The Arc®
Washington County

Benefits for Plan Year 2023
January 1, 2023 - December 31, 2023

2023 EMPLOYEE BENEFITS

WELCOME TO YOUR BENEFITS

Your health and the health of your family are important to The Arc of Washington County – this is the reason we offer comprehensive health care coverage with ancillary benefit options to eligible employees and their families. The Arc WC's Benefits Package is designed to focus on your total well-being. This guide describes The Arc WC's Employee Benefits Package. Please read through all of your materials very carefully.

You have many resources available for any questions related to your plans as you enroll and throughout the year. Take advantage of those resources to be sure you receive the full benefits you need and all that is available to you. The health care coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. The Arc of Washington County's health care benefit year begins January 1st and ends December 31st.

Important State and Federal Notices

These notices, along with Summary Plan Descriptions (SPD) and Summary of Benefits and Coverage (SBC), can be found on the KTBS benefits portal and in the back of this guide. Or you may contact your Human Resources department for a printed copy.

- HIPAA Notice of Special Enrollment
- Women's Health & Cancer Rights
- Privacy Practice and Rights Under HIPAA
- General COBRA Notice of Rights
- CHIPRA Notice
- Medicare Part D Creditable Coverage Notice
- Health Care Reform Provision Notices
- Summaries of Benefits and Coverage (SBC)

CONTENTS

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by The Arc WC. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

Eligibility

All regular full-time (working 30 or more hours per week) and part-time (working 20-29 hours per week) employees are eligible for benefits. As a new hire, you are eligible for benefits on the first day of the month following 60 days of eligible employment. Additionally, you may enroll during your annual Open Enrollment period for a January 1st effective date.

You may enroll the following eligible dependents in our group benefit plans:

- Your legal spouse
- Your natural, adopted or stepchildren up to age 26
- Unmarried children of any age if disabled and claimed as a dependent on your federal income taxes

Making Your Benefit Elections

It is important to make your benefit elections within the timeframe allowed during your New Hire or Open Enrollment period. Postponing the confirmation of your elections will result in a delay in enrollment processing. In other words, if you wish to see a doctor or fill a prescription soon after your benefits begin, please make your elections in a timely fashion or you may experience a delay. Once you confirm your benefit elections, your next opportunity to change or elect benefits will not be until the next Open Enrollment period, unless you experience a qualifying Life Event.

Making Changes to Your Benefits

Outside of your initial New Hire or Open Enrollment period, changes to your benefits can only be made throughout the year within 30 days of a qualifying Life Event. Examples of a qualifying Life Event include:

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

To report a Life Event, contact your Human Resources Department. Documentation must be provided.

Your Responsibility

- Review this booklet in its entirety.
- Utilize the available benefit resources outlined in this guide if you have any questions or for more information.
- Determine which benefits are best for you and your family.
- Login to ktbsonline.com during your enrollment window and make your benefit elections.
- You must fully confirm your benefit choices through the KTBS benefits portal in order for them to be effective.

Your Benefit Resources

More details about the benefits offered to you can be found by:

- Logging into ktbsonline.com
- Registering on the insurance company websites
- Downloading the insurance company smartphone apps (if available)
- Calling the insurance company directly

If you have questions or need assistance enrolling, contact Human Resources or our partners at McGriff.

MEDICAL BENEFITS

The Arc WC employees have the choice between three medical plans offered through Aetna. Part time employees have the choice between two medical plans: a Qualified High Deductible Health Plan (QHDHP) $2,000 with HSA and Network Services Only (NSO) plan. With the NSO plan, you pay a copay for office visits and other in-network services are paid by the plan coinsurance once you reach your deductible. With the HSA and HRA plans, you are eligible to participate in either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). These plans pay 80% for in-network office visits and other covered services once you satisfy your calendar year deductible.

Each plan offers preventive care at 100% and an out-of-pocket maximum to protect you should a catastrophic event occur. Out-of-network coverage is not available with the NSO plan. You can find Aetna providers online at aetna.com/docfind or by calling 888-982-3862.

You also have access to the Aetna Concierge program to answer questions about your health plan such as how to find the right specialist, what to do after receiving a diagnosis, health plan coverage, and more. In addition, your Health Advocate offers 24/7 assistance for second opinions, medical decision support, and help with bills, claim denials and other questions.

Wellness Contribution

Enrolled employees who complete their annual routine adult wellness exam by December 31, 2022 will receive a $15 per pay wellness credit, up to $390 per year, while enrolled in health insurance sponsored by The Arc WC. This wellness contribution will be transitioned to the new Peak Health wellness program beginning July 2023.

