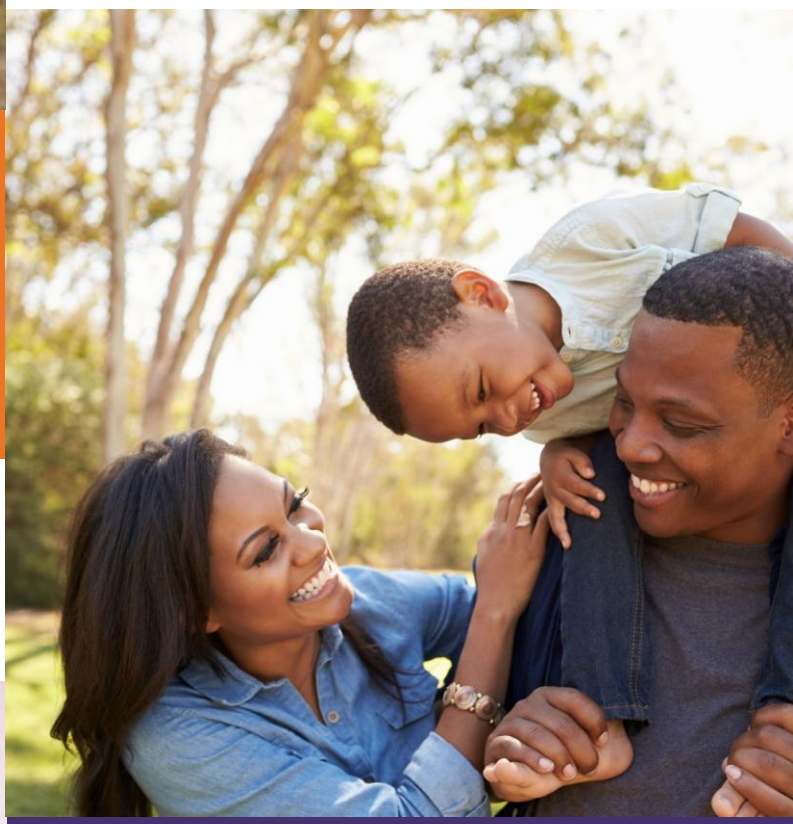
The Arc
Washington County



Benefits for Plan Year 2026

January 1, 2026 - December 31, 2026

2026 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 Paycor 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)

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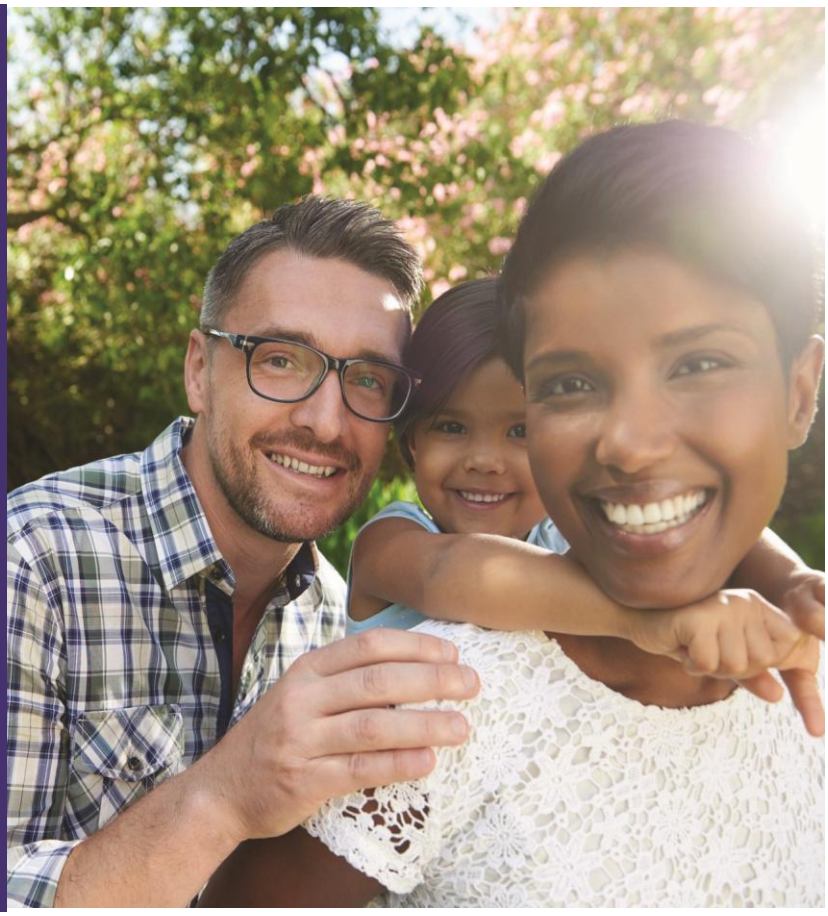


The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by The Arc WC. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, 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 & ENROLLMENT

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 Paycor during your enrollment window and make your benefit elections.
- You must fully confirm your benefit choices through the Paycor 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 Paycor
- 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.

