



OPEN ENROLLMENT BENEFITS INFORMATION

2026–2027 School Year



Frederick County Public Schools

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Open Enrollment is **May 1st through May 22nd**. Please review this important information to see if you need to take action regarding your benefits.

Benefits Open Enrollment

To enroll or make changes, you must do so **ONLINE** through the employee Self-Service Portal, which opens on May 1st.

You can use Employee Self Service to enroll/change the following benefits:

- **Flexible Spending Account Plan** (You must re-enroll in this plan every year): Elect your Annual Amount
- **Medical Coverage:** If no change, no action required
- **Dental Coverage:** If no change, no action required for options available
 - Standard (\$1,500 maximum allowance)
 - Dental Buy-Up (\$2,500 maximum allowance)
- All changes and/or new enrollments must be submitted by May 22nd
 - Additional information and instructions are available on the **Benefits Dashboard**
- When you have finished updating the desired enrollments scroll to the top of the screen and click Submit.

Benefits Enrollment

The Enrollment Overview displays which benefit options are open for edits. All of your benefit changes will be effective the date of the open enrollment event.

Enrollment Summary

The screenshot displays the 'Enrollment Summary' section. On the left, it shows 'Your Pay Period Cost \$' and 'Status Submitted 05/01/2025 12:54PM'. Below this is a 'Preview Statement' button and a 'Submit' button, which is highlighted with a red box and a red arrow pointing to it. On the right, there is a pie chart titled 'Full Cost' with two segments: 'FSA H' (orange) and 'Medical' (blue).

- After submitting your changes, you will receive a pop-up message confirming your selections. Click view to review your Election Preview Statement.
- After submitting your changes in the Self Service, please check your inbox for a confirmation email.
 - If you receive the email: Your submission was successful.
 - If you do NOT receive the email: Your changes were not saved.

Please Note

You may add eligible dependents to your medical and/or dental coverage.

An eligible dependent is defined as follows:

- The eligible employee's legal married spouse;
- Children from birth through the end of the month in which they attain the age of twenty-six (26) including:
 - Biological children
 - Adopted children or children placed for adoption or Stepchildren
 - Legal ward children
 - Unmarried, incapacitated Dependent children, age of twenty-six (26) (Limiting Age) and over will be eligible for coverage if:
 - The Dependent child is chiefly dependent for support upon the employee (Subscriber) or the employee's Dependent spouse and this is verified via a current year tax return showing the Dependent child claimed as a dependent (income information may be redacted); and
 - At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age.
 - The Subscriber provides proof of disability to medical carrier within thirty (30) days of enrollment opportunity, Qualified Life Event or within thirty (30) days of when coverage would otherwise terminate. Proof is shared using the medical insurance carrier's form (**CareFirst Disability Certification - Overage Dependent**); record of approval must be on file with our carrier.

What's New

Updates for the 26-27 Plan Year

- Along with premium change, new plan design changes, will also be in effect, July 1
- FSA Health maximum limit has increased from \$3,300 to \$3,400
- FSA Health carryover maximum has increased from \$660 to \$680
- FSA Dependent Care maximum limit has increased from \$5,000 to \$7,500 for individuals or married couples filing jointly (\$3,750 for a married person filing separately).

Overview of July 1, 2026 Plan Design Changes

To ensure the long-term sustainability of our self-insured health plan, the Insurance Council has recommended a set of plan design adjustments for the 2026-2027 plan year. These updates are intended to balance rising healthcare costs while continuing to provide high-quality, comprehensive coverage for employees and their families.

Plan Design Changes	Current	July 1, 2026
Primary Care Visit Copay	\$20 Copay	\$25 Copay
Urgent Care Visit Copay	\$20 Copay	\$35 Copay
In-Network Deductible	\$0	\$100 Individual/\$200 Family
Out-of-Network (OON) Deductible	\$200 Individual / \$400 Family	\$400 Individual / \$800 Family
Specialist Copay	\$35 Copay	\$40 Copay
Physical Therapy	\$0 PT / \$20 all other therapies	\$20 PT / \$20 all other therapies
Emergency Room Copay	\$0 Emergency; \$75 Non-emergency	\$150 Copay per visit, regardless if emergency or non-emergency
Inpatient Hospital Copay	\$100 per admission	\$150 per admission
Outpatient Surgery	\$0 Copay	\$100 Copay
Infertility (Assisted Infertility/In Vitro)	0% Coinsurance	10% Coinsurance
Out-of-Pocket Maximum	\$1,250 Individual / \$2,500 Family (OON only)	\$2,500 individual / \$5,000 family (OON only)
Generics	\$13 retail / \$21 mail-order	\$20 retail / \$25 mail-order
Preferred Brands	\$25 retail / \$45 mail-order	\$35 retail / \$60 mail-order
Non-Preferred Brands	\$40 retail / \$65 mail-order	\$45 retail / \$90 mail-order
Complex Radiology/ Imaging such as MRI/CT/PET Scan	\$0 Copay	\$40 Copay