Healthy Steps with Peak Health

In 2023, we're introducing our NEW wellness program, **Healthy Steps,** in collaboration with Peak Health. This voluntary program for employees enrolled in health insurance sponsored by The Arc WC, provides nurse-administered health evaluations and wellness education to help you understand, adopt, and maintain a healthy lifestyle. You'll receive free direct access to convenient nurse visits on a regular basis and access to a robust wellness portal to keep your health on track. Get rewarded for your efforts in reach health goals—receive a $30 per pay wellness credit once you qualify. In 2023, the credit will be based on your participating, and you will be classified in one of five phases. In 2024, your wellness credit will be based on your Healthy Steps phase.

Tobacco Surcharge

Employees who use tobacco products in any form (including electronic delivery systems, vaping, chewing, etc.) will pay an additional amount equal to 10% of the total monthly premium. For example, the tobacco surcharge for employee only coverage in the HSA or HRA plan is $30.83 biweekly. Free tobacco cessation services are available by calling 800-QUIT-NOW.

MEDICAL PLAN COMPARISON

	$2,000 QHDHP HSA PLAN	$2,000 QDHP HRA PLAN	$2,000 NSO PLAN
In-Network Services			
Deductible Individual / Family	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000
Out-of-Pocket Max Individual / Family	$6,550 / $9,100	$6,550 / $9,100	$7,350 / $14,700
Network	Aetna Choice® POS II	Aetna Choice® POS II	Network Services Only
Preventive Care Visit	Covered at 100%, deductible waived	Covered at 100%, deductible waived	Covered at 100%, deductible waived
Primary Care Visit	20% after deductible	20% after deductible	$25 copay
Specialist Visit	20% after deductible	20% after deductible	$50 copay
Urgent Care	20% after deductible	20% after deductible	10%, deductible waived
Emergency Room	20% after deductible	20% after deductible	10% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	10% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	10% after deductible
Reimbursement Account*	HSA *The Arc WC contributes up to $520 annually*	HRA *The Arc WC contributes $1,000 toward deductible*	N/A
Out-of-Network Services			
Deductible Individual / Family	$2,000 / $4,000	$2,000 / $4,000	N/A
Coinsurance	60%	60%	N/A
Emergency	20% after deductible	20% after deductible	10% coinsurance
Out-of-Pocket Max	$30,000 / $60,000	$30,000 / $60,000	N/A

*Full-time employees who participate in the HSA plan will receive a $20 per pay contribution to their HSA account from The Arc of Washington County. Employees enrolled in the HRA will receive $1,000 towards their medical deductible after paying the first $1,000 of the deductible. This is meant to be a brief summary only. For full plan details refer to the SPD.

Teladoc Virtual Visits

Get access to U.S. board-certified doctors 24/7 through the convenience of phone, video and mobile app visits for affordable, quality care with Teladoc. Talk to a doctor anytime for $49 or less! Visit teladoc.com/aetna, call 855-835-2362, or download the mobile app.

PRESCRIPTION DRUG BENEFITS

	$2,000 QHDHP HSA PLAN	$2,000 QDHP HRA PLAN	$2,000 NSO PLAN
Deductible	Medical deductible	Medical deductible	$200 / $400
RETAIL - 30 DAY SUPPLY			
Generic	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Preferred Brand	$40 copay after deductible	$40 copay after deductible	$40 copay after deductible
Non-preferred Brand	$70 copay after deductible	$70 copay after deductible	$70 copay after deductible
Specialty (Preferred/Non-Preferred Brand)	$100/$200 copay after deductible	$100/$200 copay after deductible	$100 / $200 after deductible
RETAIL - 31-90 DAY SUPPLY			
Generic	$60 copay after deductible	$60 copay after deductible	$60 copay after deductible
Preferred Brand	$120 copay after deductible	$120 copay after deductible	$120 copay after deductible
Non-preferred Brand	$210 copay after deductible	$210 copay after deductible	$210 copay after deductible
MAIL ORDER - 90 DAY SUPPLY			
Generic	$40 copay after deductible	$40 copay after deductible	$40 copay after deductible
Preferred Brand	$80 copay after deductible	$80 copay after deductible	$80 copay after deductible
Non-preferred Brand	$140 copay after deductible	$140 copay after deductible	$140 copay after deductible

The Arc WC participates in the Caremark pharmacy network. Contact RxBenefits Member Services at (800) 334-8134 to inquire about a specific pharmacy. Member Services is available from 7:00AM to 8:00PM CST, Monday-Friday. They can also be reached via email at customercare@rxbenefits.com. On weekend, after hours, and on holidays, members are given the option to speak with an CVS/Caremark representative or leave a message for the RxBenefits Member Services Team to return their call.