Healthy Steps with Peak Health

Healthy Steps, powered by Peak Health, for employees enrolled in a medical plan sponsored by The Arc WC, is designed to reward you for your efforts in developing and maintaining a healthy lifestyle. The program provides health and fitness education, including information on disease prevention and behaviors that may be negatively affecting your overall wellbeing. In this program, you will have the opportunity to complete an online Health Assessment, obtain regular labs (blood-work), participate in preventive care, and be regularly evaluated by a board certified RN (registered nurse). Your assigned RN will review your medical information with you, help you establish realistic and attainable health goals, and assign you to a "health phase/incentive level" based upon the NEW points phasing guide for 2026.

Employees who participate will earn wellness credits towards their medical premiums. Your efforts to reduce health risks and reach target health goals will determine your incentive level and amount of wellness credits. Participants can earn up to $30 per biweekly paycheck—an annual savings of up to $780! Peak Health will keep you updated on appointments and deadlines after your initial nurse appointment. To continue earning wellness credits, you must remain active in the Healthy Steps program by attending regular nurse visits.

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 **$42.53 biweekly,** and the Network Services Only plan is **$45.94 biweekly**. Free tobacco cessation services are available by calling 800- QUIT-NOW.

MEDICAL PLAN COMPARISON

	$2,000 QHDHP HSA PLAN	$2,000 QHDHP 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 - ASC	Aetna Choice® POS II - ASC	Aetna Open Access Aetna Select℠
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 $58 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 QHDHP 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.

Register for the new member portal, My RxBenefits, at http://member.rxbenefits.com. My RxBenefits allows members to conveniently access key pharmacy benefits information 24/7, including ID cards, claims history and prior authorization status.

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 retail pharmacy location.
- Register at caremark.com to check drug costs and coverage or contact RxBenefits Member Services
- ***PrudentRx Program*** (eligible only with $2,000 NSO Plan) - offered by CVS Caremark, enables eligible members to access a third-party copay assistance program to help save money when filling a specialty drug Rx.

ScriptSourcing

Beginning January 1, 2026, The Arc has partnered with ScriptSourcing for our prescription drug program, along with RxBenefits.

One of the enhancements allows The Arc enrollees to receive certain medications for a $0 copay! You may take a prescription medication that is eligible for a $0 copay through the International Pharmacy Program (IPP).

Benefits of ScriptSourcing's International Pharmacy Program:

- The Arc's Members have a $0 copay for name brand medications
- A 90-day supply will be shipped directly to your home
- ScriptSourcing saves our health plan money, which translates into lower premiums, copays, and deductibles

In order to take advantage of this special opportunity, you must speak to a pharmacy advocate from ScriptSourcing. Follow the instructions in the GET STARTED section below.

Please note: This Rx program is completely voluntary and we want you to do what is best for you and your family's health. You will still have the option to use your CVS/Caremark prescription card and pay the applicable copay for your medication(s) at the pharmacy or via mail-order.

What is ScriptSourcing's International Pharmacy Program?
United States consumers pay up to 16x more than other countries for the exact same name-brand medications. The International Pharmacy program delivers your medications safely and affordably from 'tier 1' countries and you pay nothing. You don't even need to pay for shipping.

A 'tier-one' country is a country deemed by Congress to have the same or higher standards as the United States Federal Drug Administration (FDA). ScriptSourcing only uses 'tier-one', English-speaking countries that negotiate directly with the pharmaceutical manufacturers. The 'tier-one' Countries include: Canada, United Kingdom, Australia, and New Zealand.

****AVAILABLE January 2026****

GET STARTED

Enrollment in the International Pharmacy Program

Use the link below to schedule a 15-30 minute call with a Pharmacy Advocate:

https://calendly.com/member-advocacy-team/enroll-in-our-0-rx-copay-program

or

Contact ScriptSourcing Directly: 1 (410) 902-8811

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.

Local 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., use Registration Code AT6FD2R.

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 2026 Single coverage - $4,400 / Family coverage - $8,750

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

What are the advantages of participating?

