2023 EMPLOYEE BENEFITS GUIDE

WASHINGTON COLLEGE

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WASHINGTON COLLEGE EMPLOYEE BENEFITS

As an employee of Washington College, you may be eligible for certain benefits such as medical, dental, vision and supplemental life insurance at group rates. Washington College pays for the majority of the monthly cost of the benefits you choose to enroll in, and you pay a portion as well. In addition, the company pays for the entire cost of a life/ad&d insurance policy on your behalf.

Your company-sponsored benefits are more valuable than ever before and they account for a large portion of the total compensation you receive as an employee of Washington College. Rest assured that we are working hard to provide the best pay and benefits for you and for your family. It's important that you read through this benefits guide carefully so that you can understand what each benefit provides, and how to access coverage when you need it. You may want to share this information with family members as well.

After you read this information, you may contact Liz Behrmann (lbehrmann2@washcoll.edu, 410-778-7260) with questions. **Remember, i**t's important you enroll during your initial eligibility period as you will not have an opportunity to enroll afterwards until the next open enrollment unless you have a qualifying life event (keep reading to learn more).

Thank you for taking the time to learn about your benefits choices and for enrolling on time.

*Your domestic partner is eligible for benefits if he or she is not a relative and has lived with you for at least six months in a committed relationship. For more information about domestic partner benefits, contact Human Resources.

BENEFIT BASICS

ELIGIBILITY

Regular Full-time employees scheduled to work 30 hours per week are eligible for benefits (see HR for more information on eligibility for Retirement). All employees are required to have health insurance and must either join a plan offered by the College or show evidence of coverage by another plan. Most of your benefits are effective on the first day of the month following your date of hire. Your dependents can also enroll for coverage, including:

- Your legal spouse
- Your domestic partner*
- Your children up to age 26

Remember that you may only change coverage if you experience a qualifying life event, as described here.

QUALIFYING LIFE EVENTS

Generally, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child or your domestic partner's child
- Death of your spouse, domestic partner or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse/ domestic partner or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- New entitlement to Medicare of Medicaid

You must log into Paycom within 30 days of a life event to initiate the qualifying event. Depending on the type of event, you may need to provide proof of the event, such as a marriage license.

Contact HR, if you have any questions on the documentation required.

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GETTING STARTED — ENROLL ONLINE USING PAYCOM.COM OR THE PAYCOM APP

Have your dependent/beneficiary Social Security numbers and dates of birth, before beginning the enrollment process.

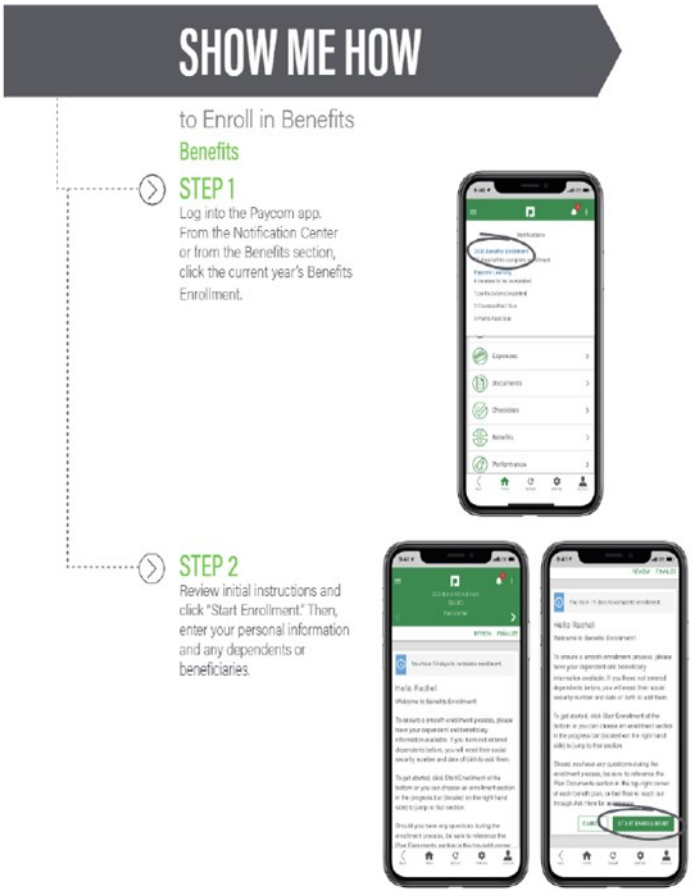
1. Log in to the Paycom app
2. Within the notification center, select “Benefits Enrollment”
3. Click “Start Enrollment” and enter your personal information and any dependents or beneficiaries
4. After reading each benefit plan, choose your coverage, then elect either to enroll or decline
5. As you go through the enrollment process, your selections will display and add up on the benefits summary tracker to the right
6. To complete enrollment, click “Finalize”, then “Sign and Submit”