Additional Features of RxBenefits/Caremark Pharmacy:

- Manufacturer Copay Assistance Program (MCAP) - assistance for some Specialty medications through Caremark's True Accum + PrudentRx program(s)
- Generic Policy—Dispense As Written (DAW) - if a brand name drug is filled when a generic equivalent is available, you will be required to pay the Brand cost share plus the difference in cost between Generic and Brand drug. This does not apply if prescription indicates the Brand must be dispensed.
- Maintenance Drug—After 30-day supply fills at a retail pharmacy location, your plan requires maintenance medications be filled in 90-day supplies by Caremark's mail order pharmacy or a CVS retain pharmacy location.
- Register at caremark.com to check drug costs and coverage or contact RxBenefits Member Services

GET THE BEST Rx PRICES

Are you worried about managing prescription drug costs? Here are some resources that may be able to help.

Talk with your health care provider. Share your cost concerns with your health care provider and ask if you are able to take a generic medication or if there is a less costly medication that is effective. Or find out if a lifestyle change may be able to produce the desired outcome (i.e., manage high cholesterol with dietary changes). Your healthcare provider may also be able to provide a free sample.

Visit the RxBenefits/Caremark member website or call Member Services. Find out what Caremark covers and what local pharmacies charge for your medication. The formulary is Standard with ACSF. Certain medications for preventive and chronic needs may be available for the cost of the copayment only; the deductible is waived for these medications.

For maintenance medications, use Caremark or a CVS retail pharmacy. Receive a 90-day supply of your medications and enjoy two ways to save with Caremark Mail Service pharmacy or at a CVS pharmacy near you.

Use price comparison sites. Visit price comparison sites such as goodrx.com. GoodRx finds the lowest prices and discounts by collecting and comparing prices for every FDA-approved prescription drug at more than 70,000 U.S. pharmacies, finding free coupons to use at the pharmacy, and showing the lowest price at each pharmacy near you at no cost to you.

Ask the pharmacist. Ask what your medication would cost with and without insurance to see if it qualifies for a reduced rate such as the "$4 Plan" or the "$10 Plan" offered by some pharmacies. Also ask if the price is the lowest available. According to Consumer Reports, some pharmacies have contracts for Medicare Part D plans that prohibit pharmacists from offering a better cash price to a customer unless a customer asks.

Find assistance at RxAssist.org. RxAssist provides an online comprehensive directory of Patient Assistance Programs. Find information about free and low-cost medicine programs and other ways to manage your medication costs.

Check with your local community health center. Some Federally Qualified Health Centers (FQHCs) have pharmacies that can offer discounts on medication. These centers also offer services on a sliding fee scale based on income.

Washington County FQHCs

Hagerstown: Family Healthcare of Hagerstown, 301-745-3777
Hancock: Tri-State Community Health Center, 301-678-5187
Chambersburg: Keystone Health, 717-709-7977
Martinsburg: Shenandoah Community Health Center, 304-263-4999

Ask your Health Advocate. Free and confidential assistance is available 24/7 from the Health Advocate service provided by our insurance broker. An advocate can help with questions about your benefits, claims, pharmacy issues and more. Call 866-695-8622, email answers@HealthAdvocate.com or visit healthadvocate.com/members.

Visit the Mark Cuban Cost Plus Drug Company at costplusdrugs.com a new online pharmacy that offers hundreds of common medications at the lowest possible prices.

Pay with pre-tax dollars. Although it won't affect the price of your medication, it will result in a savings for you when you pay with your HSA or FSA dollars. For your convenience, HSA and FSA plans both come with a debit card that you can use at the pharmacy.

Health Savings Account

When you elect to enroll in the HSA medical plan, you are eligible to open a Health Savings Account (HSA) through HealthEquity. You have the opportunity to have pre-tax dollars deducted from your paycheck and deposited into this account. You are the owner of this bank account and your funds can roll over from year-to-year and build over time. If you are new to the HSA medical plan, this account will be set up for you after you confirm your plan elections and a banking welcome kit and debit card will be mailed to your home address.

Full-time employees who participate in the HSA plan will receive a $20 per pay contribution to their HSA account from The Arc WC ($520* annualized). This contribution will be made on a biweekly basis. Employees can also contribute their own money tax-free up to the IRS annual limits including The Arc WC's contribution. HSAs can be used to pay for qualified expenses such as medical deductibles and copays, prescriptions, dental and vision care, and more.

The IRS annual maximum contributions for 2023: Single coverage - $3,850 / Family coverage - $7,750

Persons age 55-64 may set aside an additional $1,000 in catch-up contributions each year.

What are the advantages of participating?

