provider or Marathon Health Center

- Diagnosis & treatment of illness, chronic conditions, regular check-ups

Need care now: Urgent Care Center or Marathon Health Center

- Non-life-threatening illness or injury requiring immediate care

Emergency: 911 or Nearest ER

- Life-threatening illness or injury
- Open 24/7

Go to <https://www.carefirst.com/stmarys/> for additional Plan information

Medical Coverage

Full-time and Regular Part-Time Employees

Below is a summary of the plan options. Visit the bswift Library for the Benefit Summaries and Plan Documents.

	BlueChoice HMO Open Access	BlueChoice Advantage	
	In-Network Only (There is no out-of-network coverage for this plan)	In-Network	Out-of-Network
Annual Deductible Individual	None	\$250	\$500
Annual Deductible Family	None	\$500	\$1,000
Coinsurance for most services	You pay 0%	After annual deductible, you pay a copay	After annual deductible, you pay 20%
Contract year out-of- pocket maximum Individual	\$2,000	\$1,000	\$1,000
Contract year out-of- pocket maximum Family	\$6,000	\$2,000	\$2,000
Preventive care (office visits and routine annual lab visits)	You pay \$0	You pay 0%	After annual deductible, you pay 20%
Physician office visit PCP copay	\$10	\$20	After annual deductible, you pay 20%
Physician office visit Specialist copay	\$20	\$20	After annual deductible, you pay 20%
Inpatient hospitalization Pre-certification required (semi-private hospital room and board and ancillary services)	You pay \$0	After annual deductible, you pay 0%	After annual deductible, you pay 20%
Prescription drugs 30-day supply Generic	You pay \$10	You pay \$10	You pay \$10
Prescription drugs 30-day supply Brand	You pay \$20	You pay \$20	You pay \$20
Prescription drugs 30-day supply Non-Formulary	You pay \$35	You pay \$35	You pay \$35

Medical Coverage (cont.)

Full-time and Regular Part-Time Employees

Below is a summary of the three plan options. Visit the bswift Library for the Benefit Summaries and Plan Documents.

	BlueChoice HMO Open Access	BlueChoice Advantage	BlueChoice Advantage
	In-Network Only (There is no out-of-network coverage for this plan)	In-Network	Out-of-Network
Prescription drugs 90-day supply Generic	You pay \$20	You pay \$20	You pay \$20
Prescription drugs 90-day supply Brand	You pay \$40	You pay \$40	You pay \$40
Prescription drugs 90-day supply Non-Formulary	You pay \$70	You pay \$70	You pay \$70
Prudent Rx for specialty medications	Enrollment is required. If you do not enroll, you will be responsible for high cost-sharing amount.	Enrollment is required. If you do not enroll, you will be responsible for high cost-sharing amount.	Enrollment is required. If you do not enroll, you will be responsible for high cost-sharing amount.



Medical Coverage (cont.)

Hourly employees working an average of 30 hours per week

BlueChoice HMO Open Access	In-Network
Annual Deductible - Individual	None
Annual Deductible - Family	None
Coinsurance for most services	You pay 0%
Contract year out-of-pocket maximum - Individual	\$2,000
Contract year out-of-pocket maximum - Family	\$6,000
Preventive Care (office visits and routine annual lab tests)	You pay \$0
Physician office visit PCP copay	\$10
Physician office visit Specialist copay	\$20
Inpatient hospitalization Pre-certification required (semi-private hospital room and board and ancillary services)	You pay \$0
Prescription drugs, 30-day supply Generic	You pay \$10
Prescription drugs, 30-day supply Brand	You pay \$20
Prescription drugs, 30-day supply Non-Formulary	You pay \$35
Prescription drugs, 90-day supply Generic	You pay \$20
Prescription drugs, 90-day supply Brand	You pay \$40
Prescription drugs, 90-day supply Non-Formulary	You pay \$70
Prudent Rx for specialty medications	Enrollment is required. If you do not enroll, you will be responsible for high cost-sharing amount.

Blue Rewards

Employees and their spouses who are covered under the County’s medical plan can each earn up to \$100 in gift cards and/or a Blue Rewards Visa Card! Whether you complete one incentive activity or any combination of them, you get rewarded! Complete up to four of any of these activities between July 1, 2026, and April 30, 2027.

Earn \$50

Complete a Biometric Screening or an Annual Wellness Visit. Onsite (CVS, Marathon Health or PCP options) or complete an Annual Wellness visit with your Primary Care Physician.

Earn \$50

Complete an Age Appropriate Preventative Screening. Includes colonoscopy, mammogram, routine GYN visit/PAP test, prostate cancer screening, and osteoporosis screening.

Earn \$25

Take the RealAge Test. RealAge is a short questionnaire designed to determine your physical age compared to your calendar year age.

Earn \$25

Visit your dentist for a check-up. Let us know that you have. If not, be sure to schedule your visit to take advantage of this incentive.

Earn \$25

Complete a preventative vaccine. Includes Flu and/or the most recently eligible COVID-19 vaccine. Let us know that you have. If not, be sure to schedule your visit to take advantage of this incentive.

Earn \$25

Visit an optometrist for an eye exam. Let us know that you have. If not, be sure to schedule your visit to take advantage of this incentive.

To get started visit CareFirst WellBeing www.carefirst.com/wellbeing. You’ll need to enter your CareFirst My Account username and password and complete the one-time registration with CareFirst WellBeing to sync your CareFirst account information with your CareFirst WellBeing Account. Gift card options include major retailers, restaurants, Visa gift cards and more. Blue Rewards Visa cards can be used until June 30, 2027, to pay for out-of-pocket medical expenses incurred by covered employees, spouses, and dependents. Rewards will be auto-redeemed via virtual Visa gift card if you do not redeem your rewards via the marketplace by June 30, 2027. Health Screening forms for both your primary care physician or Marathon Health Center and the CVS Minute Clinic can be found in the “Benefits” section of the Employee Portal under “Wellness and Blue Rewards Program.” Employees can receive a \$50 incentive for the annual wellness visit or a biometric screening but not both.