What This Means For You

While some cost-sharing elements may change, such as deductibles, copays, or premiums, the plan continues to provide comprehensive medical coverage, access to broad provider networks through our providers, preventive services at no cost, and prescription coverage and wellness resources. Our plan is designed to support employee health and well-being through affordable, high-quality benefits.

Information Sessions

The FCPS Benefits department is organizing web based informational sessions for May of 2026. Select a link below to sign up for participation in an Information Session.

Virtual Information Sessions

Topic	Date (click to register)	Time	Format
Benefits Presentation and Open Enrollment Information	Monday, May 4	4:30 P.M.	Google Meet hosted by FCPS Benefits to present a general overview of available benefits and information about open enrollment
Benefits Presentation and Open Enrollment Information	Friday, May 8	7:30 A.M.	Google Meet hosted by FCPS Benefits to present a general overview of available benefits and information about open enrollment
Benefits Presentation and Open Enrollment Information	Friday, May 15	3:30 P.M.	Google Meet hosted by FCPS Benefits to present a general overview of available benefits and information about open enrollment

Note: The premium rate chart on the following page contains Board recommended premium payroll deductions. The premium rates and benefits included in this material are contingent upon final contract negotiations with FCTA, FASSE, FCASA and final adoption of the Board of Education’s Fiscal Year 2027 budget. These rates represent a 13% increase in premiums for medical insurance and a 2.21% increase in premiums for dental insurance for 2026–2027 Fiscal Year.



Premium Rates Fiscal Year 27

Medical, Vision, and Prescription Insurance Rates

	Payroll deductions – Each pay period ¹				
	Health insurance ² CareFirst BlueChoice Advantage CareFirst BlueVision Plus CVS CareMark Prescription				Employer's contribution (How much FCPS pays on your behalf)
	10-Month Employees 19 Pays	10-Month Employees 20 Pays	11-Month Employees 22 Pays	12-Month Employees 24 Pays	Employer Annual Contribution
Employee Only	\$36.44	\$34.62	\$31.47	\$28.85	\$13,150.72
Employee + One Dependent ³	\$277.17	\$263.32	\$239.38	\$219.43	\$24,911.92
Employee + Family ⁴	\$367.95	\$349.55	\$317.77	\$291.29	\$24,848.34
Employees + Family ^{4,5} (Both parents employed by FCPS)	\$72.88	\$69.24	\$62.95	\$57.70	\$30,454.53

Dental Insurance Rates

	Payroll deductions – Each pay period ¹							
	Dental insurance ² Standard Delta Dental \$1,500 Maximum Benefit Per Covered Person				Dental insurance ² Buy-Up Delta Dental \$2,500 Maximum Benefit Per Covered Person			
	10-Month Emps. 19 Pays	10-Month Emps. 20 Pays	11-Month Emps. 22 Pays	12-Month Emps. 24 Pays	10-Month Emps. 19 Pays	10-Month Emps. 20 Pays	11-Month Emps. 22 Pays	12-Month Emps. 24 Pays
Employee Only	Paid 100% by FCPS	Paid 100% by FCPS	Paid 100% by FCPS	Paid 100% by FCPS	\$7.09	\$6.73	\$6.12	\$5.61
Employee + One Dependent ³	\$39.66	\$37.68	\$34.25	\$31.40	\$61.65	\$58.57	\$53.25	\$48.81
Employee + Family ⁴	\$45.92	\$43.62	\$39.66	\$36.35	\$70.21	\$66.70	\$60.63	\$55.58
Employees + Family ^{4,5} (Both parents employed by FCPS)	\$27.04	\$25.68	\$23.35	\$21.40	\$51.33	\$48.76	\$44.32	\$40.63

¹ The premium rate chart contains Board recommended premium payroll deductions. The premium rates and benefits included in this material are contingent upon final contract negotiations with FCTA, FASSE, FCASA and final adoption of the Board of Education's Fiscal Year 2027 budget.

