WASHINGTON COLLEGE

2020 EMPLOYEE BENEFITS GUIDE

Welcome to the 2020 Benefits Open Enrollment

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

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

After you read this information, you may contact Kate Laking (klaking2@washcoll.edu, 410-778-7799) with questions. **Remember that the open enrollment window ends on November 22nd.** It's important you enroll during this time period as you will not have an opportunity to enroll afterwards unless you have a qualifying life event (keep reading to learn more).

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

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

Benefit Basics

ELIGIBILITY

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

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

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

QUALIFYING LIFE EVENTS

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

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

You must notify Human Resources within 30 days of a qualifying event. Depending on the type of event, you may need to provide proof of the event, such as a marriage license.

Human Resources will let you know what documentation you should provide. If you do not contact HR within 30 days of the qualified event, you will have to wait until the next open enrollment window to make changes.

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact your Washington College Human Resources representative.

Medical
Cigna
www.mycigna.com
1-800-244-6224

Dental
Delta Dental
www.deltadentalins.com
1-800-932-0783

Vision
VSP
www.vsp.com
1-800-877-7195

Basic Life and AD&D, Voluntary Life and AD&D, Dependent Life, Short-Term Disability and Long-Term Disability
Unum
www.unum.com
1-866-679-3054

Retirement
TIAA-CREF
www.tiaa-cref.org
1-800-842-2776

Health Savings Accounts (HSA)
HSA Bank
www.hsabank.com
1-800-357-6246

Emergency Travel Assistance
Unum
www.unum.com
1-800-872-1414 (in U.S.)
1-609-986-1234 (Outside U.S.)

Employee Assistance Program
ComPsych
www.compsych.com
1-855-399-2524

Identity Theft Protection Services
Unum—CLC
www.clcidprotect.com
1-800-984-6812

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MEDICAL INSURANCE

HOW TO GET STARTED

1 SELECT YOUR MEDICAL PLAN

- ☐ **OPTION 1: The Preserver**
- ☐ **OPTION 2: The Protector**
- ☐ **OPTION 3: The Protector Plus**

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

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

Will I receive a new Medical ID card?

Anyone switching plans will receive a new ID card. You will not receive a new ID card if you are remaining in your current plan.

Does the deductible run on a calendar year or policy year basis?

A calendar year basis.

How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

I just got hired. When will my benefits become effective?

Your benefits will begin 1st of the month coinciding with or following hire date

YOUR HEALTH PLAN OPTIONS

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

For each, your deductible will run from January 1–December 31.

While one of the plans give you the option of using out-of-network providers, you can save money by using in-network providers because Cigna has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Cigna UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

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

THE PRESERVER OFFERS SEVERAL BENEFITS:

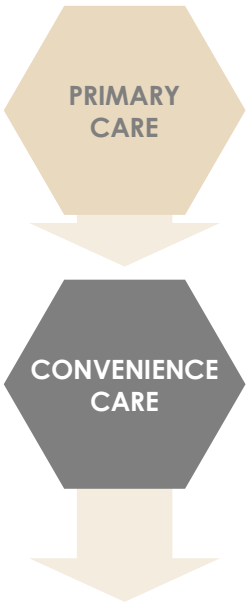
- Lower premium contributions and potential maximum out-of-pocket expenses
- Routine preventive exams are covered at 100%
- Catastrophic coverage
- The HSA is owned by you
- You have more control over your health care dollars

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

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

CARE OPTIONS AND WHEN TO USE THEM

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



- Routine, primary/ preventive care
- Non-urgent treatment

- Common infections (bronchitis, bladder and ear infections, pink eye, strep throat)
- Minor skin conditions (athlete's foot, cold sores, minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

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

- Heavy bleeding
- Large open wounds
- Chest pain
- Sudden change in vision
- Spinal injuries
- Difficulty breathing
- Major burns
- Sudden weakness or trouble walking
- Severe head injuries

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 911

PRIMARY CARE

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

CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

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

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in any of the following:

- Serious jeopardy to your health or the health of an unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

If you obtain care at an emergency room, you will likely pay more out of pocket than if you were treated at your doctor's office, a Convenience Care Center, or Urgent Care facility.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

