Washington College

2026

EMPLOYEE BENEFITS GUIDE

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WASHINGTON COLLEGE EMPLOYEE BENEFITS

As an employee of Washington College, you may be eligible for certain benefits such as medical, dental, vision and 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 College pays for the entire cost of Life and Disability benefits 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 Human Resources (hr@washcoll.edu, 410-778-7260) with questions.

Remember, it's important you enroll during your initial eligibility period as you will not have an opportunity to enroll afterwards until the next open enrollment unless you have a qualifying life event (keep reading to learn more).

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

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

BENEFIT BASICS

ELIGIBILITY

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

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

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

QUALIFYING LIFE EVENTS

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

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

You must compete a Benefits Enrollment/Change form within 30 days of a life event to initiate the qualifying event. Depending on the type of event, you may need to provide proof of the event, such as a marriage license.

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

INSTRUCTIONS ON HOW TO ENROLL for OPEN ENROLLMENT

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

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

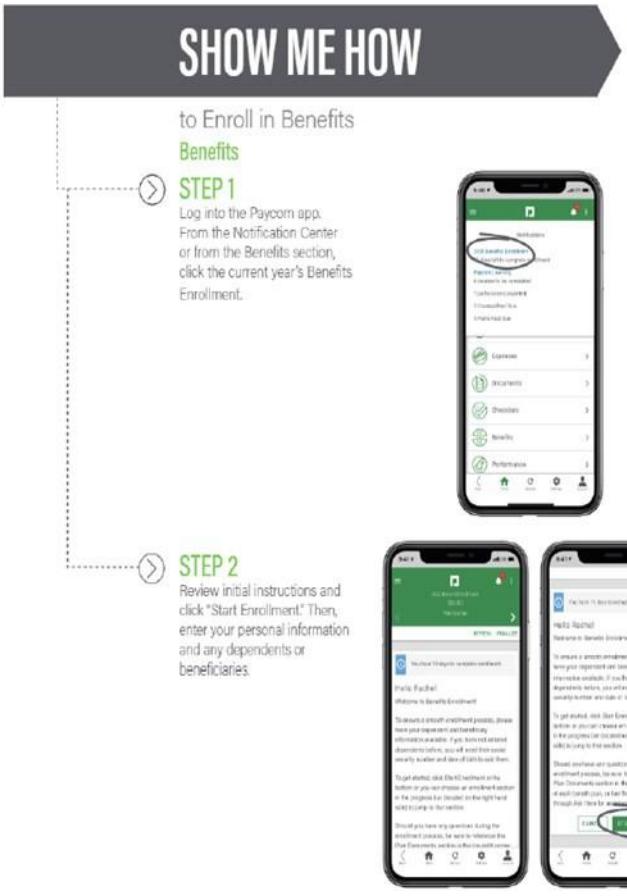
1. Log in to the Paycom app
2. From the notification center (Bell Icon)  select "2026 Benefits Enrollment" OR

   From your employee self service page select "2026 Benefits Enrollment"
3. Click "Start Enrollment" and enter your personal information and any dependents or beneficiaries
4. On each benefit screen, click on plan documents for additional details of the plans. After reviewing each benefit plan, enroll or decline coverage
5. As you go through the enrollment process, your selections and the cost will display on the benefits summary tracker to the right
6. To complete enrollment, click "Finalize", then "Sign and Submit"
7. Don't forget, you can ask questions by clicking the "ASK Here" icon in Paycom 