- Pre-tax savings – never pay federal taxes on your HSA funds as long as you spend the money on eligible IRS 213(d) health care (medical, dental, vision) expenses
- Unused funds carry over from year to year and can build over time
- Complete control over how and when funds are used
- Funds remaining in your account after you reach the age of 65 can be used for non-medical expenses with ordinary taxes paid, similar to a 401(k) or 403(b)
- HSAs are portable; if you leave The Arc of Washington County you can take the account and all funds in it with you

Health Reimbursement Arrangement

A Health Reimbursement Arrangement allows The Arc of Washington County to share in your medical expenses and pay a portion of the deductible for full-time employees working 30 or more hours per week who enroll in the HRA medical plan. Employees receive **$1,000 towards their medical deductible** after paying the first $1,000 of the deductible.

Explanation of Benefits (EOBs) or detailed prescription labels are required to be submitted to CareFlex to verify that your portion of the deductible has been paid out-of-pocket before HRA funds are available. Once CareFlex has reviewed and verified your EOBs, your HRA funds will be made available to reimburse you for future eligible medical expenses.

- Coverage only includes employees enrolled in the HRA medical plan; dependents enrolled in the plan are not eligible under the HRA.
- Eligible expenses include medical and prescription expenses incurred by the employee and determined by the health insurance as eligible and specified as the patient's responsibility such as medical and prescription copayments and deductibles.
- HRA participants may also participate in a Health Care Flexible Spending Account.

*Contribution will be pro-rated based on the number of months enrolled in the HSA plan.

FLEXIBLE SPENDING ACCOUNTS

Health Care FSA

With a Health Care Flexible Spending Account (FSA), you can set aside pre-tax dollars to pay for out-of-pocket expenses incurred for health care . Because the amount you elect is taken on a pre-tax basis, you have the opportunity to **save up to an estimated 25%** of your out-of-pocket expenses. Health Care FSA accounts are available to eligible employees working more than 20 hours a week and enrolled in a qualifying medical plan (HRA or Network Services Only).

Based on your estimated amount of medical out-of-pocket expenses, the annual amount you elect is evenly deducted out of each paycheck throughout the year. Once you have elected your FSA amount, you may not change it without a qualifying Life Event until the next Open Enrollment.

- The IRS annual maximum contribution to your Health Care FSA is $3,050.
- Coverage includes all qualified dependents, including spouse and dependent children up to their 26th birthday.
- Benefit reimbursement is made through manual claims and the benefit card.
- Eligible expenses include all qualified 213(d) medical expenses not reimbursed by other insurance including vision and dental expenses, over-the-counter medications, PPE supplies such as masks, gloves, sanitizer and medical supplies. You will have a 75-day grace period after December 31, 2023 through March 15, 2024 that allows reimbursement from any remaining 2023 funds.
- There is a 90-day run out period after December 31, 2023 through March 31, 2024 that allows you to submit claims for expenses incurred during the 2022 plan year. Expenses are eligible based on the date of service, not the payment date.

The CareFlex Benefits Card

When you use your card for a Health Care expense, CareFlex will confirm its eligibility. To complete this review, CareFlex will need the EOB, an itemized receipt or pharmacy receipt. You can submit your claim online, through the mobile app, or via email, fax or regular mail.

Dependent Care FSA

With a Dependent Care Flexible Spending Account (FSA), you can set aside pre-tax dollars to pay for out-of-pocket expenses incurred for dependent care expenses. Because the amount you elect is taken on a pre-tax basis, you have the opportunity to **save up to an estimated 25%** of your out-of-pocket expenses. Dependent Care FSA accounts are available to eligible employees working more than 20 hours a week enrolled in a qualifying medical plan.

A Dependent Care FSA is available to employees who have a dependent child or parent for which they pay expenses such as day care, preschool, or after school care. Funds in the account are not to be used for medical care. It is advised that you seek advice from your tax preparer.

- The IRS annual maximum contribution to your Dependent Care FSA is $5,000. If you are married and file a separate tax return, the maximum election is $2,500.
- Coverage includes dependents through age 12 and disabled/elder dependents regardless of age.
- Eligible expenses include care centers, providers of care outside of the home, dependent care providers who come to your home, before/after school care and summer day camps.
- Benefit reimbursement will be made through manual claims.
- There is a 90-day run out period after December 31, 2023 through March 31, 2024 that allows you to submit claims for expenses incurred during the 2023 plan year. Expenses are eligible based on the date of service, not the payment date.

Visit careflexexpress.com to view the FSA Expense Guides.