² Contributions for medical and dental insurance coverage are deducted from your gross earnings before taxes are calculated.

³ In this context, "Employee + One Dependent" would refer to employee + spouse or employee + dependent.

⁴ In this context, "Family" refers to Employee + two or more dependents.

⁵ The employees must be legally married spouses to qualify for rate tier.

This publication is intended to provide an overview of FCPS benefits; complete details can be found in the insurance companies' documents and the plans' legal documents, which will always govern in case of a dispute. The Board of Education of Frederick County, FCTA, FASSE and FCASA jointly reserve the right at any time to modify or amend, in whole or in part, any or all plan provisions.

Summary of Benefit Plans

CareFirst BlueChoice Advantage Medical Plan

FCPS will continue to offer medical coverage through CareFirst for the 2026–2027 plan year; In-Network and Out-of-network benefits. To find a provider near you, visit the website at www.carefirst.com/frederick

- **In-network** – Selecting a physician or health care provider within the CareFirst’s BlueChoice Advantage large local and national network means maximum coverage and lower out-of-pocket expenses. Copayments are charged for eligible services, and referrals are not required for specialty services.
- **Out-of-network** – Annual deductibles must be met and paid out-of-pocket. Out-of-network coverage includes Participating and Non-Participating Practitioners.
 - **Participating Health Care Providers** – Expenses are reimbursed at 80% of Allowed Benefit for a Covered Service and the member pays 20% co-insurance.
 - **Non-Participating Health Care Providers** – Expenses are reimbursed at 80% of Allowed Benefit for a Covered Service and the member pays 20% co-insurance. The member is also responsible for the difference between the Allowed Benefit and the practitioner’s actual charge.
**Please review the Summary of Benefits Plan Description for full details*
- Below is an at-a-glance chart that highlights the medical benefits under the CareFirst medical plans. This is not intended to be a comprehensive summary, it will only give you basic details about your plans. For more details, please refer to the Summary of Benefits for each plan.

In Network		Out of Network	
Individual deductible: \$100		Co-insurance: Member pays deductible and then 20% of Allowed Benefit	
Family deductible: \$200		Individual deductible	\$400
Co-payments:		Family deductible	\$800
Primary Care Physician	\$25	Individual maximum out-of-pocket	\$2,500
Specialist	\$40	Family maximum out-of-pocket	\$5,000
Urgent Care	\$35	Maximum out-of-pocket: Includes Annual Deductible	
Inpatient Hospital	\$150		
Emergency Room	\$150		
Maximum out-of-pocket: No Out-of-Pocket Maximum			

CareFirst Vision Plan

The vision plan through CareFirst provides vision benefits for you and your eligible dependents. You may see any vision provider, but to keep your out-of-pocket costs down, consider using an in-network provider. You can use these benefits in addition to the coverage provided through our medical plans. Out-of-network – Adults are reimbursed according to a fee schedule for exam, lenses and frames. To locate a provider near you, visit the website at www.carefirst.com/frederick

CareFirst BlueVision Plus

Benefit Level	In-Network, Adult Age 20 or Older	In-Network, Children Age 19 or Under
Eye exam (every 12 months)	\$0 copay	\$0 copay

Lenses (every 12 months)

Single vision lenses	\$0 copay	\$0 copay
Anti-reflective lenses	\$0 copay	\$0 copay
Progressive lenses	\$0 copay	\$0 copay

Contact lenses or frames (every 12 months)

Frames	Up to \$150 retail allowance	Up to \$200 retail allowance
Elective contact lenses	Up to \$150 allowance	Up to \$150 allowance

Please refer to the vision summary plans for more details.



Delta Dental Plan

FCPS offers two dental plan options to allow you to choose the plan that best meets your needs. Both options provide a rich benefit for covered preventive dental services to encourage good dental habits. We use Delta Dental as our dental carrier.



You'll receive the greatest value when you visit a Delta Dental PPO dentist because they generally accept lower fees for their services, and the Plan has enhanced Diagnostic and Preventive benefits with a PPO provider. Delta Dental Premier dentists also discount their fees, which can help reduce your out-of-pocket costs.