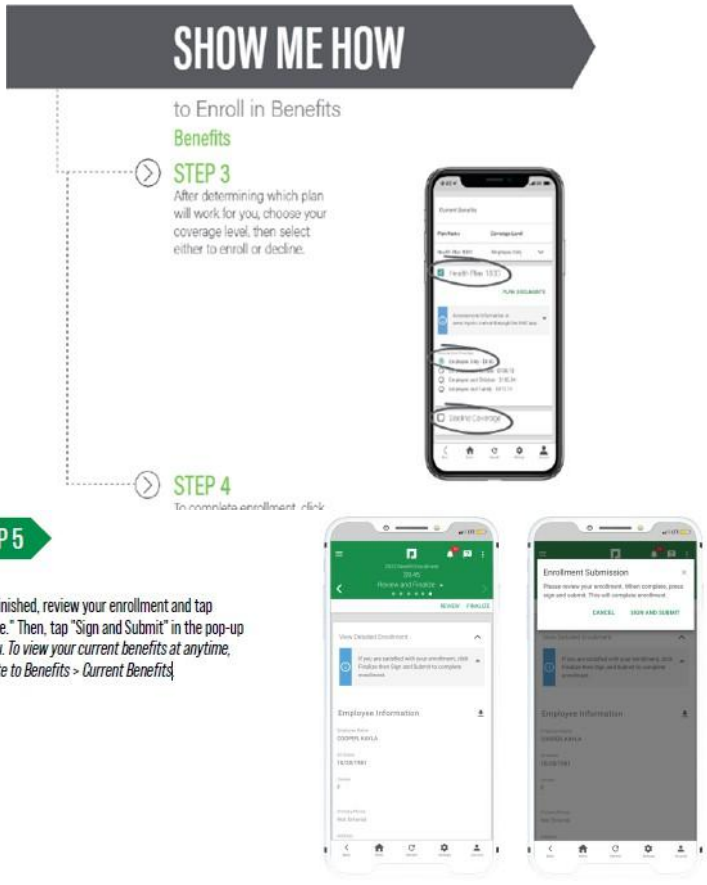
Enroll Online

paycom

ENROLLMENT PERIOD for OPEN ENROLLMENT: November 7 - November 19, 2025



Easy Enrollment Steps on the Paycom App



TIP

REMEMBER! The plan year ends on December 31. Open Enrollment is the time when you can make any changes you want without a qualifying event.

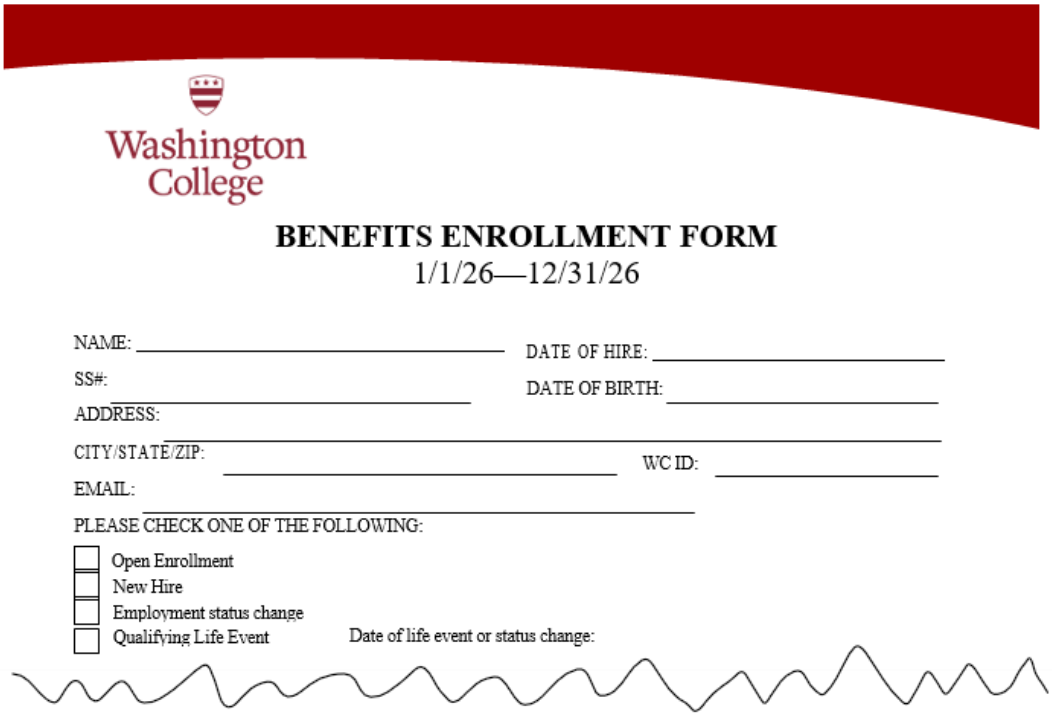
INSTRUCTIONS ON HOW TO ENROLL for NEW HIRE ENROLLMENT & QUALIFYING EVENTS

As a full-time benefits-eligible new hire (or rehire) to Washington College, you can select and enroll for many benefits within your first 30 days of employment; you can also waive coverage if you have health benefits elsewhere.

You will use a Benefits Enrollment Form provided to you by the HR Department to choose your plans, coverage levels and other elections for all the benefits you elect or waive.

Your enrollment will be effective the 1st day of the month coinciding with or after your first date of employment.

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



Washington College

BENEFITS ENROLLMENT FORM

1/1/26—12/31/26

NAME: _____ DATE OF HIRE: _____

SS#: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ WC ID: _____

EMAIL: _____

PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ Open Enrollment
- ☐ New Hire
- ☐ Employment status change
- ☐ Qualifying Life Event

Date of life event or status change:

If you have a Qualifying Life Event (as outlined on page 2 of this guide) and want to change your benefits elections, you must compete a Benefits Enrollment Form within 30 days of that life event. Depending on the type of event, you may need to provide proof of the event, such as a marriage license. Contact HR for the form and if you have any questions on the documentation required.