Vision Coverage

The County offers eligible employees a BlueVision Plus vision plan, through the Davis Vision, Inc., national network. The Vision Plan includes routine eye examinations, eyeglasses, and contact lenses offered through a national network of providers.

For Plan details, please go to the bswift Library for the Summary of Benefits.

Benefit	Description	Davis Vision In-Network
WellVision exam Every 12 months	Focuses on your eyes and overall wellness	You pay \$10
Prescription glasses - Frames	Davis Frame Collection	\$0 copay (for approximately 200 frames)
Prescription glasses - Frames	Other frames	Plan pays up to \$100, you pay balance
Lenses	Single vision	\$0 copay
Lenses	Bifocal	\$0 copay
Lenses	Trifocal	\$0 copay
Contacts	Elective contact lenses	Plan pays \$97, you pay balance
Contacts	Medically necessary	\$0 copay (with prior approval)

Enhanced wellness coverage includes one additional eye exam for members with diabetes, hypertension and/or pregnancy (up to 6 months post-delivery) with no additional cost.

Finding an In-Network Provider

To find an in-network provider, search online at <https://www.carefirst.com/stmarys/> and utilize the Find a Provider Feature or call Davis Vision at 800-783-5602. Be sure to ask your provider if they participate in the Davis Vision network.



Medical & Vision Premiums

Full-Time Employees - 40+ Hours per week

Note: 24 pays per year

	CareFirst HMO Open Access w/Rx	CareFirst BlueChoice Advantage w/Rx	CareFirst BlueVision Plus
Employee only Employer cost per pay	\$363.77	\$463.36	\$2.13
Employee only Employee cost per pay	\$64.19	\$81.77	\$0.38
Employee + child Employer cost per pay	\$619.85	\$695.06	\$3.07
Employee + child Employee cost per pay	\$109.39	\$122.66	\$0.54
Employee + spouse Employer cost per pay	\$825.78	\$926.70	\$4.28
Employee + spouse Employee cost per pay	\$145.73	\$163.54	\$0.76
Family Employer cost per pay	\$1,071.79	\$1,204.75	\$5.27
Family Employee cost per pay	\$189.14	\$212.60	\$0.93

Regular Part-Time Employees - 30-39 Hours per week

Note: 24 pays per year

	CareFirst HMO Open Access w/Rx	CareFirst BlueChoice Advantage w/Rx	CareFirst BlueVision Plus
Employee only Employer cost per pay	\$363.77	\$419.75	\$1.93
Employee only Employee cost per pay	\$64.19	\$125.38	\$0.58
Employee + child Employer cost per pay	\$561.51	\$629.64	\$2.78
Employee + child Employee cost per pay	\$167.72	\$188.08	\$0.83
Employee + spouse Employer cost per pay	\$748.96	\$839.48	\$3.88
Employee + spouse Employee cost per pay	\$223.45	\$250.75	\$1.16
Family Employer cost per pay	\$970.92	\$1,091.36	\$4.77
Family Employee cost per pay	\$290.01	\$325.99	\$1.47

Medical & Vision Premiums

Regular Part-Time Employees - 20-29 Hours per week

Note: 24 pays per year

	CareFirst HMO Open Access w/Rx	CareFirst BlueChoice Advantage w/Rx	CareFirst BlueVision Plus
Employee only Employer cost per pay	\$363.77	\$294.37	\$1.36
Employee only Employee cost per pay	\$64.19	\$250.76	\$1.15
Employee + child Employer cost per pay	\$393.79	\$441.57	\$1.95
Employee + child Employee cost per pay	\$335.45	\$376.15	\$1.66
Employee + spouse Employer cost per pay	\$524.61	\$588.73	\$2.72
Employee + spouse Employee cost per pay	\$446.89	\$501.51	\$2.32
Family Employer cost per pay	\$680.90	\$765.37	\$3.35
Family Employee cost per pay	\$580.03	\$651.98	\$2.85

Hourly Employees Eligible for Coverage

Note: 24 pays per year

	CareFirst HMO Open Access w/Rx	CareFirst BlueVision Plus
Employee only Employer cost per pay	\$363.77	N/A
Employee only Employee cost per pay	\$64.19	\$2.51
Employee + child Employer cost per pay	\$561.51	N/A
Employee + child Employee cost per pay	\$167.72	\$3.62
Employee + spouse Employer cost per pay	\$748.06	N/A
Employee + spouse Employee cost per pay	\$223.45	\$5.04
Family Employer cost per pay	\$970.92	N/A
Family Employee cost per pay	\$290.01	\$6.20

Marathon Health Center



Marathon is excited to partner with St. Mary's County Government (SMCG)!

When you use the Marathon Health Center, 90% of your comprehensive and primary care needs are covered, with no out-of-pocket costs. SMCG employees, dependents of employees, retirees and retiree dependents who are enrolled in the CareFirst health insurance 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 <https://my.marathon-health.com>.