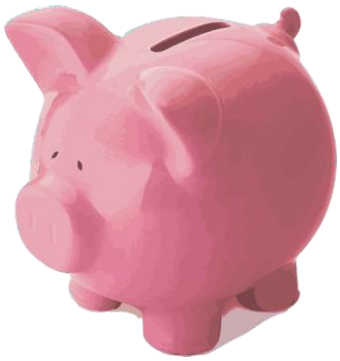
- Pre-tax savings – never pay federal taxes on your HSA funds as long as you spend the money on eligible IRS 213(d) health care (medical, dental, vision) expenses
- Unused funds carry over from year to year and can build over time
- Complete control over how and when funds are used
- Funds remaining 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.

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 $3,300.
- 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, 2026, through March 15, 2027, that allows reimbursement from any remaining 2026 funds.
- There is a 90-day run out period after December 31, 2026, through March 31, 2027, that allows you to submit claims for expenses incurred during the 2026 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 $7,500. If you are married and file a separate tax return, the maximum election is $3,750.
- 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, 2026 through March 31, 2027 that allows you to submit claims for expenses incurred during the 2026 plan year. Expenses are eligible based on the date of service, not the payment date.

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*	$4,400 Single / $8,750 Family +$1,000 catch-up for age 55 & older	N/A	Health Care: $4,400 Dependent Care: $7,500
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 2025 expenses through 3/15/2026. Must submit 2025 expenses no later than 3/31/2026.

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 all regular full-time employees (working 30 hours or more) 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.

Disability Insurance

Whether you are totally disabled and unable to work due to an accident or illness. The Arc WC will provide a Short Term Disability benefit to all full time and part time benefit eligible employees. Employees have the option to purchase 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	Benefit amount is 60% of weekly earnings up to a maximum of $1,500/week.	Benefit amount is 50% of monthly earnings up to a maximum of $2,500/month.
Waiting Period	14 days Sickness / 14 days Accident	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

An Employee Assistance Program (EAP) is a workplace-based benefit designed to support employee well-being by addressing personal, emotional, and work-related challenges that may impact health, job performance, and quality of life. The wellness support provided by an EAP can offer employees the tools and guidance they need to manage stress, overcome personal or work-related problems, enhance mental and emotional health, and boost confidence and self-awareness. EAP professionals also work in a consultative role with managers and supervisors to address employee and organizational challenges and needs. The Meritus Behavioral Health Employee Assistance Program (EAP) provides the following services:

- Short-term Counseling, Case Management, and Referrals
- Wellness Education and Training
- Crisis Incident Support
- Management Consultation
- Wellness Materials/Resources

Any information you share with an EAP professional will remain confidential. No information will be released to anyone, including employers, without an employee's written consent. The process for obtaining EAP services is kept simple and confidential. If you are an employee with the Meritus Behavioral Health EAP benefit and are interested in services, please call 301-766-7600 or 800-635-2774 to schedule an appointment with an EAP professional. 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.

Permanent Life Insurance

The Arc WC employees may also purchase Permanent Life insurance with Long Term Care through TrustMark that gives your loved ones peace of mind and protects them from the financial impact of your death. Permanent Life Insurance provides lifelong protection. Highlights of the TrustMark Life + Care insurance: no physicals or bloodwork; two in one coverage with permanent life insurance (death benefit) and long-term care benefits, professional caregiving services, and your rate doesn't increase as you get older.

****Enrollment is only offered during open enrollment for new hires throughout the year to be effective 1/1 each year—Benefits can be elected up the guarantee issue amount without requiring an EOI (Employee $100,000; Spouse $25,000; Child(ren) $10,000).**

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 administratively manages our retirement plan. They can handle any contribution changes, rollovers, withdrawals from the plan, and retirement plan loans. They can 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.

CONTRIBUTION SCHEDULE	
90 days - 4+ years	$1,500
5 years - 9+ years	$2,000
10 years+	$2,700

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	30-40 hrs/wk	20-29 hrs/wk	30-40 hrs/wk
Employee	$425.33	$39.77	$39.77	$459.42	$73.52
Employee + 1	$816.72	$251.07	$251.07	$923.87	$321.90
Family	$1,123.01	$443.89	$443.89	$1,270.35	$541.29