CIGNA TELEHEALTH CONNECTION

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

Use Cigna Telehealth Connection to connect with a doctor about:

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

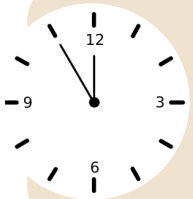
Amwell - AmwellforCigna.com - 1-855-667-9722

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

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

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

ANSWERS



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

MYCIGNA ONLINE EMPLOYEE PORTAL

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

Find in-network doctors and medical Services

Manage and track claims

See cost estimates for medical procedures

Compare quality of care for doctors and hospitals

Access a variety of health and wellness tools and resources

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

CIGNA 24/7/365

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

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

SEARCH CIGNA'S NETWORK IN 5 STEPS

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

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

Step 3 Enter the geographic location you want to search.

Step 4 Select the Open Access Plus Plan.

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

Medical Insurance Plan Options and Costs

Cigna	The Preserver	The Protector	The Protector Plus	
	Employee Cost Per Paycheck			
	If you have a spouse that is also an employee, speak to HR for discounted contributions			
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$3.50 $72.50 $55.50 $114.00	$62.50 $167.50 $140.50 $263.50	$69.50 $217.50 $182.50 $342.00	
	In-Network	**In-Network**	**In-Network**	**Out-of-Network**
Company Contribution to HSA	**$500 / $1,000 for 2020**	**N/A**	**N/A**	
Deductible Individual / Family	$1,750 / $3,500	$500 / $1,000	$500 / $1,000	$1,000 / $2,000
Out-of-Pocket Maximum Individual / Family *(includes deductible, coinsurance & copays)*	$2,500 / $4,500	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
Office Visit Primary Care Physician / Specialist	Deductible, then no charge	$25 copay/ $35 copay	$25 copay / $35 copay	Deductible, then 30%
Preventive Care	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Deductible, then 30%
Diagnostics Lab and X-ray Major Diagnostics *(MRI, CT, PET…)*	Deductible, then no charge	Deductible, then 10%	Deductible, then 10%	Deductible, then 30%
Urgent Care	Ded, then no charge	$50 copay	$50 copay	Deductible, then 30%
Emergency Room	Ded, then no charge	$100 copay, waived if admitted	$100 copay, waived if admitted	
Outpatient Surgery	Ded, then no charge	Deductible, then 10%	Deductible, then 10%	Deductible, then 30%
Inpatient Hospital Services	Ded, then no charge	Deductible, then 10% & $250 copay	Deductible, then 10% & $250 copay	Deductible, then 30% & $250 copay
Prescription Drug Deductible	Integrated with Medical Deductible	N/A	N/A	
Prescription Drug Retail *(at participating pharmacies)* *Mail Order (90-day supply)*	$10 copay/$35 copay/ $60 copay $20 copay/$70 copay/ $120 copay	$10 copay/$35 copay/ $60 copay $20 copay/$70 copay/ $120 copay	$10 copay/$35 copay/ $60 copay $20 copay/$70 copay/ $120 copay	Deductible, then 30%

All plans are detailed in Cigna's 2020 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

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

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

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

Contribute up to **$3,550** Single, or **$7,100** Family

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

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

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

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

WHAT ARE THE RULES?

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

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2020 are $3,550 for Single and $7,100 for Family coverage. If you're age 55 or older, you are allowed to make extra contributions each year.
- The College contributes $500 (employee coverage) / $1,000 (family coverage) for those enrolled in the high deductible health plan. The amount will be on your 1st paycheck of the year. This amount is prorated for new hires.
- The maximum contribution limit is inclusive of both your contribution, as well as the College's contribution.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.

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

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

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

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

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

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

This may be the best plan option for you if any of the following is true:

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

FREQUENTLY ASKED QUESTIONS

What will I pay at the pharmacy with the HSA qualified plan options?

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

What will I pay at the physician's office with the HSA qualified plan?

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

Where can I get a copy of an EOB?

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

FLEXIBLE SPENDING ACCOUNTS (FSA)

2 SELECT A SAVINGS ACCOUNT

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Expense Account**
- ☐ **Health Savings Account (HSA) - *must be enrolled in The Preserver Plan***

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

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

Here's a look at how much you can save when you use an FSA to pay for your health care and dependent care expenses.