Services

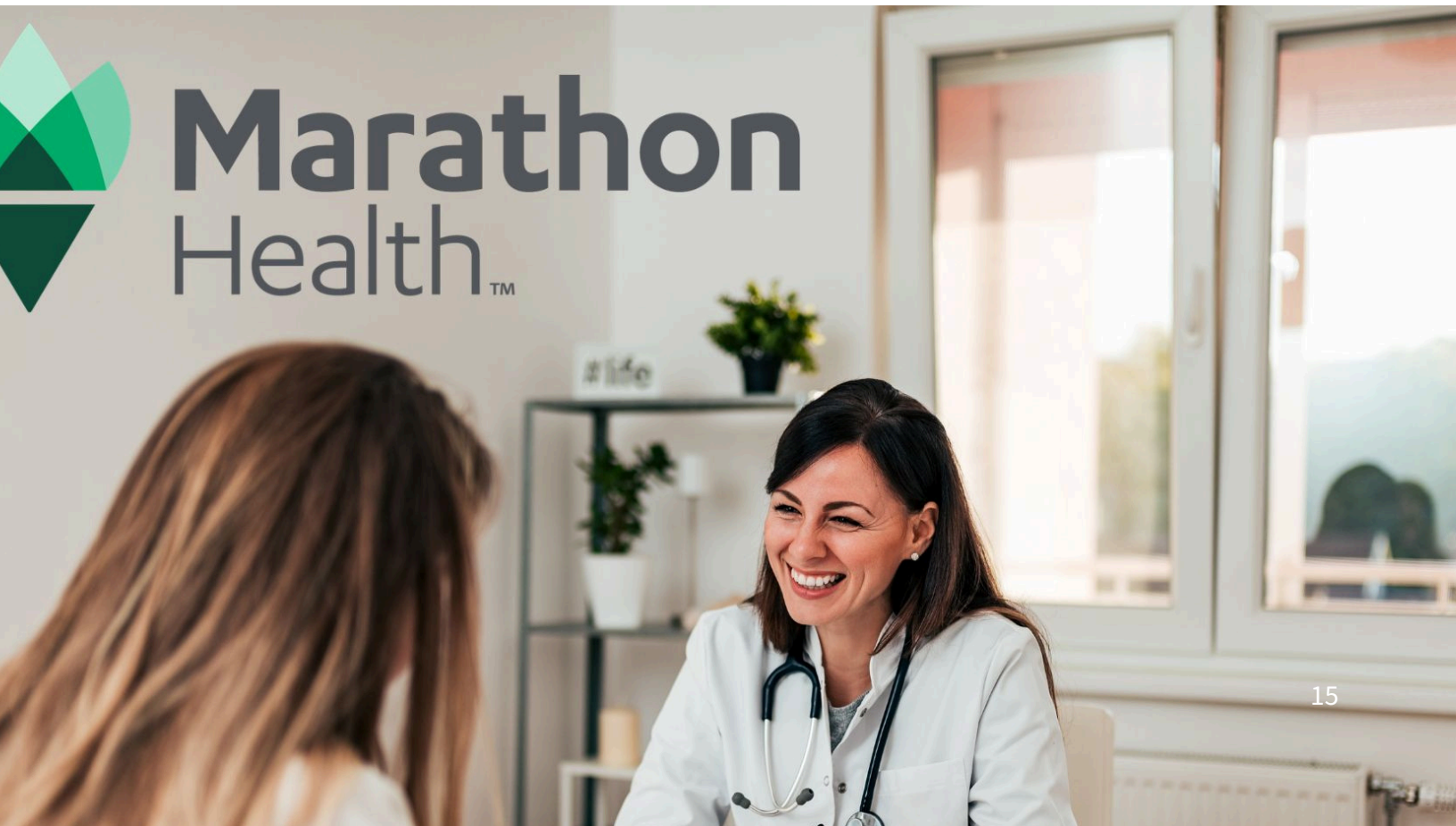
- Annual physical exams
- Chronic condition management
- Full-scope family medicine
- Men's & women's health
- Mental health support
- No cost on-site lab work
- School and sports physicals
- Select on-site medications at little to no cost
- Sick and urgent care
 - Same or next-day appointments are available by calling the health center

Clinic Location

23000 Moakley Street, #202
Leonardtown MD 20650
240-744-1100
<https://clients.marathon.health/smc>

Clinic Hours

Monday-Friday	6am - 5pm
Saturday	8am - 1pm



Dental Coverage

The County offers eligible employees the CareFirst Preferred Dental PPO Plan. The Preferred Dental PPO plan provides coverage in and out of network, but you will pay less when you use in-network PPO providers. Search for in-network providers at <https://www.carefirst.com/stmarys/>. The following chart shows what you pay for covered dental services:

This is only a brief summary of the plans. For more details, please go to the bswift Library for the Summary of Benefits and Patient Charge Schedule.

Preferred Dental	In-Network	Out-of-Network
Calendar Year Deductible Individual	You pay \$25	You pay \$50
Calendar Year Deductible Family	You pay \$75	You pay \$150
Calendar Year Benefit Maximum	\$1,500	\$1,500
Preventive and Diagnostic Services (e.g., cleanings)	You pay \$0	You pay 25%
Basic services (e.g., fillings)	After annual deductible, you pay 20%	After annual deductible, you pay 40%
Major surgical services (e.g., root canals, surgical extractions)	After annual deductible, you pay 20%	After annual deductible, you pay 40%
Major restorative services (e.g., dentures, crowns, bridges, and night guards)	After annual deductible, you pay 50%	After annual deductible, you pay 65%
Orthodontic services	You pay 50%, \$1,000 lifetime maximum	You pay 65%, \$1,000 lifetime maximum

Dental Premiums

All premiums noted below are per pay. Note: There are 24 pays per year.

CareFirst Dental PPO	
Coverage Level	Employee Cost Per Pay
Employee	\$14.65
EE + Child	\$23.24
EE + Spouse	\$31.81
Family	\$43.15

Keep in Mind
Enhanced wellness coverage includes two (2) additional dental exams for members with diabetes, hypertension and/or pregnancy (up to six (6) months post-delivery) with no additional cost.

Employee Pays 100% of the cost.

Flexible Spending Accounts - Voya

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 to participate in an FSA.**

FSA Contributions

When you elect an FSA, you contribute a portion of your salary to pay for out-of-pocket health or dependent care expenses. The amount of your FSA contribution is pre-tax and is automatically deducted from your earnings in regular, biweekly payments (24 times annually). FSAs allow you to save money as your contributions reduce your taxable income.

Expenses you pay for dependent care while you are out of 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 from July 1, 2026, to June 30, 2027 is:

- \$7,500 if single, or married, filing jointly
- \$3,750 if married, filing separately

Healthcare Flexible Spending Account (HC FSA)

Healthcare FSA funds may only be used to pay for eligible “out-of-pocket” medical, dental, vision and prescription drug expenses without federal tax liability or penalty.