Enrolled employees who participate in the Healthy Steps program will receive up to a $30 per pay wellness contribution while enrolled in health insurance sponsored by The Arc WC (up to $780 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 $43.53 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	$13.57	$5.96	$15.89	$7.75	$2.76	$2.76
Employee + Spouse	$32.44	$22.55	$37.98	$26.82	$5.24	$5.24
Employee + Child(ren)	$23.27	$14.49	$27.24	$17.56	$5.38	$5.38
Family	$42.01	$30.96	$49.18	$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	866-346-5800	healthequity.com
HRA & FSA - CareFlex	888-577-2762	mycareflex.wealthcareportal.com support@careflex.com
Peak Health	252-237-5090	peak-health.net/wellness
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
Permanent Life—TrustMark	866-813-7192, x3	Myvb.trustmarkbenefits.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

IMPORTANT NOTICES

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

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

Introduction

You are receiving this notice because you recently gained coverage under the Arc of Washington County, Inc. group health plan(s), collectively known as the "Plan". This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally 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 receive 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 known as 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 are an employee, you will 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 are the spouse of an employee, you will 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; or
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 written notice to: Arc of Washington County, Inc., 820 Florida Ave, Hagerstown, MD 21710.

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.

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

Plan Administrator:
Arc of Washington County, Inc., 820 Florida Ave, Hagerstown, MD 21740

Plan Contacts:
Member Services Department of Aetna Open Access Network Services Only, Aetna Choice POS II QHDHP (730 Holiday Drive, Pittsburgh, PA 15220) at 800-872-3862

Member Services Department of Aetna PPO Dental Plan, (730 Holiday Drive, Pittsburgh, PA 15220) at 800-872-3862

Member Services Department of VBA Vision, (400 Lydia Street Suite 300, Carnegie, PA 15106) at 800-432-4966

Member Services Department of CareFlex Health Reimbursement Arrangement (HRA), (205 W. Dares Beach Road, Prince Frederick, MD 20678) at 888-577-276204.

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

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, 2025. Contact your State for more information on eligibility –

Maryland Children's Health Program (MCHP)
https://health.maryland.gov/mmcp/chp/pages/home.aspx

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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

HIPAA Notice of Privacy Practices

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

The Arc of Washington County, Inc. sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents, and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of The Arc of Washington County, Inc., the Plan, and your legal rights regarding your protected health information, including certain substance use disorder (SUD) records covered by 42 CFR part 2 (Part 2), held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully insured group health plans offered by The Arc of Washington County, Inc., you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact The Arc of Washington County, Inc.

HIPAA Privacy Officer:

The Arc of Washington County, Inc.,
Attention: HIPAA Privacy Officer
Kristin Elliott
820 Florida Avenue
Hagerstown, MD 21740
(301) 733-3550 ext.2296
kmelliott@arcwc-md.org

Effective Date
This Notice, as revised, is effective February 10, 2026.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or:

- Sharepoint > Employee Benefit Docs
- https://mymonarc.org/2026-employee-benefits/
- Paycor

Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use. Examples of use:

- Sharing medical information with doctors, nurses, specialists, or other healthcare providers involved in the patient's care.
- Coordinating care among multiple healthcare providers, such as when a primary care physician refers a patient to a specialist.
- Communicating with pharmacists to ensure proper medication management.
- Providing information to emergency medical personnel to treat the patient in urgent situations.
- Consulting with other healthcare professionals to develop or adjust a treatment plan.
- Sharing information with a healthcare facility or lab for diagnostic tests or procedures.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. Examples of use:

- Submitting claims to health insurance companies or government programs (like Medicare or Medicaid) to get paid for services provided.
- Verifying eligibility or coverage with a health plan before providing care.
- Billing patients or third parties for healthcare services.
- Conducting medical necessity reviews to determine if a service is covered.
- Collecting payments or managing accounts receivable.
- Communicating with collection agencies about unpaid bills.
- Coordinating benefits with other insurers to determine payment responsibilities.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes. Examples of Use:

- Quality assessment and improvement activities
- Case management and care coordination
- Reviewing the competence or qualifications of health care professionals
- Conducting training programs for staff on health care delivery
- Accreditation, certification, licensing, or credentialing activities
- Underwriting, premium rating, and other activities related to health insurance coverage
- Conducting or arranging for medical reviews, audits, or legal services
- Business planning and development, including cost management and planning-related analyses
- Customer service and complaint resolution

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information, including SUD treatment records, to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

SUD treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official — in response to a court order, subpoena, warrant, summons or similar process:
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain
- the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:
the individual identifiers have been removed; or
when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of SUD Part 2 treatment records, psychotherapy notes, and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights
You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed, and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period The Arc of Washington County, Inc. has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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 1/31/2026)

NOTES

Last updated: 02.11.2026