HEALTH EXPENSE FUND COMPARISON

	Health Savings Account	Health Reimbursement Arrangement	Flexible Spending Accounts
Eligibility	HSA-qualified health coverage and other HSA requirements (i.e. no other healthcare or Medicare)	HRA-qualified health coverage	Must be benefits eligible
Funding	The Arc WC contributes $20/pay up to $520 annually. You may set aside desired amount, up to annual limit.	You pay the first $1,000 of your medical/Rx deductible expenses, The Arc WC **reimburses next $1,000**, and you pay the remaining $1,000.	You set your desired amount, up to annual limit.
Maximum Annual Contribution*	$3,850 Single / $7,750 Family +$1,000 catch-up for age 55 & older	N/A	Health Care: $3,050 Dependent Care: $5,000
Tax Treatment	Tax-free	Tax-free	Tax-free
Allowed Expenses	IRS 213(d) expenses for employee and enrolled dependents including medical deductibles, coinsurance, Rx, dental, vision, etc.	Medical and Rx deductible expenses for employee only.	IRS 213(d) expenses for employee and eligible dependents including medical deductibles, coinsurance, Rx, dental, vision, etc.
Bank Account	Yes	No	No
Interest/Investment Earnings	Yes	No	No
Unused Funds Carryover	Yes	No	No**
Portability	Yes	No	No
Debit Card	Yes	No	Yes
Contribution Changes	Yes, as often as once a month.	N/A	No, unless experiencing a qualifying event.
Administrator	Employee (save receipts, in case of audit)	CareFlex (receipts requested per transaction)	CareFlex (receipts requested per transaction)

*IRS limits include contributions between The Arc WC and the employee combined.
**Grace period to incur 2023 expenses through 3/15/2024. Must submit 2023 expenses no later than 3/31/2024.

DENTAL & VISION BENEFITS

Dental Care

Dental coverage is offered through Aetna. Regular dental cleanings and check-ups are extremely important to your overall health and you are encouraged to take advantage of your preventive dental benefits.

The Arc WC plan provides for exams and cleanings every six months. You may seek care from any dentist, but by choosing in-network providers, you will lower your out-of-pocket costs. To find an in-network dentist, visit aetna.com or call 877-238-6200.

Visit Your Dentist Regularly

Keeping up regular dental visits is about more than maintaining a great smile. Because poor dental hygiene is not just limited to bad breath, gum disease and tooth decay; serious medical conditions such as cancer, heart disease and diabetes have been linked to poor oral health. Take advantage of your preventive dental benefits at no cost to you including routine exams and cleanings.

	BASE PPO PLAN	BUY-UP PPO PLAN
Deductible	$50 Individual / $150 Family max	$50 Individual / $150 Family max
Annual Maximum	$1,500	$2,500
Preventive Care	Plan pays 100%, deductible waived	Plan pays 100%, deductible waived
Basic Services	Plan pays 80% after deductible	Plan pays 90% after deductible
Major Services	Plan pays 50% after deductible	Plan pays 60% after deductible
Orthodontia	Not covered	Plan pays 50% after deductible, $1,500 lifetime max

In-network services only are illustrated above. This is meant to be a brief summary only, for full plan details refer to the SPD.

Vision Care

Vision coverage is offered through VBA. Your routine vision exams, eyeglasses or contact lenses are available through VBA's national network of vision care providers. In addition to the benefits outlined below, you have access to discounts on lens options and Laser Vision Correction. To find an in-network provider, go to vbaplans.com/vision or call 800-432-4966.

VBA Hearing Discount

When you enroll in the VBA Vision plan, you also receive Hearing benefits with Your Hearing Network including discounts and access to the Hearing Care Program.

	VISION PLAN
Eye Exams *Once per 12 months*	$10 copay
Materials Copay	$20 copay
Frames *Once per 12 months*	$55 wholesale allowance
Standard Lenses *Once per 12 months*	Covered at 100%
Contact Lenses *Once per 12 months**	$130 allowance

*In lieu of eyeglass lenses. In-network services only are illustrated. This is meant to be a brief summary only, for full plan details refer to the SPD.

Basic Life and AD&D

The Arc WC provides each employee with Basic Life and AD&D insurance through The Hartford and **pays for the full cost of coverage**. Employees receive 1x their annual earnings to a maximum of $50,000.

Supplemental Life Insurance

The Arc of Washington County employees have the option to supplement their Basic Life and AD&D by purchasing additional amounts of coverage through The Hartford. Voluntary Life insurance may also be purchased to cover a spouse and/or child(ren) after electing coverage for yourself.

	EMPLOYEE	SPOUSE	CHILD(REN)
Increments	$5,000	$1,000	$10,000
Guarantee Issue*	$175,000	$30,000	$10,000
Maximum Benefit	Lesser of 5x annual earnings or $500,000	Lesser of 100% of employee amount or $250,000	$10,000

*The Guarantee Issue amount is the highest amount of coverage that you or your dependents may elect without completing an Evidence of Insurability (EOI) form. If you elect an amount of coverage above the guaranteed issue limit, or elect to increase your benefit amount at a future date, the benefit amount over the Guaranteed Issue level will not go into effect until your EOI has been reviewed and approved and payroll deductions have begun. This is meant to be a brief summary only. For full plan details refer to the SPD.