Account Type	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$36,299	$35,645
Tax savings with the Medical and Dependent Care FSA	**$654**	**N/A**

To see a list eligible FSA expense examples from the IRS, go to

http://www.hsacenter.com/what-is-an-hsa/qualified-medical-expenses/.

How the Health Care Flexible Spending Account Works

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

Maximum Contribution

Health Care Flexible Spending Account	$2,700 max
Dependent Care Expense Account	$5,000 max

DEPENDENT CARE EXPENSE ACCOUNT

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

Contact Information

Request a full statement of your accounts at any time by calling 1-800-532-3327 or log on to flores247.com to review your FSA balance.

At flores247.com you can:

Sample Instructions

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

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

DELTA DENTAL IS THE DENTAL CARRIER FOR 2020.

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

Dependent children are eligible until the end of the month in which they turn age 26.

Delta Dental

FIND A DENTIST

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

Sample Directions:

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

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

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

Dental Insurance Plan Options and Costs

Delta Dental	**Delta Dental Base Employee Cost Per Paycheck**		**Delta Dental Buy-up Plan Employee Cost Per Paycheck**	
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$14.61 $32.11 $22.13 $41.28		$19.32 $42.54 $32.49 $56.98	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual / Family	$50/$150	$50/$150	$50/$150	$50/$150
Annual Maximum	$1,000		$2,500	
Type A Preventive Services	Plan pay 100% no deductible	Plan pay 80% no deductible	Plan pay 100% no deductible	Plan pay 100% no deductible
Type B Basic Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible
Type C Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontia Children & Adults	N/A		Lifetime maximum of $2,000 per member	

You can use your FSA or HSA dollars to pay for dental deductibles, copays or braces!

The Buy-up Dental plan now covers adult orthodontia! Orthodontia is available for your entire family.

VISION INSURANCE

4 REVIEW YOUR VISION PLAN

VSP IS THE VISION CARRIER FOR 2020.

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

Also, if you are considering Lasik surgery, there is a discount available with some providers. To find a participating provider, go to www.vsp.com.

DID YOU KNOW?
There are discounts available for Lasik surgery.

VSP

FIND A PROVIDER

SAMPLE INSTRUCTIONS

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

Vision Insurance Plan Options and Costs

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

You can use FSA or HSA dollars to pay for glasses, contacts, & copays!

LIFE INSURANCE AND AD&D

Unum

5 REVIEW YOUR LIFE INSURANCE POLICY

- ☐ **Update your beneficiary**
- ☐ **Review your current Voluntary Life coverage**

DID YOU KNOW?

Washington College provides you Basic Life and AD&D AT NO CHARGE

BASIC LIFE AND AD&D

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

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what Washington College provides. As a new hire, you are eligible for guaranteed issue coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** minimum $10,000 to a maximum of 5x your annual salary, or $500,000, in $10,000 increments. Guarantee issue up to $200,000
- **Optional Dependent Life & AD&D for spouse:** minimum $10,000 up to the lesser of 100% of the employee amount or $500,000, in $10,000 increments. Guarantee issue up to $30,000.
- **Optional Dependent Life & AD&D for children:** minimum $2,500 up to $10,000 maximum. Guarantee issue up to $10,000.
- If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by Unum before you're able to get coverage in the future.

Voluntary Life and AD&D and Dependent Life Options and Costs

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

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

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

DISABILITY INSURANCE & LONG-TERM CARE

Unum

6 REVIEW YOUR DISABILITY COVERAGE

- ☐ Long-Term Disability
- ☐ Elect Pre or Post Tax

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

LONG-TERM DISABILITY

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

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

The benefits begin after a 180 day waiting period.