To find a network provider, visit the website at www.deltadentalins.com

What you pay

	Standard		Buy-up	
	In-Network	Out-of- Network ¹	In-Network	Out-of- Network ¹
Individual Calendar Year Deductible (per person)	\$0	\$50	\$0	\$50
Family Calendar Year Annual Deductible (per family)	\$0	\$100	\$0	\$100
Annual Maximum/Person	\$1,500		\$2,500	
Preventive and Diagnostic (Deductible waived for preventive services)	\$0		\$0	
Basic Services	20%		20%	
Major Services	50%		50%	
Orthodontia	50%		50%	
Orthodontia Lifetime Maximum	Unlimited	After deductible (\$2,000)	Unlimited	After deductible (\$2,000)

¹ Out-of-network dentists can bill you for the difference between what the plan pays and what the dentist actually charges.

CVS/Caremark Prescription Drug Coverage

When you enroll in the FCPS medical plan, you automatically receive prescription drug coverage through CVS/Caremark. The Pharmacy Management Formulary Program provides a defined list of FDA-approved medications chosen for their medical effectiveness and value. The formulary list includes both generic and brand-name drugs. Your share of the cost will always be less for drugs that are on the formulary list; however, coverage is available for many non-formulary drugs.

The formulary drug program is divided into copayment categories called tiers. To get an updated copy of the tiered formulary list of drugs, visit www.caremark.com or at www.fcps.org/benefits.

The prescription plan includes, but not limited to, the following programs:

- **Maintenance Choice Program** – plan participants who take maintenance medications have the choice to purchase their 90-day supply from the mail order program or purchase from a CVS/Pharmacy store and pay the same mail order copayment.
- **Mandatory Generics** – when available as well as mandatory specialty pharmacy program for specialty prescription drugs.
- **Diabetic Meter Program** – plan participants with diabetes may qualify for a free blood glucose meter when diabetic testing supplies are ordered.
- **Good RX** – Cost Saver will help you save money on commonly dispensed generic medications. Caremark Cost Saver makes certain that you automatically receive the lowest price for medications covered under our plan.
- **Smart Logic Prior Authorization Program** – GLP-1, GIP/GLP-1 medications - to help make sure the medications covered by your plan are used safely and appropriately as prior authorization has been implemented. During a claim review, for substantiation not found to support the drug, prior authorization will be needed from your provider.

CVS/Caremark

Benefit	You pay	
Retail (any pharmacy, up to 30-day supply)	Generic	\$20
	Brand	\$35
	Non-formulary	\$45
Mail Order or CVS Pharmacy (up to 90-day supply)	Generic	\$25
	Brand	\$60
	Non-formulary	\$90

Save Money - Use Mail Order!

The prescription plan also includes a Mail Order program through CVS/Caremark which allows you to purchase up to a 90-day supply of medications you take on an ongoing basis (known as maintenance drugs). When you order prescriptions through the mail or at a CVS Pharmacy, you will receive a significant savings for a 90-day supply.

To use the mail order program, have your doctor fill out your prescription and fill out an order form. Mail your form to CVS/CareMark, P.O. Box 94467, Palatine, IL 60094-4467. You can also fax it to 800-323-0161.

Go Generic! Keep You and Your Wallet Healthy

1. *What are generic drugs?*

Generic drugs are prescription medications that have the same active ingredients, dosage amounts, strength, safety, and quality as brand-name prescription medications.

2. *Are generic drugs just as safe as brand-name drugs?*

Yes. Laboratories that produce generic drugs must meet the same high FDA standards as the facilities of brand-name drugs, and all generic drugs are FDA-approved to be therapeutically equivalent to brand-name drugs.

3. *Why are generic drugs less expensive?*

When a new medicine is invented, a patent is filed so that no other company may reproduce that drug. While the patent is current, companies can charge a much higher price for the drug because there is no competition. In addition, companies often spend large amounts of money for advertising and promotion, further increasing the cost of the brand name medication. When a medication's patent expires, other companies may produce this drug, creating generic medications. Due to increased competition, and because these other companies rarely spend money on advertising, the price of the generic drug is significantly lower.

4. *What is different about generic?*

The appearance of brand-name drugs is protected by law, so generic drugs will have different shapes, flavors, and/or colors. However, since the active ingredients are the same, they will work the same way in your body as the brand-name drug.