For some life events, the change in health insurance coverage will be the date of the event; for other events, it may be the 1st day of the month coinciding with or after the event. HR will guide you through that information.

Have your dependent/beneficiary Social Security numbers and dates of birth, before beginning the enrollment/change process – especially if they are new dependents!

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

CONTACT INFORMATION

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

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

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

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

BASIC LIFE/AD&D, DISABILITY INSURANCE / VOLUNTARY LIFE/AD&D
Reliance reliancematrix.com
800-351-7500

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

FLEXIBLE SPENCING ACCOUNT (FSA)
Flores flores247.com
800-532-3327

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

EMERGENCY TRAVEL ASSISTANCE
On Call International
oncallinternational.com
800-456-3893 (in U.S.)
603-328-1966 (Outside U.S.)

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

WASHINGTON COLLEGE BENEFITS
Human Resources
hr@washcoll.edu
410-778-7260

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

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

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

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

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

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

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

FREQUENTLY ASKED QUESTIONS

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

? Will I receive a new Medical ID card?

Cigna ID cards are now digital! If you would like a physical card, you can request one from mycigna.com or by calling the customer service number found in the table of contents of this guide.

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

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

? I am a new hire, when will my benefits become effective?
Your medical insurance benefit will begin on the 1st of the month coinciding with or following hire date.

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

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

THE PRESERVER OFFERS SEVERAL BENEFITS:

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

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

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

MEDICAL INSURANCE

Cigna	The Preserver	The Protector	The Protector Plus
	Employee Cost Per Paycheck*	Employee Cost Per Paycheck*	Employee Cost Per Paycheck*
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$7.50 $86.50 $68.00 $132.00	$77.50 $205.00 $172.50 $318.50	$89.50 $276.00 $232.00 $429.00
	In-Network	**In-Network**	**In-Network**
Deductible[1] Individual / Family	$2,000 / $4,000	$500 / $1,000	$500 / $1,000
Company Contribution to HSA**	$500 / $1,000	n/a	n/a
Out-of-Pocket Maximum[2] Individual / Family	$2,500 / $4,500	$3,000 / $6,000	$3,000 / $6,000
Office Visits Preventative Care Primary Care Physician/Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% Deductible then no charge Deductible then no charge Deductible then no charge	Covered at 100% $25 copay / $35 copay Deductible then 10% $50 copay	Covered at 100% $25 copay / $35 copay Deductible then 10% $50 copay
Hospital Visits Inpatient Care (Facility/Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	Deductible then no charge Deductible then no charge Deductible then no charge Deductible then no charge	Deductible then 10% & $250 Deductible then 10% Deductible then 10% $100 copay, waived if admitted	Deductible then 10% & $250 Deductible then 10% Deductible then 10% $100 copay, waived if admitted
Prescription Drug Deductible Retail Tier 1 / 2 / 3 Copay Mail Order (90-day supply) Copay	Integrated with Medical Deductible $10 copay / $35 copay / $60 $20 copay / $70 copay / $120	N/A $10 copay / $35 copay / $60 $20 copay / $70 copay / $120	N/A $10 copay / $35 copay / $60 $20 copay / $70 copay / $120
	Out-of-Network	**Out-of-Network**	**Out-of-Network**[3]
Deductible Individual / Family	Not Covered	Not Covered	$1,000 / $2,000
Coinsurance (Member Pays)	Not Covered	Not Covered	30%
Out-of-Pocket Maximum Individual / Family	Not Covered	Not Covered	$3,000 / $6,000

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

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

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

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

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

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

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

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

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

PRIMARY CARE

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

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

CONVENIENCE CARE

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

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

URGENT CARE

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

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

EMERGENCY ROOM

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

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

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

Options for Care

CIGNA TOOLS AND RESOURCES

VIRTUAL CARE FROM MDLIVE

Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options available by phone or video.

Contact a board-certified MDLIVE doctor for:

- Primary Care
  Preventive care, routine care, specialist referrals
- Urgent Care
  On-demand care for minor medical conditions
- Behavioral Care
  Talk therapy and psychiatry from the privacy of home
- Dermatology
  Fast, customized care for skin, hair and nails

MDLIVE

3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:

1. Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)
2. Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE
3. Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Cigna resources are designed to help you make smarter choices to improve your whole health and health plan spending.

First, register on myCigna.com[1] to access your digital ID cards and activate all available programs

When your plan year begins, register on **myCigna.com**. That way you're ready to go whenever you need to find in-network health care providers, estimate costs or use My Health Assistant.