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

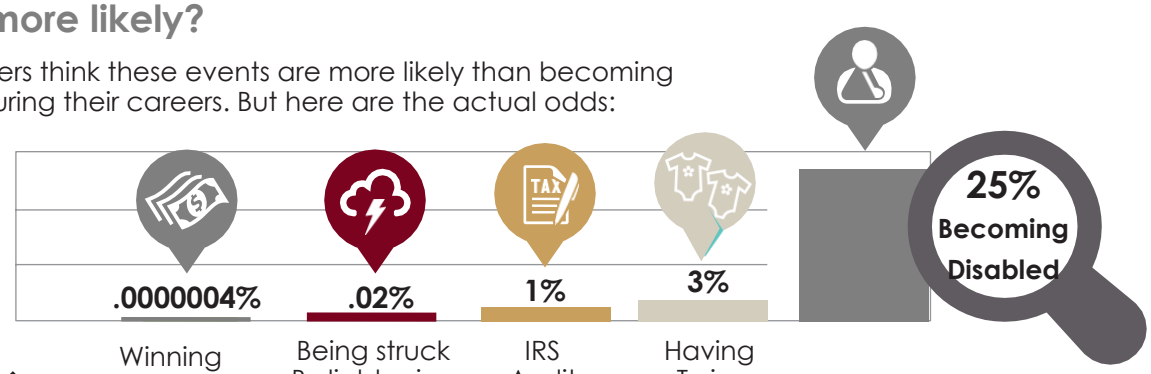
Could you pay the bills if you weren't working?

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

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

What's more likely?

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



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

RETIREMENT

7 ELECT YOUR 403(B) CONTRIBUTION

2020 CONTRIBUTION LIMIT
$19,500

ADDITIONAL $6,500 ALLOWED FOR EMPLOYEES OVER AGE 50

OUR 403(B) PLAN IS MANAGED BY TIAA.

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

ELIGIBILITY

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

EMPLOYEE CONTRIBUTIONS

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

EMPLOYER CONTRIUTIONS

The College will contribute 3% of your pay to your account regardless of how much you contribute. The College will match your contribution dollar for dollar if you contribute between 3 and 7.5%. The college contribution and match will not exceed 7.5% of your pay. Here are some examples:

If you earn $30,000 and contribute 3% or $900 to the plan each year, the College will contribute $900 to your account.

If you earn $30,000 and contribute 10% or $3,000, the College will contribute 7.5% or $2,250.

If you earn $30,000 and contribute 5% or $1,500, the College will contribute 5% or $1,500.

Tips on How to Save Smart for Retirement

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

Article adapted from the U.S. Department of Labor publication of the same title. www.dol.gov/ebsa/pdf/savingsfitness.pdf.

VESTING

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

PAID LEAVE PLANS

Eligible employees earn paid leave starting on the first day of employment with the College. Faculty should contact the Provost and Dean, or review the Faculty Handbook for details about faculty leave.

Eligible employees accrue increasing amounts of vacation depending on length of service based on the following:

Length of	Exempt (Salaried) Staff	Non-Exempt
Less than 3 years	4 weeks per year	2 weeks per year
3-6 years	4 weeks per year	3 weeks per year
Over 6 years	4 weeks per year	4 weeks per year

Sick Leave is accrued in addition to vacation at the rate of two weeks per year. Non-exempt staff also receive 3 days of Personal Leave which does not require advance notice. Finally, the College maintains a sick leave pool that allows employees to donate leave to benefit co-workers who do not have enough sick or vacation leave to continue their pay during an eligible medical situation.

PARENTAL LEAVE

The College provides up to 15 weeks of paid leave for eligible employees who've become new parents through adoption or birth. The leave runs concurrently with any leave available to the employee under the Family and Medical Leave Act. If both parents of the child are employees of the College who qualify for this benefit, they may divide the leave between them.

For questions regarding eligibility for any paid leave plan, please consult with the Human Resources Staff.

PAID TIME OFF

Washington College typically has 14 annual holidays including:

- Memorial Day
- Independence Day
- Your Birthday
- Thanksgiving Day, day before and the day after
- Time between Christmas Eve & New Year's Eve

The full year holiday schedule is available from HR.

Washington College also provides the following additional leaves for employees:

- Vacation Leave - Accrues per day
- Personal Leave - Set number of hours beginning July 1 each year for non-exempt staff only
- Sick Leave - Accrues per day
- Sick Leave Pool Program

Exempt employees earn 4 weeks of vacation. Non-exempt (hourly) workers earn vacation on a sliding scale depending on length of service. For additional information on the specific accrual rates and hours contact HR.