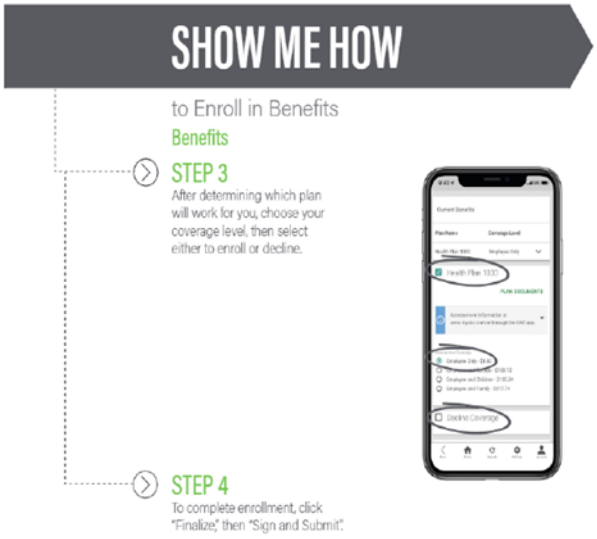
Note: Compliance notices and detailed plan design information can be found on Paycom.

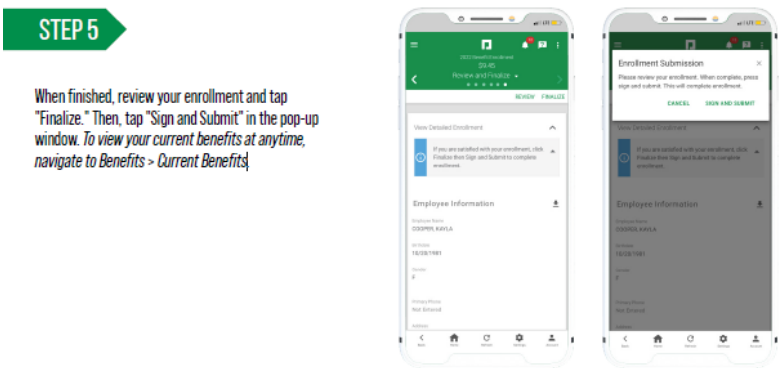
Enroll Online

paycom

Easy Enrollment Steps on the Paycom App







TIP

REMEMBER! The plan year ends on December 31. You will have the option to update coverage in annual enrollment for January 1.

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CONTACT INFORMATION

If you have any questions regarding your benefits please contact the carriers, or your Washington College Human Resources representative listed below.

MEDICAL INSURANCE
Cigna / Policy #: 3339923
mycigna.com
800-244-6224

DENTAL INSURANCE
Delta Dental / Policy #: 18397
deltadentalins.com
800-932-0783

VISION INSURANCE
VSP / Policy #: 30094301
vsp.com
800-877-7195

BASIC LIFE/AD&D, DISABILITY INSURANCE / VOLUNTARY LIFE/AD&D
Unum / Policy #: 629360 / 629361
unum.com
866-679-3054

403(B) RETIREMENT
TIAA-CREF
tiaa-cref.org/washcoll
800-842-2776

HEALTH SAVINGS ACCOUNTS (HSA)
HSA Bank
hsabank.com
800-357-6246

EMERGENCY TRAVEL ASSISTANCE
Assist America
Policy #: 629360
unum.com / medservices@assistamerica.com
800-872-1414 (in U.S.)
609-986-1234 (Outside U.S.)
Reference #: 01-AA-UN-762490

EMPLOYEE ASSISTANCE PROGRAM
ComPsych / ID #: COM589
guidanceresources.com
855-399-2524

WASHINGTON COLLEGE BENEFITS
Liz Behrmann, Benefits Manager
lbehrmann2@washcoll.edu
410-778-7260

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of Washington College, you have the choice of three medical plan options: Preserver Plan, Protector Plan or Protector Plus Plan.