Universal Life Insurance

The Arc WC employees may also purchase Universal Life insurance through Transamerica that gives your loved ones peace of mind and protects them from the financial impact of your death. Universal Life Insurance provides lifelong protection. Highlights of the TransElite Universal Life insurance benefit: no physicals or bloodwork; accumulates cash value; guaranteed 3% interest rate; loan and withdrawal options; and convenient payroll deductions. Riders include accelerated death benefit for terminal condition; waiver of monthly deductions for layoff or strike; accelerated death benefit for chronic condition; and child term rider. Universal Life is available to eligible employees, spouse and children.

Disability Insurance

Whether you are totally disabled and unable to work due to an accident or illness, The Arc WC provides the option to purchase both Short and Long-Term Disability benefits through The Hartford. Disability benefits provide for a percentage of your salary once you satisfy the waiting period.

	SHORT-TERM	LONG-TERM
Benefit Amount	Choose amount in increments of $25, from $100 to $1,500 not to exceed 60% of your weekly earnings.	Benefit amount is 50% of monthly earnings up to a maximum of $2,500/month.
Waiting Period	Choose from 8, 15 or 30 days after Injury/Illness.	90 days
Benefit Duration	Duration of disability or up to 13 weeks	End of disability or until the greater of your Social Security Retirement Age or 4 years. Payments may reduce if your disability occurs at age 63 or above.

SUPPLEMENTAL BENEFITS

Critical Illness

Facing a serious illness can be devastating both emotionally and financially. Even with major medical insurance, out-of-pocket expenses can add up quickly. Critical Illness insurance can provide a lump sum benefit upon diagnosis that can be used however you choose—from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or utility bills. The Arc of Washington County offers eligible employees working at least 20 hours per week the opportunity to purchase supplemental Critical Illness insurance through The Hartford in amounts from $5,000 to $20,000. Employees may also purchase coverage for their family.

Accident

Accident insurance provides an extra layer of protection that pays you a lump sum in cash after you suffer a covered accident like a severe burn, broken bone, or emergency room visit. You can use the payment in any way you choose—from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills. Eligible employees of The Arc WC working at least 20 hours per week may purchase supplemental Accident insurance through The Hartford for themselves and their family.

Hospital Indemnity

Hospital Indemnity insurance pays a cash benefit if you or an insured dependent are confined in a hospital for a covered illness or injury. It also provides additional daily benefits for related services. Benefits are paid in lump sum amounts and can help offset expenses that your primary health insurance doesn't cover, like deductibles and coinsurance. Or benefits may be used for non-related expenses such as housing costs and groceries. The Arc WC offers eligible employees working at least 20 hours per week the opportunity to purchase supplemental HI insurance through The Hartford with a choice of three plans to best suit your needs. Employees may also purchase coverage for their family.

HOSPITAL CARE	LOW PLAN	MID PLAN	HIGH PLAN
First Day Hospital Confinement-Up to 1 day per year	$1,000	$1,500	$2,000
Daily Hospital Confinement (Day 2+)-Up to 90 days per yr	$100	$150	$50
Daily ICU Confinement (Day 1+) - Up to 30 days per yr	$200	$300	Not Included
Health Screening	$50	$50	$50

Employee Assistance Program

Your Employee Assistance Program (or EAP) plays a key role in helping you, your co-workers, and your family members cope with emotional, physical, or any other type of problem affecting your personal wellbeing or your job performance.

If you are having personal problems or trouble managing your life, you may contact a counselor by calling **301-766-7600**. A professional counselor will discuss your problem with you and set up a counseling appointment as soon as possible. The process is kept simple and confidential.

In some instances, your work supervisor may recommend that you call EAP, particularly if your on-the-job performance or attendance has deteriorated. EAP can be an important source of help to resolve difficulties and improve performance.

There is **no charge** to you or members of your family for the services offered by EAP. The professional staff will work with you to resolve a problem. You may find that is all the help you need; however, if you and the counselor determine that additional help would be beneficial, you or your family member will be given an appropriate referral.

Your Employee Assistance Program has been specially tailored to meet your needs. Confidentiality is assured. Learn more at meritushealth.com.

Paid Time Off (PTO)

PAID TIME OFF					
Bi-weekly accrual	**40 hours/week**	**37.5 hours/week**	**37.5 hours/week**	**30 hours/week**	**20 hours/week**
1st year	4.34620	4.07474	3.80292	3.25980	2.17320
2nd-4th year	6.19240	5.80500	5.41834	4.64400	3.09600
5th-9th year	7.11540	6.67050	6.22598	5.33640	3.55760
10th year+	8.96160	8.40150	7.84140	6.72120	4.48080

Holidays

- New Year's Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Employees also receive one Floating Holiday after three years of service. For additional information, please refer to the Leave Policy (X 1028).