5. *Does every brand-name drug have a generic drug equivalent?*

No. Pharmaceutical companies have a patent on their brand-name medications, so new drugs will not have a generic equivalent until the patent expires.

6. *What if my brand-name drug is not available in generic form?*

Even if your brand name drug is not available in generic form, there may be a different generic drug that could work just as well. Ask your doctor if a therapeutic alternative might be right for you. A generic therapeutic alternative is the equivalent for a different brand-name drug and treats your condition using a different active ingredient. If your doctor agrees, you can feel confident about using the generic therapeutic alternative and feel good about saving money too!

FCPS Cafeteria Plan At-A-Glance

One of the many benefits of being employed with FCPS is that you have access to a Cafeteria Plan established by FCPS. A Cafeteria Plan allows you to pay for out-of-pocket medical expenses. The major advantage of FCPS's Cafeteria Plan is that, by participating, you save money by paying for benefits you would normally pay but save money on federal, state and FICA taxes. If you participate in the Cafeteria Plan, you would not be eligible for a Federal income tax credit on your next tax return.

FCPS Plan Information

Plan Name:	Frederick County Public Schools
Address:	191 South East St. Frederick, MD 21701
Telephone:	301-644-5080
Plan Number:	37854
Plan Year Begin:	July 1
Amended:	N/A
Plan Year End:	June 30
Maximum Health FSA Limit:	\$3,400
Maximum Dependent Care Limit:	\$7,500, file married FSA Dependent Care maximum limit has increased from \$5,000 to \$7,500 for individuals or married couples filing jointly (\$3,750 for a married person filing separately)
Annual Health FSA Rollover Maximum:	\$680
Grace Period:	No
Run-out Period for Active Employees:	90 days after Plan year ends (last day to submit claims is September 28th)
Run-out Period for Terminated Employees:	90 days after your termination date
Plan Administrator:	FCPS
Service Provider:	WEX
Service Provider Website:	www.wexinc.com
Service Provider Phone:	866-451-3399

Elections

It is important for you to decide what benefits you will need for each Plan year. Your decision should be carefully made based on your expected health expenses for the coming year.

Unless a qualifying "change in status" event occurs, you will not be able to change your elections after the Open Enrollment period ends. To see a list of the qualifying "change in status" events please see your Summary Plan Description (SPD).

Beginning and Ending of Coverage

The coverage will begin the first day of the Plan Year for those who enroll during the open enrollment period. For mid-year enrollments the coverage date will begin as set forth by FCPS (see eligibility). The coverage will end at the end of the month of the termination date, or at the end of any applicable run- out/carryover period. This plan is subject to COBRA (see the Summary Plan Description for more details.)

Benefits Available

The FCPS Cafeteria Plan offers the following benefits:

Summary Plan Description

Plan Document

Health Flexible Spending Account

A Health Flexible Spending Account (FSA) allows you to pay for qualified medical expenses with pre-tax funds (see Section 213 D and Section 105 of the Internal Revenue Code for list of eligible expenses. You cannot use your FSA for expenses that have been paid by your medical insurance plan.) The maximum annual election amount is \$3,400.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account allows you to be reimbursed for qualified dependent day-care expenses with pre-tax funds. FSA Dependent Care maximum limit has increased from \$5,000 to \$7,500 for individuals or married couples filing jointly (\$3,750 for

a married person filing separately). This is not financial advice, and all selections should be reviewed with a professional per our tax situation. To be eligible for reimbursement you will need to provide a statement from the service provider with the following information: name, address, taxpayer identification number (in most cases), and incurred expense amount.

Please see the Summary Plan Description for dependent eligibility requirements.

Reimbursement

Throughout the Plan year you can submit for reimbursement for qualified medical and dependent care expenses in the following ways: fax (forms available at www.wexinc.com), email, online, or mobile application. Employees may also pay for their qualified medical expenses directly from their FSA with the WEX debit card. See the SPD for further details.

Expenses are “incurred” when the service has been provided. The reimbursement requirements will be listed on the reimbursement claim forms.

For Health and Dependent Care Accounts reimbursement claims must be submitted no later than 90 days after the end of the Plan Year. Any Health FSA funds exceeding \$660.00 left over after the 90-day run-out period will be forfeited. See “Rollover” section below for additional details.

Non-Discrimination

Per compliance with the various rules and regulations of the Internal Revenue Code the election amounts of “highly compensated employees” and “key employees” (officers, shareholders or highly paid employees) may be limited due to non-discrimination regulations. For more information, please see the Summary Plan Description.