For each, your deductible will run from JANUARY 1 – DECEMBER 31.

The Preserver plan option offers you significantly lower premiums (payroll deductions) and higher deductible than the Protector and the Protector Plus. You can establish a Health Savings Account (HSA) with HSABank and contribute all or part of the premium savings into the HSA. These funds can be used to cover medical expenses, including deductibles, and they're yours forever — even if you leave Washington College. And unlike a Flexible Spending Account (FSA), the contributions are not forfeited.

The Protector plan is an in-network plan with reasonable payroll deductions and deductibles.

The Protector Plus plan gives you the option of using in-network or out-of-network providers. You can save money by using in-network providers because Cigna has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and the Cigna allowed amount, plus your out-of-network deductible and coinsurance.

TIP Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?
You must be a regular full-time employee working a minimum of 30 hours per week on a regular basis.

Will I receive a new Medical ID card?
Cigna will mail ID cards to your home.

Does the deductible run on a calendar year basis?
A calendar year basis.

How long can I cover my dependent children?
Dependent children are eligible until the end of the month in which they turn age 26.

I am a new hire, when will my benefits become effective?

Your medical insurance benefit will begin on the 1st of the month coinciding with or following hire date.

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- OPTION 1: **PRESERVER PLAN**
- OPTION 2: **PROTECTOR PLAN**
- OPTION 3: **PROTECTOR PLUS PLAN**

THE PRESERVER OFFERS SEVERAL BENEFITS:

- Lower premium contributions and potential maximum out-of-pocket expenses
- Routine preventive exams are covered at 100%
- Catastrophic coverage
- The HSA is owned by you
- You have more control over your health care dollars

THE PROTECTOR AND THE PROTECTOR PLUS MAY BE FOR YOU IF THE FOLLOWING IS TRUE:

- You are not interested in establishing a Health Savings Account
- You would rather pay more in monthly premiums and less on medical expenses when they occur
- You Protector Plus includes out-of-network coverage

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting mycigna.com.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Primary Care vs. Urgent Care vs. ER

MEDICAL INSURANCE

Cigna	The Preserver	The Protector	The Protector Plus
	Employee Cost Per Paycheck*	Employee Cost Per Paycheck*	Employee Cost Per Paycheck*
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$3.50 $77.50 $59.50 $122.00	$72.00 $193.00 $161.50 $303.50	$82.50 $258.50 $216.50 $406.00
	In-Network	**In-Network**	**In-Network**
Deductible[1] Individual / Family	$2,000 / $4,000	$500 / $1,000	$500 / $1,000
Company Contribution to HSA**	$500 / $1,000	n/a	n/a
Out-of-Pocket Maximum[2] Individual / Family	$2,500 / $4,500	$3,000 / $6,000	$3,000 / $6,000
Office Visits Preventative Care Primary Care Physician/Specialist Diagnostic Lab / X-Ray Urgent Care	 Covered at 100% Deductible then no charge Deductible then no charge Deductible then no charge	 Covered at 100% $25 copay / $35 copay Deductible then 10% $50 copay	 Covered at 100% $25 copay / $35 copay Deductible then 10% $50 copay
Hospital Visits Inpatient Care (Facility/Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	 Deductible then no charge Deductible then no charge Deductible then no charge Deductible then no charge	 Deductible then 10% & $250 Deductible then 10% Deductible then 10% $100 copay, waived if admitted	 Deductible then 10% & $250 Deductible then 10% Deductible then 10% $100 copay, waived if admitted
Prescription Drug Deductible Retail Tier 1 / 2 / 3 Copay Mail Order (90-day supply) Copay	 Integrated with Medical Deductible $10 copay / $35 copay / $60 $20 copay / $70 copay / $120	 N/A $10 copay / $35 copay / $60 $20 copay / $70 copay / $120	 N/A $10 copay / $35 copay / $60 $20 copay / $70copay / $120
	Out-of-Network	**Out-of-Network**	**Out-of-Network**[3]
Deductible Individual / Family	Not Covered	Not Covered	$1,000 / $2,000
Coinsurance (Member Pays)	Not Covered	Not Covered	30%
Out-of-Pocket Maximum Individual / Family	Not Covered	Not Covered	$3,000 / $6,000