ADDITIONAL BENEFITS

Counseling and Health Support Services

If you become disabled from an accident or are diagnosed with a critical illness, your first priority should be focusing on your treatment and recovery. When you enroll in either Disability or Critical Illness insurance with The Hartford, you receive access to HealthChampion and Ability Assist services that provide you with extra support when you need it most.

Health Advocate

Health Advocate can support you in handling a wide range of healthcare-related and insurance issues to save you time, money, and worry. Health Advocate experts can answer questions about diagnosis and treatment options, help you find the right in-network doctors and make appointments, research, and arrange expert second opinions, facilitate pre-authorizations and coordinate benefits, resolve insurance claims and billing issues and explain benefits and your share of the costs. Experts can be reached at 866-695-8622 or by email at answers@HealthAdvocate.com. Health Advocate is a free and confidential service for employees of The Arc of Washington County and their families.

Legal Services

MetLaw offers you and your family value, convenience and peace of mind by giving you low-cost access to attorneys for a wide variety of personal legal services. Payments are made conveniently and easily through payroll deductions. It's like having your own attorney on retainer, but for a lot less.

ADDITIONAL BENEFITS

Retirement Benefits

The Arc WC sponsors a 403(b) Retirement Plan that is a tax deferred annuity with Principal Financial. Eligibility to participate is open to all employees effective the first day of employment. It is a matching defined contribution Plan. Your contributions are made through payroll deduction. Matching contributions are effective when you have completed your 90-day orientation period. Matches, along with your contribution, are submitted each pay period.

Retirement Plan Enrollment

Enrollment information may be obtained from Michael Kipe, CFO. It is always open enrollment for the Retirement Plan. If you are joining the Plan you will need competent financial advice. Tribridge Health Partners is our advisor. The Orenda Retirement Client Service Team may be contacted either by phone at 212-564-2464 or email at participant@orendaretirement.com. There is no charge for the Plan investment advice offered to employees. To enroll in your retirement plan, visit principal.com/welcome. For assistance with logging in, please contact Principal Financial at 800-986-3343. You will need to sign a waiver form if you are currently not participating in the Plan.

CONTRIBUTION SCHEDULE	
90 days - 4+ years	$1,000
5 years - 9+ years	$1,500
10 years+	$2,200

Matching contributions are made according to years of service based on a Plan Year July 1 to June 30.

myMonarc.org is a wellness website developed specifically for employees of The Arc of Washington County. Our hope is that by inspiring each of us to eat, move, do, thrive, and connect a little bit better. Find information about current and upcoming wellness challenges, local events, your employee benefits, and more.

myMonarc.org is where, together, we will begin transforming lives every day by providing the valuable information, tools, and resources needed when making the thousands of little decisions throughout your day that contribute to keeping you healthy by choice, and not by chance.

my Monarc.org
Transforming lives every day

BI-WEEKLY CONTRIBUTIONS

Medical

	HSA PLAN		HRA PLAN		NSO PLAN	
	20-29 hrs/wk	30-40 hrs/wk	20-29 hrs/wk	30-40 hrs/wk	20-29 hrs/wk	30-40 hrs/wk
Employee	$308.27	$39.77	$308.27	$39.77	$332.97	$73.52
Employee + 1	$591.94	$251.07	$591.94	$251.07	$669.60	$321.90
Family	$813.92	$443.89	$813.92	$443.89	$920.71	$541.29

Enrolled employees who complete their annual routine adult wellness exam by December 31, 2022 will receive a $15 per pay wellness contribution while enrolled in health insurance sponsored by The Arc WC (up to $390 annualized). Employees who use tobacco products in any form (including electronic delivery systems, vaping, chewing, etc.) will pay an additional amount equal to 10% of the total monthly premium. For example, the tobacco surcharge for employee only coverage in the HSA or HRA plan is $31.93 biweekly.

Dental & Vision

	DENTAL BASE PLAN		DENTAL BUY-UP PLAN		VISION PLAN	
	20-29 hrs/wk	30-40 hrs/wk	20-29 hrs/wk	30-40 hrs/wk	20-29 hrs/wk	30-40 hrs/wk
Employee	$13.15	$5.96	$15.40	$7.75	$2.76	$2.76
Employee + Spouse	$31.45	$22.55	$36.82	$26.82	$5.24	$5.24
Employee + Child(ren)	$22.56	$14.49	$26.41	$17.56	$5.38	$5.38
Family	$40.73	$30.96	$47.68	$36.50	$7.18	$7.18

The MetLaw Legal Services plan can be purchased for $8.22 per pay period to cover you, your spouse and/or children.