Family and Medical Leave Act (FMLA)

If you go on a qualifying FMLA Leave this plan will comply with the rules and regulations set forth in the proposed CFR-IRS Regulation 1.125-3 as well as any additional policies established by FCPS. Please see the Summary Plan Description for more details.

Rollover

Under IRS regulations, employees will be able to rollover up to \$680.00 of their Health FSA funds from one Plan year to the next. (Any amount rolled over will not affect the election amount for the new Plan year. Any funds above \$680.00 left over after the 90-day run-out period will be forfeited.)

Frequently Asked Questions

What is a Flexible Spending Account (FSA)?

Flexible Spending is an employer sponsored program that allows you to set aside money pre-tax to use for certain IRS eligible expenses. The Medical FSA covers not only medical expenses, but also dental, prescription and vision services.

How does an FSA work?

During the open enrollment period with your employer, you will make an election for the amount you want to contribute to your FSA. That annual amount will be divided equally over your yearly pay schedule, and deductions will be made pre-tax from each pay check and deposited to that account. As you incur expenses, you will submit for reimbursement from your account, either with a paper claim or with the WEX debit card.

What are the advantages to having an FSA?

When you participate in the Flexible Spending program, your eligible expenses are paid for with tax-free money. Also, as the contributions are withheld from your paycheck pre-tax, it lowers your taxable income, meaning you pay less in taxes, and take more money home.

What are considered eligible expenses?

There are 3 things to consider as you determine whether an expense is eligible for reimbursement from your Medical FSA – services, service dates, and eligible dependents.

Services: Eligible medical expenses are defined by IRS Code §213(d) and must not be excluded by the plan documents. In order to qualify for reimbursement, the expense must diagnose, cure, mitigate, treat, or prevent disease, or affect a structure or function of the body. Expenses aimed at maintaining general

health or improving a person's appearance (cosmetic procedures), are not considered eligible expenses.

Service Dates: In order to be eligible for reimbursement, services must be provided/incurred during the time that you are covered and active under the plan. The IRS is concerned with the actual date of service, not the date of payment.

Eligible Dependents: Coverage for a Medical FSA is extended to the employee, the employee's spouse, and the employee's child who is under age 26 or someone else who is a qualified tax dependent of the employee.

When can I enroll?

You may enroll in the plan during your employer's open enrollment period prior to the start of the plan year. You may also enroll mid-year if you are a newly hired employee, or if you have a qualified Status Change Event as outlined in the Summary Plan Description.

Can I make changes to my account mid-year?

Once you make your election during the open enrollment period, it cannot be changed or canceled during the plan year, it is irrevocable. Exceptions to the irrevocability rule are allowed mid-year with a qualified Status Change Event such as a marriage, divorce, birth, adoption, death, change number of dependents, dependent care changes etc. The election changes must be consistent with the status change.

What if my spouse has a Health Savings Account?

If your spouse is participating in a Health Savings Account (HSA), participation in this FSA may disqualify them from further contributions to that HSA.

What happens to money left in the account at the end of the plan year?

Under IRS regulations, employees are now able to rollover up to \$680.00 of their Health FSA funds from one plan year into the next. This will allow participants an additional 12 months to spend the remaining balance. Funds that are rolled over will not affect election amounts for the new plan year. A run-out period will still be applicable, allowing you time to submit reimbursement claims for expenses incurred prior to the end of the plan year.

Rollover does not apply to the Dependent Care FSA.

Do I have to wait for the money to be deposited before requesting reimbursement?

With a Medical FSA, you do not have to wait for the deposits to be made before requesting reimbursement. Your full annual election amount is available to you on the first day of the plan year.

What information do I need for reimbursement?

In order to verify the eligibility of an expense, we need a third-party statement indicating the provider's name and contact information, the patient, the date of service (not the date of payment), a description of services rendered, and your portion of the expense. You should also retain a copy of the statement for your records.

How do I submit a reimbursement claim and when can I expect payment?

Reimbursement claims may be submitted electronically with the "Online Claims Entry" option on your account through www.wexinc.com. Reimbursements may also be submitted with a printed reimbursement claim form and sent to the WEX office via email, fax or postal service. Reimbursement claims will be processed daily.

Where can I find out my account information and balance?