ADDITIONAL BENEFITS

EDUCATIONAL ASSISTANCE

Washington College offers several Tuition and Educational Assistance programs:

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

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

Forms and applications can be found on the Tuition Programs page: https://www.washcoll.edu/offices/human-resources/tuition-programs-.php

MEMBERSHIPS AVAILABLE

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

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

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

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

IDENTITY THEFT ASSISTANCE

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

VIDEO RESOURCES

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP vs. PPO
- HDHP With HSA Overview

INSURANCE 101

- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What Is A Health Savings Account?
- What Is A Flexible Spending Account?
- What Is A 401(k) Retirement Plan?

ANCILLARY BENEFITS

- What Is Dental Insurance?
- What Is Vision Insurance?
- What Is Life And AD&D Insurance?

IMPORTANT NOTICES

HIPAA 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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] 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 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 [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The Women's Health and Cancer Rights Act requires that group medical plans provide the following services to any person receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Under WHCRA, mastectomy benefits may be subject to annual deductibles and co-insurance consistent with those established for other benefits under the plan or coverage. The law also contains prohibitions against:

- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plan to avoid the requirements of WHCRA.

Plans and issuers providing incentives, or penalizing physicians to induce them to provide care in a manner inconsistent with the WHCRA.

Group health plans, health insurance companies and HMOs covered by the law must notify individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or to less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

MEDICARE PART D CREDITABLE COVERAGE FOR MEDICARE-ELIGIBLE EMPLOYEES

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Washington College has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Washington College coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Washington College coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Washington College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Washington College changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

Date:	January 1, 2020
Name of Entity/Sender:	Washington College
Contact--Position/Office:	Kate Laking
Address:	300 Washington Ave, Chestertown, MD 21620
Phone Number:	410-778-7799

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**IOWA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
ALASKA – Medicaid	**KANSAS – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ARKANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://chfs.ky.gov Phone: 1-800-635-2570
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**LOUISIANA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
FLORIDA – Medicaid	**MAINE – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: https://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739

MISSOURI – Medicaid	RHODE ISLAND – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
MONTANA – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEBRASKA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEVADA – Medicaid	**TEXAS – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW HAMPSHIRE – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW JERSEY – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW YORK – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NORTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
NORTH DAKOTA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
OKLAHOMA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
OREGON – Medicaid	**WYOMING – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
PENNSYLVANIA – Medicaid	
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

COBRA CONTINUATION COVERAGE

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?

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

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

- Your hours of employment are reduced, or
- Your employment is terminated due to reasons other than retirement

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

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

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

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both),
- The parents become divorced or legally separated, or
- The child stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA Continuation Coverage Available?

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

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

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

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

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

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

- **Disability extension of 18-month period of COBRA continuation coverage**. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please contact the CCPS Benefit team within 30 days of the Social Security determination.
- **Second qualifying event extension of 18-month period of continuation coverage**. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

Keep Your Plan Informed of Address Changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. You may contact the Washington College HR Department at -410-778-7298.

GLOSSARY OF MEDICAL TERMS

Brand Name Drugs—Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

Coinsurance—The percentage of a covered charge paid by the plan.

Consumer Driven Health Plan (CDHP)—A medical plan used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

Copayment (Copay)—A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible—The annual amount you and your family must pay each year before the plan pays benefits.

Generic Drugs—Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

High Deductible Health Plan (HDHP)—A medical plan that may be used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

Health Savings Account (HSA)—A fund you can use to help pay for eligible medical costs not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions. Equity partners can have monthly contributions charged against their monthly draw account.

In-Network—Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Out-of-Network—Use of a health care provider that does not participate in a plan's network.

Mail Order Pharmacy—Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Inpatient—Services provided to an individual during an overnight hospital stay.