- You may contribute a minimum of \$100.00 or up to a maximum of \$3,400 to your HC FSA from July 1, 2026, to June 30, 2027

Dependent Care Flexible Spending Account (DC FSA)

The Dependent Care FSA 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.

The Dependent Care FSA can also be used to provide dependent care while you or your spouse are actively looking for work (does not include unpaid volunteer work, or volunteer work for a nominal salary). If you are married, you can use the Dependent Care FSA only if your spouse is employed, a full-time student for at least five months of the year or disabled.

Important FSA Rules

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

Participants in the HC FSA with unused funds at plan year end on June 30, 2027 may carry over up to \$680 of unused funds into the next plan year without changing the amount they can contribute in the new plan year.

You will have 60 days from June 30, 2027 to submit claims for expenses incurred between July 1, 2026 and June 30, 2027.

If your employment ends during the year, you will have 60 days from your date of termination to submit HC FSA claims for reimbursement for claims incurred prior to your date of termination.

Critical Illness Insurance - The Standard

Critical Illness Insurance can help relieve the financial impact of a sudden, life-threatening illness.

You may have medical insurance, but that does not mean you're covered for all expenses resulting from a serious illness that you probably haven't budgeted for — things like copays, deductibles, loss of income, childcare, and travel expenses. Group Critical Illness insurance helps fill the gap caused by these out-of-pocket costs, creating a financial safety net for you and your family.

The Critical Illness plan provides:

- Premiums that are locked in at the age when you purchase the coverage
- Guaranteed Issue coverage of up to \$30,000 for you and your spouse
- Coverage for children automatically at 100% of the employee's elected amount
- \$100 Health Maintenance Screening benefit paid per insured per calendar year
- Covered conditions:

Heart attack	Advanced MS	Advanced
Stroke	ALS	Alzheimer's
Cancer	Coma	Bone Marrow
Paralysis	End-stage	transplant
Major organ failure	Renal failure	+ 21 children's diseases

- No Evidence of Insurability requirement when you enroll in any coverage amount this year or for any increase during Open Enrollment in future years up to the \$30,000 maximum coverage—that means no health questions are required. Plus, the rate at which you purchased your initial policy will be the rate used for the additional coverage.
- Pre-existing condition limitations have been waived. That means The Standard will not complete any investigation into a claim related to a pre-existing condition. If the claim meets The Standard's definition of a covered critical illness, then The Standard would pay the claim. However, the plan requires that the initial diagnosis of the critical illness be made while covered under the group policy.

AT A GLANCE

\$10,000 Policy

Age at Issue	Rates per pay
30	\$2.85
40	\$4.65
50	\$7.45
60	\$12.40

All premiums noted above are per pay. Note: There are 24 pay periods in the 2026-2027 Plan Year

For full details of the benefits covered under the Critical Illness Plan and exclusions, please review plan documents available in the bswift library.



Watch a short video on how Critical Illness Insurance benefits you and your family:

<https://sites.standard.com/edu/st-marys-county-government/79961/critical-illness>

Accident Insurance - The Standard

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

Accidents happen frequently in all aspects of life (e.g., working around the house, driving a car, or children riding bikes or playing sports). Accidents can be painful and costly. Even with major medical insurance, there may be out-of-pocket expenses that you'll have to pay.

The Standard 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. It also helps with surgery expenses, hospital stays, needed medical appliances (e.g., braces, canes, wheelchairs, prostheses), and hearing aids, and daily expenses during recovery.

Additional Benefits

- **\$50 Health Maintenance Screening Benefit**
Per insured per calendar year
- **Youth Organized Sports Benefit**
Additional 25% of total benefit payable
- **Hospital Admission and Daily Confinement Benefit**
\$1,500 for first 24 hours admitted; \$400/day after

Rates Per Pay

Accident rates are not based on age or smoker status. Note: There are 24 deductions per year.

Coverage Level	Employee	Employee & Spouse	Employee & Child(ren)	Family
Pay per deduction	\$7.15	\$11.19	\$13.50	\$21.15

Keep in Mind

Most injuries are not work related and, therefore, are not covered by Workers Compensation.

You can cover yourself, your spouse, and your children under the Accident Insurance plan.



Go to <https://sites.standard.com/edu/st-marys-county-government/79961/accident> to watch a short video on how Accident Insurance benefits you and your family.

Hospital Indemnity Insurance - The Standard

Hospital Indemnity Insurance pays an amount for each day the insured is hospitalized, up to specific maximum limits. Because the benefits are paid directly to the insured, they can be used to help pay for out-of-pocket expenses, such as deductibles and copays, as well as costs that would be hard to pay due to missed time at work, like a car payment, rent, and childcare.

Plan Features

Hospital Admission

Pays \$1,000 for a stay at a hospital for at least 20 consecutive hours for examination by a physician for diagnosis or treatment of a loss. This benefit is limited to one payment per calendar year.

Daily Hospital Confinement Benefit

Pays \$100 each day an insured person is confined to a hospital as the result of a covered accident or sickness. This covers up to 15 days per stay.

Critical Care Unit Admission

Pays \$500 for a stay in a Critical Care Unit for at least 20 consecutive hours for examination by a physician for diagnosis or treatment of a loss. Pays in addition to the Hospital Admission benefit. This benefit is limited to one payment per calendar year.

Daily Critical Care Unit Confinement

Pays \$100 each day an insured person is confined to a critical care unit as the result of a covered accident or sickness. This covers up to 15 days per stay. Pays in addition to the Hospital Confinement benefit.

Health Maintenance Screening

The plan pays \$100 annually per insured individual for one of 22 covered health screening tests, such as lipid panels, mammograms, and colonoscopies. Refer to the bswift Library for a list of covered health screenings.

Rates Per Pay

All premiums noted below are per pay. There are 24 deductions per year. Hospital Indemnity rates are not based on age or smoker status.