Contacts

BENEFIT	PHONE	WEB/EMAIL
Medical - Aetna, *Group #835147*	800-962-6842	aetna.com
RxBenefits/Caremark	800-334-8134	Caremark.com
HSA - Health Equity	866-855-4066	healthequity.com
HRA & FSA - CareFlex	888-577-2762	mycareflex.wealthcareportal.com support@careflex.com
Peak Health	252-237-5090	
Dental - Aetna, *Group #835147*	877-238-6200	aetna.com
Vision - VBA, *Group #9113*	800-432-4966	vbaplans.com/vision
Health Advocate	866-695-8622	healthadvocate.com/members
Group Life, Disability & Supplemental - The Hartford, *Group #886117*	800-523-2233	thehartford.com
Universal Life—Transamerica	888-763-7474	transamerica.com
Whole Life - Unum	866-679-3054	unum.com
EAP - Meritus Health	301-766-7600 800-635-2774	meritushealth.com
Retirement - Orenda	212-564-2464	participant@orendaretirement.com
Human Resources - Janis Williamson, SHRM-CP	301-797-2121 x2236	jlwilliamson@Arcwc-md.org or via ICM

IMPORTANT NOTICES

Disclaimer: This document contains many of the required Health and Welfare Plan model notices templates provided by the Department of Labor and other Federal agencies. Most employers prefer to include model notices in their open enrollment materials for ease of distribution. Some of these notices may require distribution outside of the open enrollment period or to both employees as well as dependent participants (for example, the General COBRA Notice must be provided to not only participating employees but also to participating spouses). In addition, some of these notices may require further customization, based on the specific terms of your plan. Employers may also be subject to additional State laws and Federal disclosures not outlined in these materials (for example, if you offer a self-funded health plan or a fully-insured health plan with access to Protected Health Information, you may also be required to distribute a Notice of Privacy Practices).

You may always ask your McGriff Account team for additional clarity on the notices provided herein. You are encouraged to retain ERISA counsel to determine which additional disclosures you are required to provide to your employees and plan participants.

Medicare Part D Creditable Coverage Notice
Important Notice from The Arc of Washington County.
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 offered by the $2,000 QHDHP Open Access with HSA/HRA; $2,000 Network Services Only (NSO) through The Arc of Washington County 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. **The Arc of Washington County has determined that the prescription drug coverage offered by the $2,000 QHDHP Open Access with HSA/HRA; $2,000 Network Services Only (NSO) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage through The Arc of Washington County will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current group health coverage through The Arc of Washington County, be aware that you and your dependents will be able to get this coverage back. If you are able to get this coverage back, reentry into the plan is subject to the underlying terms of the Plan.

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 group health coverage through The Arc of Washington County 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 Plan Administrator 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 The Arc of Washington County changes. You 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).

For purposes of this notice, the Plan Administrator is:

Janis Williamson, SHRM-CP
301-797-2121

Newborns' Act Disclosure

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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA Enrollment/Annual Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

For purposes of this notice, the plan administrator is:
Janis Williamson, SHRM-CP
301-797-2121

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

****Continuation Coverage Rights Under COBRA****

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 does not 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,

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."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to The Arc of Washington County and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of coverage under the Plan.

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;
- If the Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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. You must provide this notice to Janis Williamson, SHRM-CP.

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 the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator **in writing**, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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.

In order for this disability extension to apply, you must timely notify the Plan Administrator **in writing** of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event; (ii) the date on which coverage would be lost because of the initial qualifying event; or (iii) the date of the SSA disability determination. **This notice must be mailed to Janis Williamson, SHRM-CP at 820 Florida Avenue, Hagerstown, MD 21740**. Oral notice, including notice by telephone, is not acceptable. The written notice must include the name and address of the employee covered under the plan; the name of the disabled qualified beneficiary; the date that the qualified beneficiary became disabled; and the date that the SSA made its determination of disability. Your notice must also include a copy of the SSA disability determination. If these procedures are not followed or if written notice is not provided to the Plan Administrator within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of any revocation of Social Security disability benefits.

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.

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, 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 **www.healthcare.gov**.

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

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.

(see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods). 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 https://www.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 www.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 www.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

$2,000 QHDHP Open Access with HSA/HRA; $2,000 Network Services Only (NSO)
The Arc of Washington County
820 Florida Avenue, Hagerstown, MD 21740
301-797-2121

Special Enrollment Notice

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

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

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below:
Janis Williamson, SHRM-CP
301-797-2121

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

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

If you or your dependents are already enrolled in Medicaid or CHIP 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 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health 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: http://dhss.alaska.gov/dpa/Pages/medicaid/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

GEORGIA Medicaid	MASSACHUSETTS Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
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
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/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ 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

To see if any other states have added a premium assistance program since July 31, 2022, 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-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, and displays 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 person shall 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)

NOTES

NOTES

Last updated: 11.03.2022