If you have a spouse employed at Washington College, contact HR to see if you are eligible for a discount on your medical premiums

***** Deposited with 1st paycheck of the year. Pro-rated for new hires during the calendar year.***

(1) Family deductible on The Preserver is non-embedded; no family member will receive post-deductible benefits until the entire family deductible is met

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) Out-of-Network services subject to deductible, coinsurance and balance billing

Premiums are withheld from your paycheck on a pre-tax basis unless you request otherwise

Your election can only be changed during the plan year if you experience a qualifying life status change. If you have qualifying life event, log into Paycom to request the coverage change within 30 days of the event.

CIGNA TOOLS AND RESOURCES

CIGNA TELEHEALTH CONNECTION

Washington College offers access to telehealth services through MDLive as part of your medical plan. Cigna Telehealth Connection provides you with 24/7/365 access to board-certified doctors via video chat or phone. The cost of a phone or online visit is the same or less than with your primary care provider

Use Cigna Telehealth Connection to connect with a doctor about:

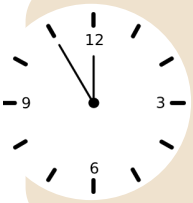
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Diarrhea
- Earaches
- Headache
- Infections
- Nausea
- Sinus Infections
- Rashes
- Sore Throat

MDLive - MDLIVEforCigna.com - 1-888-726-3171

MDLive is only available for medical visits. For covered services related to mental health and substance abuse, you have access to the Cigna Behavioral Health network of providers.

- Go to Cignabehavioral.com to search for a video telehealth specialist.
- Call to make an appointment with your selected provider.

ANSWERS



Cigna is on the clock for you 24/7/365

MYCIGNA ONLINE EMPLOYEE PORTAL

Online and on the go - myCigna.com and myCigna mobile App.

Find in-network doctors and medical Services

Manage and track claims

See cost estimates for medical procedures

Compare quality of care for doctors and hospitals

Access a variety of health and wellness tools and resources

1. Launch the myCigna App or to go myCigna.com and select "Register Now"
2. Enter your personal information
3. Confirm your identity
4. Create your security information and provide your primary eMail address for enhanced security protection and notifications
5. Review, then select "Submit"

CIGNA 24/7/365

By phone, anytime day or night - live, 24/7 customer service, 365 days a year (call the number on the back of your Cigna ID card).

- Order an ID card, update insurance information and check claim status
- Speak with a health coach about your health goals and questions

SEARCH CIGNA'S NETWORK IN 5 STEPS

Step 1 Go to Cigna.com, click on FIND A DOCTOR at the top of the screen. Then select the orange box that reads "Plans through your employer or school". If you already plan, log into myCigna.

Step 2 Choose whether you're looking for a doctor or a place to receive medical care.

Step 3 Enter the geographic location you want to search.

Step 4 Select the **Open Access Plus Plan.**

Step 5 Enter a name, specialty or other search word. Click SEARCH to see your results.

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN CONTRIBUTE MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, or
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future — even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses — even if they're not covered by your medical plan.

What Is A Health Savings Account?

Contribute up to $3,850 Single, or $7,750 Family

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are $3,850 for Single and $7,750 for Family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- Washington College contributes $500 (employee only) / $1,000 (family) towards the HSA. The amount is funded during your first month of enrollment and is prorated for new hires. The amount is included in IRS maximums.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.

TIP Health Savings Account (HSA) - must be enrolled in The Preserver plan

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to Cigna. You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from Cigna that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to mycigna.com.