Coverage Level	Cost
Employee	\$6.56
Employee + Spouse	\$11.42
Employee + Child(ren)	\$9.33
Family	\$16.52

The Bottom Line

- Includes a \$100 Health Maintenance screening benefit per insured per calendar year.
- No pre-existing condition limitations.
- No termination age for employees or spouses.
- Annual Guaranteed Issue enrollment with issue age to 99.
- Coverage is portable at same rates.
- Provides coverage for injuries and illnesses, including pregnancy.



Go to <https://sites.standard.com/edu/st-marys-county-government/79961/hospital-indemnity> to watch a short video on how Hospital Indemnity Insurance benefits you and your family. You can also find claim forms in the bswift Library.

Life and AD&D Coverage

Life insurance provides your beneficiaries with a benefit in the event of your death. The County life insurance plans allow you to decide how much life insurance is right for you. You also have a variety of life insurance options for your dependents.

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

Full-time and regular part-time employees are provided with Basic Life and Accidental Death and Dismemberment Insurance equal to one times your annual salary up to a \$150,000 maximum. The coverage is automatic, and the premiums are 100% employer paid while employed by the County. Coverage decreases to 65% of salary at age 70.

The AD&D insurance pays in addition to the Basic Life, in the event an employee dies in a covered accident or suffers a dismemberment or disability as defined by the insurance company.

Important Information

If you terminate employment you may be able to continue some or all of your life insurance coverage under the plan's portability or conversion provision.

Rates and coverage amounts for terminated employees will vary and will be provided by Securian when you apply to continue your coverage.

Supplemental Employee Term Life Insurance

Eligible employees can purchase Supplemental Term Life Insurance coverage for themselves and their family members. Consider the cost of funeral expenses, legal expenses, and general living expenses for your surviving family members when electing your additional coverage.

Please note this is a post-tax benefit. Rates can be viewed in the bswift platform.

	Employee	Spouse	Child
Benefit Schedule	Increments of \$5,000	Increments of \$5,000	\$10,000 or \$15,000
Maximum Benefit	\$500,000	\$250,000	\$15,000
Minimum Benefit	\$5,000	\$5,000	\$10,000
Guarantee Issue (new hires only)	\$250,000	\$50,000	\$15,000
Age Reduction Schedule	N/A	N/A	N/A
Employer Contribution	0%	0%	0%

An Accelerated Benefit is included. Terminally ill members may withdraw up to 75% 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.



Hit PLAY! Watch this [informational video](#) about Group Life Insurance.

Whole Life Insurance with Chronic Care - Unum

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.

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 long 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!



Go to <https://sites.standard.com/edu/st-marys-county-government/79961/home> to see a video that explains the difference between this policy and the group term plan.

Here's how it works:

You can select life insurance coverage from \$10,000 up to \$200,000. This coverage is known as the face amount or death benefit—the sum paid to your beneficiary if you pass away while the policy is active. The benefit includes a cash value feature that grows over time, earning at least 3.75% interest annually. Once the cash value has accumulated, you may be able to borrow against it.

You may keep your policy while employed with St. Mary's County Government, or, continue it after leaving by paying Unum directly at the same rates.

- To maintain coverage, pay premiums and your beneficiary will receive the death benefit.
- If you cancel your policy, coverage ends and you'll receive a check for your cash value.
- If you stop paying premiums and use your cash value for a new, smaller policy (Reduced Paid-Up option), you must notify Unum to choose this option.

REMINDER

Schedule an appointment with a Decision Support Specialist, <https://go.oncehub.com/smcg> or send an email to service@boltonusa.com if you have additional questions on the Whole Life Insurance plan or need assistance enrolling.

Whole Life Insurance with Chronic Care

Chronic Care Rider

The Chronic Care Rider provides a monthly benefit of 6% or a one-time lump sum payment of 50% of the death benefit, your choice; no care setting required. You are eligible if you require substantial supervision due to severe cognitive impairment or inability to perform at least two of the six Activities of Daily Living (ADLs). The ADLs are bathing, dressing, eating, continence, toileting, transferring, and severe cognitive impairment.

The easiest way to learn more about this is to schedule a call with a Decision Support Specialist by clicking here: <https://go.oncehub.com/SMCG>. You can send an email to Service@BoltonUSA.com if you need help with your enrollment.

Identity Protection

Allstate Identity Protection Pro Plus Cyber

Regular part-time and full-time employees of St. Mary's County Government are provided with employer-paid identity protection services through Allstate Identity Protection Pro Plus Cyber (AIP). AIP delivers comprehensive fraud monitoring and powerful mobile and desktop cybersecurity to help you protect yourself, your family, and your finances from emerging threats. See and manage your personal data, safeguard your devices, and protect your identity. If fraud occurs, you can rely on our full-service restoration, plus up to \$1 million in fraud expense reimbursement – or up to \$2 million for families to cover stolen funds or out-of-pocket cost.

- Family protection
- Cyber protection
- Privacy and data monitoring
- Identity and financial monitoring
- Credit monitoring
- Full service, 24/7 remediation support
- Stolen fund reimbursement
- \$1 million identity theft insurance

REMINDER

Employees will receive a welcome email from Allstate Identity Protection (AIP) which contains their Member ID and a link to login to the AIP portal. If you have misplaced your email, you may call Allstate directly (1-800-789-2720) to get your member ID for registration.

Long -Term Disability Insurance

Regular part-time and full-time employees of St. Mary's County Government are provided with a Long-Term Disability plan 100% paid for by the County. Long-Term Disability is meant to provide protection for more significant disabilities that cause you to be out of work for longer than 180 days.

Highlights of the Long-Term Disability Plan:

- Pays a benefit of 60% of monthly pay up to a maximum monthly benefit of \$5,000.
- Benefits are paid for a maximum of 5 years.
- If you become disabled at age 60 or older, the benefit duration is determined by your age when disability begins.