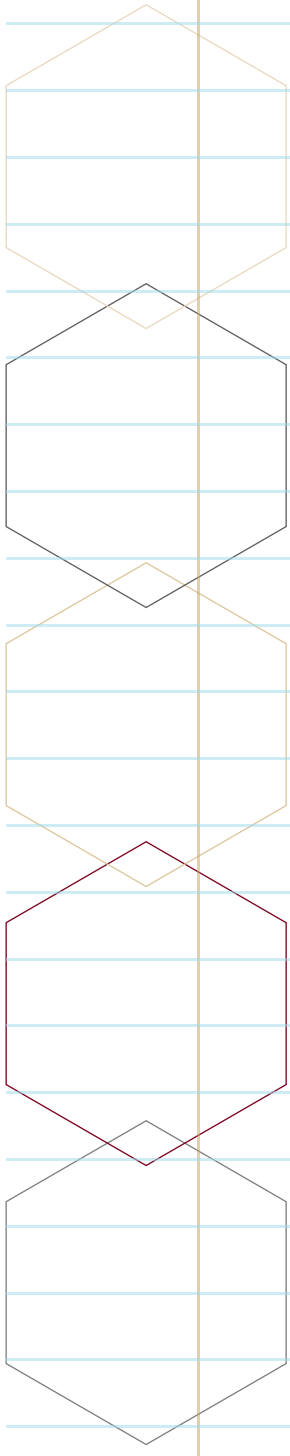
Outpatient—Services provided to an individual at a hospital facility without an overnight hospital stay.

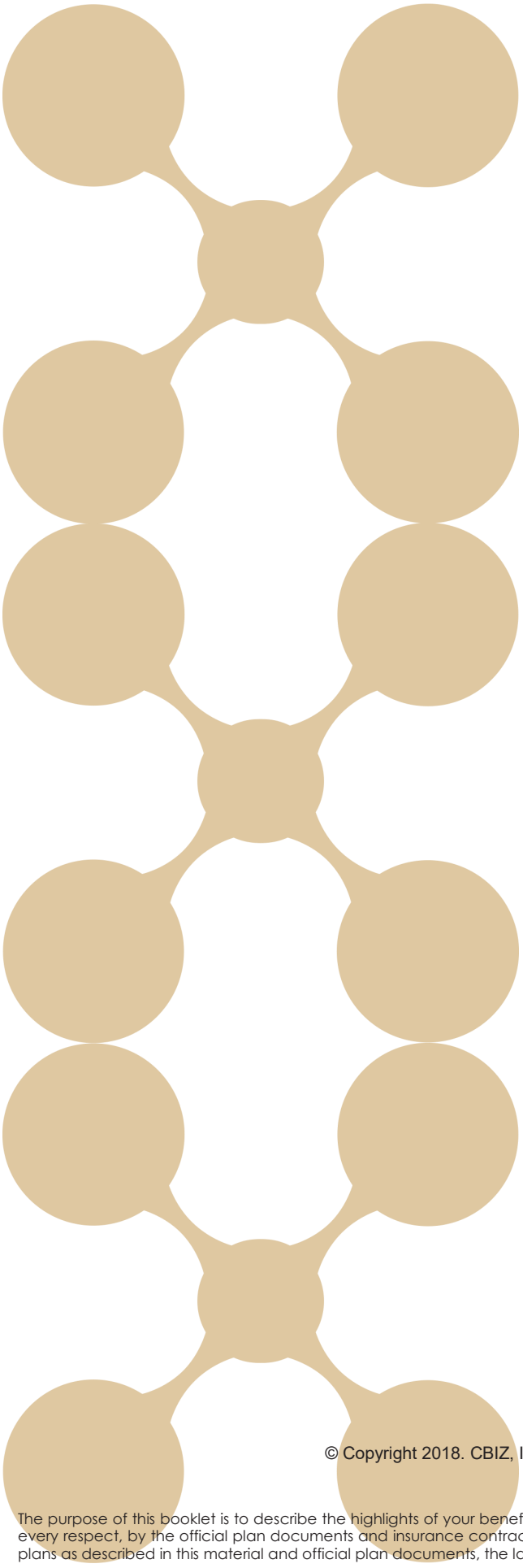
Out-of-Pocket Maximum—The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year, except for prescriptions under all medical plans except the HSA Plan.

Primary Care Physician (PCP)—physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Specialist—A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

NOTES





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