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care expenses, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware — any unused portion of the account at the end of the plan year is forfeited.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Flores. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

2023 Maximum Contributions

Health Care Flexible Spending Account	$3,050 max
Dependent Care Expense Account	$5,000 max

For a full list of FSA expenses from the IRS visit:
https://fsastore.com/FSA-Eligibility-list.aspx

What Is A Flexible Spending Account?

2. SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE EXPENSE ACCOUNT

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800-532-3327, or log on to flores247.com to review your FSA balance.

At flores247.com, you can:

Sample Instructions

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

DENTAL INSURANCE

3. REVIEW YOUR DENTAL PLAN

DELTA DENTAL IS THE DENTAL CARRIER

The dental plans are PPOs that offer coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental's negotiated fees, plus any deductible and coinsurance associated with your procedure. Dependent children are eligible until the end of the month in which they turn age 26.

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

What Is Dental Insurance?

DENTAL INSURANCE PLAN OPTIONS AND COSTS

Delta Dental	Delta Dental Base Employee Cost Per Paycheck		Delta Dental Buy-up Employee Cost Per Paycheck	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$15.56 $34.20 $23.57 $43.97		$20.57 $45.31 $34.61 $60.69	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual / Family	$50 / $150		$50 / $150	
Annual Maximum	$1,000		$2,500	
	Carrier Pays			
Diagnostic / Preventive Services	100% no deductible	80% no deductible	100% no deductible	100% no deductible
Basic Services	80% after deductible	60% after deductible	90% after deductible	80% after deductible
Major Services	50% after deductible	50% after deductible	60% after deductible	50% after deductible
Orthodontia Services Children & Adults	N/A		Lifetime maximum of $2,000 per member	

FIND A DENTAL PROVIDER

To find a Delta Dental Provider in your area, visit the website at deltadentalins.com.

- Click on "Find a Dentist"
- Enter your ZIP Code
- Select the "PPO network"
- Click "Submit" for a comprehensive directory of dentists

VISION INSURANCE

4. REVIEW YOUR VISION PLAN

VSP IS THE VISION CARRIER

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to vsp.com.

What Is Vision Insurance?

VISION INSURANCE PLAN OPTIONS AND COSTS

VSP	Employee Cost Per Paycheck	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$3.55 $5.65 $5.76 $9.29	
	In-Network	**Out-of-Network**
Examination Copay	$10 copay	Reimbursement Up to $45
Frequency of Service Exam Lenses Frames	 Every 12 months Every 12 months Every 24 months	
Lenses Single Bifocal Trifocal	 $20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered	 Reimbursement Up to $30 Up to $50 Up to $65
Frames	$150 allowance + 20% off balance	Reimbursement Up to $70
Conventional Contacts	$150 allowance	Reimbursement Up to $105

FIND A VISION PROVIDER

To find a VSP Vision Provider in your area, visit the website at vsp.com.

- On the left side of the page you can quickly find a provider by clicking on “Find a Doctor”
- Search by location, Office, or Doctor
- Results list providers closest to your ZIP code first (if searching by Location)
- Click on the View Practice Details button next to the provider to display products, services, doctors, etc. for that location
- OR, you can call 800-877-7195 to speak with a Customer Service representative

LIFE INSURANCE AND AD&D

5. REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- REVIEW YOUR BENEFICIARIES

BASIC LIFE AND AD&D

Washington College provides 1½x your annual earnings to a maximum of $85,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through Unum at no cost to you.

What Is Life And AD&D Insurance?

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what Washington College provides. Unum guarantee issues coverage during your initial enrollment period — which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** minimum $10,000 to a maximum of 5x your annual salary, or $500,000, in $10,000 increments. Guarantee issue up to $200,000.
- **Optional Spouse Life & AD&D:** minimum $10,000 up to the lesser of 100% of the employee amount or $500,000, in $10,000 increments. Guarantee issue up to $30,000.
- **Optional Child Life & AD&D:** minimum $2,500 up to $10,000 maximum. Guarantee issue up to $10,000.

If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by Unum before you're able to get coverage in the future.