Maximum Benefit Period: Determined by your age when disability begins	Age Maximum Benefit Period
59 or younger	5 years
60-64	To age 65, but not less than 1 year
65 or older	1 year



Voya 457(b) Plan

What Is a 457(b)?

A 457(b) is a tax-advantaged retirement plan primarily for those employed by state and local governments. Like other employer-sponsored retirement plans, the 457(b) provides tax-efficient growth for retirement savings. You don't pay capital gains taxes on the investments you buy and sell in your account, giving your retirement nest egg additional room for growth.

Contribution Limits

Contributions to your 457(b) are deducted from your paycheck and may be taxed in one of two ways:

1. Taken out of your paycheck before taxes, lowering your overall tax bill today.
2. When you take out money in retirement, you pay income taxes on the withdrawals. With a Roth 457(b), you fund your account with money that's already been taxed in exchange for tax-free withdrawals in retirement. This includes any earnings your money makes while it's in your 457(b).

For 2026, the annual contribution limit for a 457(b) plan is \$24,500.

Employees aged 50 and older may make additional catchup contributions of \$8,000, for a total contribution limit of \$32,500.

Employees aged 60-63 may contribute an additional \$11,250 for a total contribution of \$35,750.

To enroll, go to: enroll.voya.com, enter plan #664270, enter verification #019149. For more information on the 457(b) Plan, go to the bswift library for literature and videos.

Employee Assistance Program

We recognize you may experience issues that affect the quality of life at home or at work. The AllOne Health Employee Assistance Program (EAP) is available to you 24 hours a day, seven days a week by calling 800-451-1834. All services are free, confidential and available to you and your family members. This includes access to short-term counseling and to the wide range of series listed below:

- Mental Health Counseling Sessions
- Life Coaching
- Financial Consultations
- Legal Referrals
- Work-life Resources and referrals
- Personal Assistant
- Medical Advocacy

LEARN MORE

For more information about the EAP services, go to <https://allonehealth.com/portal>. Enter your email address and the employer code **smcg** to create an account and sign in.

Employee Wellness Program

St. Mary's County Government offers an employee wellness program designed to encourage healthier lifestyles through holistic programs focusing on five dimensions of well-being: emotional, environmental, financial, physical, and social elements. Together these elements help to inspire a whole and healthy you! More information is available at <https://apps.stmarysmd.com/Employee/Documents/HR/Wellness>.

Emotional Wellness

Inspires self-care, relaxation, stress reduction and the development of inner strength.

- AllOne Health Employee Assistance Program
- Webinars and seminars about self-care, stress reduction and relaxation techniques
- Reflexology and Seated Massage Days
- Employee Wellness Room

Environmental Wellness

Refers to how one's environment can influence behavior and mood. These environments can include home, work and outdoors.

- Workplace safety-training and resources to keep you and your work environment safe
- Tobacco free workplace-tobacco cessation resources and classes

Financial Wellness

Involves your ability to manage money in order to manage your day-to-day expenses and achieve your long-term financial goals.

- Blue 365 Discount Program (for SMCG employees covered by CareFirst)
- Up to 20% discount on St. Mary's County Recreation & Parks programs
- Voya Financial 457(b) Deferred Compensation plan for optional tax-advantaged retirement savings

Physical Wellness

Involves taking proper care of our bodies for optimal health.

- Fitness challenges, fitness classes, fitness reimbursement program, employee health and wellness day, Blue Rewards Program, wellness room, health and wellbeing online program

Social Wellness

Involves building healthy, nurturing and supportive relationships as well as fostering a genuine connection with those around you.

- Friday Fitbit, Go Red for Women's Cardiovascular Health, Wear Blue for Men's Health Month, Wear Pink for Breast Cancer Awareness, Meal Planning and Cooking Demonstrations, United Way & Creating Healthier Communities Campaign, Volunteer Leave Program

Wellness Committee

The County has established a Wellness Committee to advocate, recommend, and advise the County Administrator regarding employee health and wellness initiatives. Membership is comprised of employees from each department or agency of the County. Regular meetings are held in January, April, July, and October. Special meetings may be called as required for particular activities. Please contact wellness@stmaryscountymd.gov if you'd like to become more involved with the County's wellness initiatives.

Human Resources Department Staff Directory

Human Resources Department

Main Telephone Number: 301-475-4200, Ext1100

<p>Dina Davis, ext. 1100 Director Dina.Davis@stmaryscountymd.gov</p>	<p>Tracie McPherson, ext. 1102 Deputy Director Tracie.McPherson@stmaryscountymd.gov</p>
<p>Heather Schrader, ext. 1111 Benefits Administrator Heather.Schrader@stmaryscountymd.gov</p>	<p>Cynthia Slattery, ext. 1110 ADA/FMLA Coordinator Cynthia.Slattery@stmaryscountymd.gov</p>
<p>Kristyn Cothren, ext. 1104 Senior HR Coordinator/Recruiter Kristyn.Cothren@stmaryscountymd.gov</p>	<p>Colleen Wood, ext. 1105 Senior HR Specialist/Benefits Colleen.Wood@stmaryscountymd.gov</p>
<p>Rachel Pulliam, ext. 1103 Risk Manager Rachel.Pulliam@stmaryscountymd.gov</p>	<p>Kerri Johnson, ext. 1112 Senior HR Specialist/Risk Kerri.Johnson@stmaryscountymd.gov</p>
<p>Cynthia Tomlinson, ext. 1108 Wellness Coordinator & Employee Engagement Specialist Cynthia.Tomlinson@stmaryscountymd.gov</p>	<p>Kelly Pelczar, ext. 1114 Senior HR Specialist/Payroll Kelly.Pelczar@stmaryscountymd.gov</p>
<p>Emily Hammett, ext. 1106 HR Assistant Emily.Hammett@stmaryscountymd.gov</p>	<p>Employee Relations Coordinator</p>

Questions?