As a participant, you will have access to a secure online account through www.wexinc.com. Here you will be able to view your account history and balance, submit reimbursement claims electronically, view a list of eligible expenses, print various forms and documents, and much more. You will be provided the online registration information after enrollment.

What happens if I do not substantiate transactions that are required?

The IRS has strict guidelines on the substantiation of claims. If upon the Plan Closing of the applicable year of spend, claims remaining unsubstantiated will require a *payroll deduction* to recoup the unsubstantiated payment.

Legal Notices

HIPAA Notice of Special Enrollment Rights

Loss of Other Coverage

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future, if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 30 calendar days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption

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/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment within 30 calendar days after the marriage and within 30 days after the birth, adoption or placement for adoption.

Termination of Medicaid or SCHIP coverage or eligibility for premium assistance under Medicaid or SCHIP

If you or your dependent is eligible, but not enrolled for coverage, you may be able to enroll yourself and/or your dependent if either of the following events occur:

- You or your dependent is covered under a Medicaid plan or under a State Child Health Insurance Plan (SCHIP) and coverage under the plan is terminated as a result of loss of eligibility; or
- You or your dependent become eligible for premium assistance under Medicaid or SCHIP. To be eligible for this special enrollment opportunity, you must request enrollment within 60 calendar days after the date you or your dependent become eligible for premium assistance or you or your dependent's Medicaid or SCHIP coverage ends.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act became effective January 1, 2010. The act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members') genetic information.

Genetic information includes:

- Genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services; and,
- The manifestation of a disease or disorder in an individual's family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history – such as through a Health Risk Assessment (HRA) – will be treated as confidential, as required by HIPAA and GINA.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother from discharging the mother or her newborn earlier than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans provide this coverage.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

- 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 all stages of mastectomy including lymphedema.

Medicare Part D 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 through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. FCPS has determined that the prescription drug coverage offered by the FCPS Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your FCPS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

If you continue your coverage through the FCPS Retiree Healthcare Plan Option, you will have prescription coverage included in your FCPS health plan that meets the creditable coverage requirements.

You should also know that if you drop or lose your coverage with FCPS and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage: Contact your Medicare Division office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through FCPS changes. You may also request a copy.

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 prescription drug plans.



For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You Handbook* for their telephone number) for personalized help
- Call 1-800-633-4227 (TTY 1-877-486-2048).
- For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Summary of Benefits and Coverage

To comply with the Patient Protection and Affordable Care Act (the Affordable Care Act), Frederick County Public Schools provides a Summary of Benefits and Coverage (“SBC”). The SBC can be found at the school system’s website, www.fcps.org/benefits and paper copies are available upon request. The SBC is intended to be educational in nature. Complete details can be found in the insurance companies’ documents and the plan’s legal documents, which will always govern in case of a disparity.

Health Care Reform Update

Health Care Reform

The Affordable Care Act (or ACA) continues to impact health insurance plans for employers like Frederick County Public Schools. For the company, it means we continue to comply with all applicable health plan coverage and administration requirements and pay all applicable taxes and fees as required by the ACA.

For individuals, since 2019 there is no longer an ACA tax penalty for those who do not maintain health insurance coverage. However, individuals still have the ability to purchase coverage through the ACA Health Insurance Marketplace (www.healthcare.gov) and premium subsidies for that coverage remain available to qualifying individuals.

As a reminder, FCPS pays the majority of the cost for the health care coverage we offer to eligible employees. It's also important to note that, because you are eligible for coverage through Frederick County Public Schools, you may not qualify for premium subsidies if you choose to purchase a plan through the Marketplace. We encourage you to evaluate all your coverage options and compare their costs to make the best choice for you and your family.

1095C Tax Forms

FCPS is required to provide all full-time employees (those working at least 30 hours per week) with an annual statement describing the health care coverage that was available to them through the company during each month of the year. If you plan to claim premium tax credit subsidies for Marketplace coverage, you will need this form when filing your federal income taxes to confirm you are eligible to claim the tax credits.



FCPS Comprehensive Group Health Plan Benefit Communications

Discrimination is Against the Law

FCPS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Frederick County Public Schools does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Communication Aids and Services

FCPS provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact 301-644-5080

If you believe that FCPS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Senior Benefit Manager:

Senior Benefit Manager
Frederick County Public Schools
191 South East Street Frederick, MD 21701
Phone: 240-586-8033
Fax: 240-586-8049
Email: benefits.office@fcps.org

Complainant may use the **Discrimination Complaint Form** attached to the Policy.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Senior Benefits Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Rm 509F, HHH Building
Washington, DC 20201
Phone: 1-800-868-1019, 1-800-537-7697 (TDD).