You must be enrolled in voluntary life and AD&D coverage in order for your spouse, and/or eligible dependent children to enroll.

Please note: If you elect Voluntary Life for yourself and/or your dependents, Voluntary AD&D is an automatic election based on the voluntary life insurance amount.

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE OPTIONS AND COSTS *PER PAYCHECK*

Unum	Rates per $10,000 of coverage		
	Age	Employee	Spouse*
Voluntary Life	<25	$0.335	$0.335
	25-29	$0.380	$0.380
	30-34	$0.475	$0.475
	35-39	$0.525	$0.525
	40-44	$0.570	$0.570
	45-49	$0.805	$0.805
	50-54	$1.180	$1.180
	55-59	$2.125	$2.125
	60-64	$3.205	$3.205
	65-69	$6.075	$6.075
	70-74	$9.790	$9.790
	75+	$9.790	$9.790
	Child(ren)	$0.25 per paycheck per $2,500 coverage	

**Spouse rate is based on the employee's age.*

DID YOU KNOW? Washington College provides you Basic Life and AD&D AT NO CHARGE.

DISABILITY INSURANCE

LONG-TERM DISABILITY INSURANCE

DID YOU KNOW?
Washington College pays for this benefit 100%

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury Coverage is automatic, but you do need to choose what type of tax treatment your benefit will receive should you need it. If you want to receive tax-free money should you become disabled, you are required to pay taxes on the value of the insurance plan (premium cost) now.

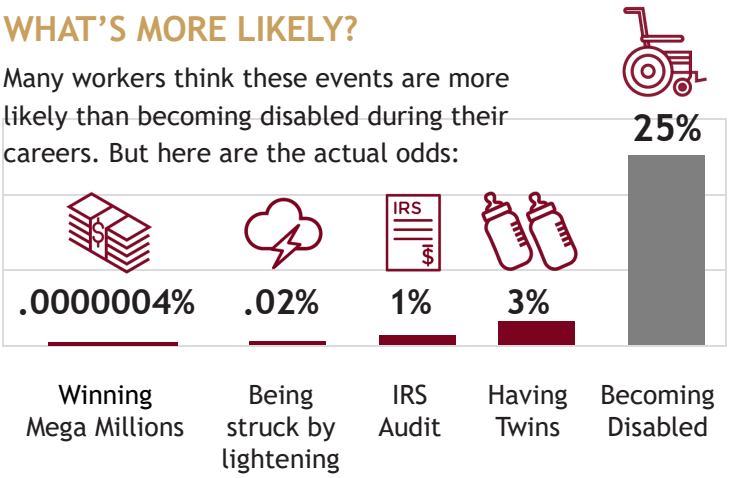
Long-Term Disability insurance offered through UNUM is provided at no cost to you. The plan benefit is 60% of basic monthly earnings up to a maximum of $ 6,000 per month maximum.

The benefits begin after a 180 day waiting period.

You have the opportunity to choose to pay for the LTD premium with **pre-tax or after-tax dollars**. If you elect to pay with pre-tax dollars, your LTD benefits will be subject to federal income tax. If you elect to pay with after-tax dollars, you'll pay more now, but if you become disabled, your LTD benefits will be exempt from income tax.

WHAT'S MORE LIKELY?

Many workers think these events are more likely than becoming disabled during their careers. But here are the actual odds:



In fact, nearly **40 million** American adults live with a disability.

What Is Disability Insurance?

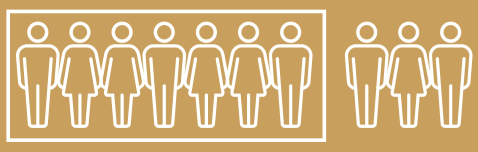
6. REVIEW YOUR DISABILITY COVERAGE

- LONG-TERM DISABILITY
- ELECT PRE OR POST TAX

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**



RETIREMENT

7. RETIREMENT

- ELECT YOUR 403(B) CONTRIBUTION

OUR 403(B) PLAN IS MANAGED BY TIAA

The Washington College 403(b) Retirement Savings Plan gives you an easy way to save for your future through payroll deductions.