Your Benefit Contacts

Benefit Plans	Contact	Phone	Website or Email
Basic & Supplemental Term Life	Minnesota Life Company	800-392-7295	www.ochsinc.com
bswift Online Enrollment	Bolton	301-276-7760	service@boltonusa.com
CareFirst/Medical	CareFirst	800-628-8549	www.carefirst.com/stmarys
Deferred Compensation Plan - 457(b)	Voya -- Marta Steane, ChFC	703-304-9077	Marta.steane@voyafa.com
Dental	CareFirst	866-891-2802	www.carefirst.com/stmarys
Employee Assistance Plan (EAP)	AllOne Health - Deer Oaks	800-451-1834	allonehealth.com/portal
Flexible Spending Account/COBRA	Voya	833-232-4673	Voya.Benstrat.com or HSAinfo@voyacom
Health Center	Marathon Health Center	240-744-1100	my.marathon-health.com
Hospital Indemnity	Bolton	301-276-7760	service@boltonusa.com
Identity Theft	Allstate	800-789-2720	Customercare@AIP.com
Long-Term Disability	Madison National Life Insurance	800-392-7295	www.ochsinc.com
The Standard Accident	Bolton	301-276-7760	service@boltonusa.com
The Standard Critical Illness	Bolton	301-276-7760	service@boltonusa.com
Vision	CareFirst/Davis	800-783-5602	www.carefirst.com/stmarys
Whole Life Insurance w/Chronic Care	Bolton	301-276-7760	service@boltonusa.com

Annual Notices

St. Mary's County Government is required by applicable law to provide you with certain notices each year that inform you of your rights and our responsibilities with respect to the County's health plan (the "Plan"). Please carefully review the information contained below and share it with your covered dependents. We suggest you keep this information for future reference.

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 if 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.

Annual Notices

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're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP 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, to see if your state has a premium assistance program, or for more information on special enrollment rights, contact the U.S. Department of Labor or the U.S. Department of Health and Human Services or the Employee Benefits Security Administration Centers for Medicare & Medicaid Services at 1-866-444-EBSA (3272) 1-877-267- 2323, Menu Option 4, Ext. 61565.

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.

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 www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

WOMEN'S HEALTH AND 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 consultation 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 lymphedema.

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.

Annual Notices

MEDICARE PART D INFORMATION--CREDITABLE COVERAGE

Important Notice from St. Mary's County Government 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 St. Mary's County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. St. Mary's County Government has determined that the prescription drug coverage offered by St. Mary's County Government 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 15th through December 7th. 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 St. Mary's County Government and enroll in Medicare prescription drug coverage, you may enroll back into St. Mary's County Government 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 St. Mary's County Government Health Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

Annual Notices

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 St. Mary's County Government 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) if 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. 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 St. Mary's County Government changes. You also may request a copy of this notice at any time.

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 whether or not you are required to pay a higher premium (a penalty).

COORDINATION OF BENEFITS (COB)

All medical and dental plans contain a "non-duplication of benefits," or Coordination of Benefits (COB), clause. Under the COB provision, 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 retiree employee and dependents pays second.
- Contact your health plan's Member Services department to confirm your plan's specific COB rules.

FAMILY & MEDICAL LEAVE (FMLA)

Employees may be eligible for leave under the Family Medical Leave Act (FMLA) if they have been employed for at least 12 months and have worked at least 1,250 hours during the 12 months immediately preceding the start of the leave.

Go to the bswift library or to www.dol.gov/whd/fmla for additional information.

Annual Notices

NEW 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, this notice provides basic information about the new 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 9.96% of your household income for the year 2026, 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

How Can I Get More Information?

For more information about health coverage offered by your employer, contact your Benefits Team at 301-475-4200, extension 1100. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Please visit www.marylandhealthconnection.gov you can also access help through the Maryland Health Connection customer service center by calling 855-642-8572 or 855-642-8573.

¹An 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. www.irs.gov/affordable-care-act and search on Employers for more information.

Annual Notices

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 see bswift for more information.

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.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communications
- Ask the Plan to limit the information the Plan shares
- Get a list of those with whom the Plan has shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

THE PLAN'S USES AND DISCLOSURES

The Plan may use and share your information to:

- Help manage the health care treatment you receive
- Help administer and review the operation of the Plan
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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Privacy Contact for Questions about the Plan's Health Information Privacy Practices:

St. Mary's County Government c/o Health Plan Privacy Official 23115 Leonardtown Drive
PO Box 653
Leonardtown, MD 20650
(301) 475-4200, extension 1100

INTRODUCTION

The health plans sponsored by St. Mary's County Government (referred to in this Notice as the "Health Plans" or just the Plan) may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by St. Mary's County Government, while other functions are performed by other service providers under contract with the Health Plans or by insurance carriers.

This Notice applies to each Health Plan sponsored by St. Mary's County Government. However, for any benefits that are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's uses or disclosures of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan. The Plan is required by law to abide by the terms of this Notice while it is in effect. **This Notice is effective beginning February 16, 2026** and will remain in effect until it is revised.

If the Plan's health information privacy practices, policies and/or procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies and/or procedures retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies/procedures were revised.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- The Plan will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Plan may charge a reasonable, cost-based fee.

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Ask the Plan to correct health and claims records

- You can ask the Plan to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask the Plan to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- The Plan will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask the Plan to limit what it uses or shares

- You can ask the Plan not to use or share certain health information for treatment, payment, or the Plan's operations.
- The Plan is not required to agree to your request and may say "no" if it would negatively affect the administration of the Plan.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times the Plan has shared your health information for 6 years prior to the date you ask, who received it, and why.
- The Plan will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Plan to make). The Plan will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- The Plan will make sure the person has this authority and can act for you before taking any action.

File a complaint if you feel your rights are violated

- You can complain if you feel the Plan has violated your rights by contacting the Plan using the Privacy Contact information on page 35.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- St. Mary's County Government will not retaliate against you for filing a complaint.

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YOUR CHOICES

For certain health information, you can tell the Plan your choices about what it may share. If you have a clear preference for how the Plan shares your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell the Plan your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety, as permitted by law.