Complaint forms are available at:
www.hhs.gov/ocr/office/file/index.html

Office for Civil Rights complaint form:
ocrportal.hhs.gov/ocr/portal/lobby.jsf

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-301-644-5112.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-301-644-5112。

Premium Assistance (Medicaid and 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 and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, 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, ask your 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 1-866-444-3272

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of *January 31, 2026*. Contact your State for more information on eligibility:

Pennsylvania

Medicaid website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Medicaid phone: 1-800-692-7462

CHIP website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx

CHIP phone: 1-800-986-5437

Virginia

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select and coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP phone: 1-800-432-5924

West Virginia

Website: dhr.wv.gov/bms and mywvhipp.com

Medicaid phone: 304-558-1700

CHIP toll-free phone: 1-855-699-8447

To see if any other states have added a premium assistance program since *January 31, 2026*, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-3272

U.S. Department of Health and Human Services Centers
for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Making Changes Once Enrolled

Enrollment changes can only be made during Open Enrollment or within 30 days of a Qualifying Life Event (QLE). QLE includes:

- Marriage/Divorce
- Birth/Adoption/Guardianship
- Gain/Loss of other insurance coverage
- Change in Medicaid or SCHIP eligibility (60 days from event)
- Death

To make an election change following a life event, employees must enter their events and upload the necessary documentation directly through **Employee Self Service** *within 30 days of the event*. If you miss the 30-day window you will need to wait until open enrollment to make an election change. All qualifying events must be supported by a proof of the event and, when adding dependents, proof of the relationship. These instructions speak to the most prevalent Life Qualifying Events. For a complete description of Life Qualifying Events relative to our plan, review the **Plan Document**.

A change in coverage elections due to a birth, adoption or placement for adoption will be effective as of the date of the birth, adoption, or placement for adoption. All other changes in coverage elections will be effective as of the first day of the month following the date the change in election application (including supporting documentation) is received by the Plan Administrator.

See instructions for **submitting a life event**.

Important Note: If the life event is related to a death, please contact the Benefits Office at benefits.office@fcps.org for assistance in making the necessary election changes as these events will not be in employee self-service.



Contacts

Insurance Company Contacts

Plan Type	Contact	Address	Phone Number	Website
Medical	CareFirst	CareFirst Administrator P.O. Box 14116, Lexington, KY 40512	1-866-386-2043	www.carefirst.com
Vision	CareFirst	CareFirst Vision Care Processing Unit E P.O. Box 1525, Latham, NY 12110	1-800-783-5602	www.carefirst.com
Dental	Delta Dental	One Delta Drive Mechanicsburg, PA 17055	1-800-932-0783	www.deltadentalins.com
Flexible Spending Accounts	WEX	P.O. Box 2926 Fargo, ND 58108-2926	1-866-451-3399	www.wexinc.com
Prescription	CVS/CareMark	Claims: P.O. Box 52010 Phoenix, AZ 85072-2010	1-866-260-4646	www.caremark.com
		Mail order: P.O. Box 94467 Palatine, IL 60094-4467	Fax: 1-800-323-0161	
Life/Disability	MetLife	200 Park Avenue New York, NY 10166	1-855-229-7306	mybenefits.metlife.com

FCPS Benefits Office Contacts

If you have any questions regarding plan changes or the enrollment process, please email our office at benefits.office@fcps.org or call **240-586-8040** so we can assist you.

For staff, benefits, about employee benefits, required notices, HIPAA Privacy notice: www.fcps.org/benefits

The HIPAA Privacy Rules require health plans to provide a Notice of Privacy Practices to persons covered under the health plan. Eligible employees may obtain a copy of the Notice of Privacy Practices by visiting the school system's website: www.fcps.org. Go to: Departments, Human Resources, Benefits Links & Forms, HIPAA Privacy Statement. Employees may also contact the school system's Benefits Office for a copy of the privacy practice notice.

Questions concerning the HIPAA Privacy Rules may be directed to: Frederick County Public Schools, Senior Benefits Manager, 191 South East Street, Frederick, MD 21701