ELIGIBILITY

You are eligible to participate in the plan after you've completed 1,000 hours of service within a plan year (for part-time employees), or immediately upon hire into a full-time position with the College.

EMPLOYEE CONTRIBUTIONS

Contributions from your pay may be made on a pretax or ROTH basis based on the amount you specify up to the IRS annual limit, If you are 50 years of age or older (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRA annual limit.

EMPLOYER CONTRIBUTIONS

Effective July 1, 2023, the College will contribute 4% of your eligible compensation to your account regardless of how much you contribute.

VESTING

Vesting refers to your right of ownership to the money in your account. You are immediately vested in all of your contributions and earnings on your contributions, and in the college's contributions.

TIPS ON HOW TO SAVE SMART FOR RETIREMENT:

- Start **NOW**. Don't wait. Time is critical.
- Start small, if necessary. Even small contributions can make a big difference given enough time and the right kind of investment.
- Save regularly. Make saving for retirement a habit.
- Be realistic about investment returns.
  Never assume that a year or two of high market returns (or market declines) will continue indefinitely.
- Roll over retirement account money if you change jobs.
- Don't dip into retirement savings.

TIP

2023 CONTRIBUTION LIMIT: $22,500 ADDITIONAL $7,500 ALLOWED FOR EMPLOYEES AGE 50 OR OLDER

[What Is A 403(b) Retirement Plan?]

WELLNESS BENEFITS

MOTIVATE ME through Cigna

Washington College has partnered with Cigna to offer the MotivateMe program that rewards you for healthy behaviors. The goal of this program is to provide personal insight into your health and well-being as well as discovering FREE health and wellness programs offered through your Cigna medical plan.

What does this mean for me? If you are on a Cigna medical plan, you have the opportunity to earn up to $175 in gift cards!

You can access the MotivateMe incentive page on myCigna.com.

headspace

Mindfulness has been shown to help people stress less, focus more, and sleep soundly, and Headspace is your personal guide. With hundreds of guided exercises for meditation, sleep, focus, and movement, their science-backed app can help you start and end your days feeling like your best self. As part of our commitment to supporting health & wellbeing, we've launched a partnership with Headspace. You have unlimited access to the entire Headspace library at no cost to you:

- Hundreds of guided meditations on stress, self-esteem, relationships and even content to use with kids
- Sleepcasts, music, and bedtime experiences for good nights and better mornings
- Start your day with The Wake Up: a new, bite-sized daily video series designed to make you smile
- Train your body and mind at the same time with Move Mode: quick workout videos and guided cardio

To enroll in Headspace for free:

Sign up, or log-in to your existing Headspace account via the landing page.

work.headspace.com/washingtoncollege/member-enroll

Verify by using your Washington College email & confirm by clicking "Verify" on the verification email.

Download the app & log-in.

Need more support? Send an email to help@headspace.com.

fitPROS

FitPROS is our virtual wellbeing portal. You can access live and on-demand programs on an array of wellness topics including health talks, fitness classes, yoga, cooking demonstrations, team building and more. The subscription is free.

Website: https://www.fitpros.com/washington-college
Password: washLIVE23

ADDITIONAL BENEFITS

EDUCATIONAL ASSISTANCE

Washington College offers several Tuition and Educational Assistance programs:

- Tuition waiver for employees
- Tuition waiver for dependents, spouses and domestic partners
- Tuition exchange for dependents
- Educational assistance for Employee (full-time employees only)

Upon hire, employees may participate in the Tuition Waiver program in the next academic semester. Part-time employees, their spouses and dependent children may participate and the benefit is prorated in proportion to the percentage of time worked in the previous anniversary year.

Contact HR with any questions.

MEMBERSHIPS AVAILABLE

Washington College participates with several clubs and organizations that can provide savings for employees:

Credit Union Membership – Employees and their families may join the Johns Hopkins Federal Credit Union. The credit union offers savings and checking accounts, loans, certificates of deposit and IRA's. Deposits and loan payments may be conveniently made through payroll deduction

Holiday Club - Holiday Club Accounts are available through Peoples Bank of Kent County, Maryland. You may open a Holiday Club Account through direct deposit.