In these cases, the Plan will never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

THE PLAN'S USES AND DISCLOSURES

How does the Plan typically share use or share your health information?

The Plan typically uses or shares your health information in the following ways, including for treatment, payment and health care operations, except where 42 CFR Part 2 ("Part 2") imposes stricter rules regarding substance use disorder (SUD) information. See the discussion of the special rules that apply to certain SUD records below as we will not disclose your SUD information subject to Part 2 without your written consent, except as expressly permitted by Part 2.

Pay for your health services

The Plan can use and disclose your health information to pay for your health services.

Example: The Plan processes your health care claims to coordinate payment to providers or to reimburse you for eligible expenses you have paid.

Health care operations

- The Plan may use or disclose PHI for purposes that are related to the operation of the Plan including utilization review programs, quality assurance reviews, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan.
- The Plan is not allowed to use genetic information to decide whether to offer you coverage or the price of that coverage.

Example: The Plan may use health information about you to offer wellness program services for you.

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Help manage the health care treatment you receive

The Plan may use your health information and share it with professionals who are treating you.

Example: A doctor sends the Plan information about your diagnosis and treatment plan so we can arrange additional services.

Administer your plan

The Plan may disclose your health information to the plan sponsor for plan administration.

Example: A business associate for the Plan may provide certain statistics to the plan sponsor to explain the costs of the Plan.

How else can we use or share your information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law, including those described in the discussion of the special rules that apply to certain SUD records below, before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

The Plan can use or share your information for health research.

Comply with the law

The Plan will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The Plan can share health information about you with organ procurement organizations.
- The Plan can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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Address Workers' Compensation, law enforcement, and other government requests

The Plan can use or share information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

The Plan can share health information about you in response to a court or administrative order, or in response to a subpoena.

THE PLAN'S RESPONSIBILITIES

- The Plan is required by law to maintain the privacy and security of your protected health information in the manner required by applicable law, including the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and information subject to more stringent protections under other applicable law such as Part 2 relating to SUD diagnosis, treatment, or referral.
- The Plan will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Plan must follow the duties and privacy practices described in this notice (as may be amended from time to time) and give you a copy of it.
- The Plan will not use or share your information other than as described here unless you authorize the Plan, in writing, to use or share your information for another purpose. If you tell us we can use information for some other purpose, you may change your mind at any time. Let the Plan know in writing if you change your mind.
- **Please note that protected health information shared with entities not bound by HIPAA (e.g., law enforcement, etc.) may be re-disclosed and lose federal protection. That is, if the Plan shares your health information (as permitted by HIPAA) with a recipient that is not subject to HIPAA, your health information may be re-disclosed by that recipient and may no longer be protected by federal privacy laws.**

Example: If you authorize the disclosure of your health information to a third party in connection with a legal action, that information may not be protected under HIPAA once shared with the third party.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) INFORMATION UNDER 42 CFR PART 2 ("PART 2")

The Plan may receive SUD treatment information from providers or programs covered by 42 CFR Part 2 (42 USC 290dd-2) (a "Part 2 Program"), other HIPAA covered entities (that are not Part 2 Programs), or the business associates of HIPAA covered entities. Part 2 provides stricter confidentiality protections than HIPAA. For example, we may only receive SUD treatment information that is subject to Part 2 if you consent to the disclosure or as otherwise permitted by law.

When we lawfully receive such information, we will only use and disclose it (or testimony relating the content of such records) as follows:

- You provide the Plan with your written consent for the use or disclosure.
- A court order entered after notice and an opportunity to be heard and that meets the requirements of Part 2 authorizes the disclosure.
- The disclosure is permitted without your consent by Part 2 regulations (such as in the case of medical emergencies, to public health authorities in certain cases where the records have been de-identified, or for scientific research, audit or evaluation in certain cases, etc.).
- The Plan received SUD information about you from a Part 2 Program, other HIPAA covered entity or HIPAA business associate through your consent to uses and disclosures of your SUD records for purposes of treatment, payment or health care operations and the Plan uses or further discloses your SUD records for any of the purposes permitted by HIPAA as described elsewhere in this Notice. Note that in this circumstance the consent through which the Plan received your SUD records was limited to treatment, payment and health care operations but Part 2 rules permit the Plan to more broadly redisclose those records for any purpose permitted by HIPAA.

In no event, however, will the Plan use or disclose your SUD records subject to Part 2 (or testimony that describes the information contained in such records), in any civil, criminal, administrative, or legislative proceedings against you, unless (a) you provide written consent or (b) unless we are required to do so pursuant to a court order after you (or the holder of the record) are provided notice of the court order and the opportunity to be heard in the manner required by applicable law. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Information disclosed pursuant to Part 2 or HIPAA may be subject to redisclosure and may no longer be protected by federal law.

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.
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 full-time and full-time equivalent employees.
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.
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. Co-insurance is not the same and does not include a co-pay.
Copayment (Copoly)	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.
Flexible Spending Account	A Flexible Spending Account (FSA) allows 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 the person applying for coverage.
Guaranteed Issue Maximum	The maximum amount of life insurance you may purchase without providing medical evidence.

General Glossary of Terms

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.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.
Medical Evidence of Insurability	You may be required to complete a health questionnaire to be approved for certain benefit plans, thus providing evidence that you are insurable. The insurance company will review your health information and determine whether they will provide coverage to you.
Non-Formulary	A drug not included on the list of approved drugs of an insurance carrier.
Non-Reimbursed Expenses	Services you have paid for, and that are not reimbursable by your insurance company; for example, co-pays, deductibles, charges more than the reasonable and customary or the allowed benefit, or other charges not covered by your insurance company
Open Enrollment	See “Annual Benefits Election Period.”
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-pays.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for St. Mary’s County Government, this is from July 1 to June 30 of the following year.
Precertification	Your insurance company may require your physician to obtain approval before services are rendered 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.
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.