Blood Bank Membership – Washington College will cover the cost of the membership to join the Blood Bank of Delaware/Eastern Shore.

IDENTITY THEFT ASSISTANCE

CLC Legal Identity Theft Recovery Service is provided through Unum. This service provides 24/7 access to anti-fraud experts who are available to guide employees through the resolution process and help remove the damage done by identity thieves. If you experience an identity theft incident, call 1-800-984-6812.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

We offer an EAP benefit through ComPsych, at no cost to you, to assist with work, life, and personal issues. The EAP has experienced and helpful specialists available to help with life's most important needs. The EAP specialists can help you with resources and information, providers, products and services in parenting, senior care, legal and financial services, home services, wellness, etc. The EAP services are completely confidential and are available to you and the family members in your household. Visit guidanceresources.com or call 1-855-399-2524 to learn more!

What Is An EAP?

VIDEO RESOURCES

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP vs. PPO
- HDHP With HSA Overview
- Tips to Save on Prescription Drugs
- How To Stretch Your HealthCare Dollars

INSURANCE 101

- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?
- What is Balance Billing?
- What is MEDICARE?
- What is COBRA?

OTHER

- How To Budget (Financial Wellness)
- Managing Stress And Mental Health
- Mental Health FAQ
- Flu Shot
- About COVID-19 Vaccine
- Building An Emergency Fund

TAX ADVANTAGE SAVINGS ACCOUNTS

- What Is A Health Savings Account?
- What Is A Flexible Spending Account?
- What Is a 403(b) Retirement

ANCILLARY BENEFITS

- What Is Dental Insurance?
- What Is Vision Insurance?
- What Is Life And AD&D Insurance?
- What Is Disability Insurance?
- What Is Accident Insurance?
- What Is Critical Illness Insurance?
- What Is Paid Time Off?
- What Is An EAP?

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authoriza-

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Benefits Key Terms Explained

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Washington College has determined that the prescription drug coverage offered by the Cigna 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 to 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 Washington College coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Washington College medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

IMPORTANT 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 Washington College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **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 Washington College changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	October 15, 2022
Name of Entity/Sender:	Washington College
Contact--Position/Office:	Liz Behrmann
Address:	300 Washington Ave, Chestertown, MD 21620
Phone Number:	410-778-7260

IMPORTANT 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 premiumassistance 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-EBSA (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 July 31, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & ChildHealth Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program- reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/ index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

IMPORTANT NOTICES

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone:1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855 MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

IMPORTANT NOTICES

To see if any other states have added a premium assistance program since July 31, 2022, or for more information onspecial enrollment rights, contact either:

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, anddisplays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no personshall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent.Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718,Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

IMPORTANT NOTICES

INITIAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Benefits department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of COBRA continuation coverage**. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please contact the CCPS Benefit team within 30 days of the Social Security determination.

- **Second qualifying event extension of 18-month period of continuation coverage**. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IMPORTANT NOTICES

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Washington College HR Department 410-778-7298

This notice is a summary. For a full description of all of Washington College's benefit plans, please refer to the Summary Plan Descriptions, located at: [CUSTOMIZE TO CLIENT].

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your Plan Administrator 410-778-7260.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits the collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered a collection of genetic information, even if there is no reward for responding (or a penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information, and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include a warning. For additional information on the benefits of including a warning against providing genetic information on wellness program materials, as well as other GINA issues related to health plan wellness programs, see Willis Human Capital Practice *Alert*, December 2010, "EEOC's GINA Regulations".

IMPORTANT NOTICES

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Washington College may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact hr@washcoll.edu.

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, anddisplays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no personshall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

IMPORTANT NOTICES

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT OF 1996 (NMHPA)

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 to 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 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

NOTICE REGARDING WELLNESS PROGRAM

MotivateMe is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, pending wellness regulations, employees who choose to participate in the wellness program may receive an incentive of a reduced employee contribution to the medical plan. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting hr@washcoll.edu.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness and/or health plan program. You also are encouraged to share your results or concerns with your own doctor.

YOUR NOTES

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.