Register now

Access virtual care

Conveniently connect with board-certified doctors, therapists, psychiatrists and dermatologists via video or phone.[2]

Connect with Cigna One Guide[3]

Our friendly guides have forward-thinking technology to answer questions on your plan, offer personalized advice and connect you to the right care. They can also proactively reach out.[3]

Ensure in-network care

myCigna and Cigna One Guide can help you stay in-network, maximize savings and avoid any surprises.

Get preventive care

Preventive care, such as check-ups, biometric screenings and wellness screenings, is available at no additional cost to you.[4] It's even available virtually for maximum convenience.

Prioritize behavioral support

229K+ behavioral health and substance use providers[5] can help, either in person or virtually. We also have 24/7 therapy, including Talkspace and Ginger for Cigna, and digital tools, such as iPrevail and Happify™.[6]

Call our 24/7 Health Information Line

Talk with a clinician who can help you choose the right care, whenever you need it – late nights, holidays and more.

Simplify with mail-order medications

Express Scripts® is one of the largest pharmacies in the United States and offers convenience, savings and stress-free prescription management.

Identity Theft protection
At no additional cost.

Bounce back with RecoveryOne™ for Cigna[7]

Virtual physical therapy from the comfort of home is convenient and available at no additional cost to you.

Utilize case management programs

Complex medical conditions can be overwhelming. Our trained teams can help you coordinate care, understand benefits and reach goals through online coaching.

Cigna.

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

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

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

WHAT IS AN HSA?

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

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

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

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

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

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

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

What Is A Health Savings Account?

Contribute up to $4,400 Single, or $8,750 Family

WHAT ARE THE RULES?

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

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual (calendar year) contribution limits. The contribution limits for 2026 are $4,400 for Single and $8,750 for Family coverage. If you are age 55 or older, you are allowed to make an extra $1,000 contribution each year. *Annual contribution limits include Washington College's contribution.*
- Washington College contributes $500 (employee only) / $1,000 (family) towards the HSA. The amount is funded during your first month of enrollment and is prorated for new hires. The amount is included in IRS maximums.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA)

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

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

More information about approved items, plus additional details about the HSA, is available in the HSABank Learning Center.

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.

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.

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

Understanding your EOB

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

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

Eligible Expenses Examples

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

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

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

2026 Maximum Contributions

Health Care Flexible Spending Account	$3,400 max
Dependent Care Expense Account	$7,500 max

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

What Is A Flexible Spending Account?

What Is A Dependent Care Account?

SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE EXPENSE ACCOUNT

DEPENDENT CARE EXPENSE ACCOUNT

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

CONTACT INFORMATION

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

At flores247.com, you can:

Sample Instructions

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

DENTAL INSURANCE

REVIEW YOUR DENTAL PLAN

DELTA DENTAL IS THE DENTAL CARRIER

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

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

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

What Is Dental Insurance?

DENTAL INSURANCE PLAN OPTIONS AND COSTS

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

FIND A DENTAL PROVIDER

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

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

VISION INSURANCE

4. REVIEW YOUR VISION PLAN

VSP IS THE VISION CARRIER

Choose base coverage, or 'buy-up' coverage, providing: Increased frame allowances, Increased frame frequency (every 12 mos. Vs. every 24 mos.), anti-glare lens coating at no cost, and an allowance for VSP LightCare.

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

VISION INSURANCE PLAN OPTIONS AND COSTS

VSP	Base Coverage		Buy-Up Coverage	
	Employee Cost Per Paycheck		Employee Cost Per Paycheck	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$3.55 $5.65 $5.76 $9.29		$6.06 $10.20 $10.42 $16.79	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examination Copay	$10 copay	Reimbursement Up to $45	$10 copay	Reimbursement Up to $45
Frequency of Service Exam Lenses Frames	Every 12 months Every 12 months Every 24 months		Every 12 months Every 12 months Every 12 months	
Lenses Single Bifocal Trifocal Anti-glare coating	$20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered Not covered	Reimbursement Up to $30 Up to $50 Up to $65 Not covered	$20 copay; 100% covered $20 copay; 100% covered $20 copay; 100% covered $0 after lens copay	Reimbursement Up to $30 Up to $50 Up to $65 Not covered
Frames	$150 allowance + 20% off balance; $170 featured frame allowance; $150 Walmart/Sam's Club allowance; $80 Costco allowance	Reimbursement Up to $70	$200 allowance + 20% off balance; $220 featured frame allowance; $200 Walmart/Sam's Club allowance; $110 Costco allowance	Reimbursement Up to $70
Conventional Contacts	$150 allowance	Reimbursement Up to $105	$150 allowance	Reimbursement Up to $105
VSP Lightcare	Not covered		$200 allowance for ready-made non-prescription sunglasses or blue light filtering glasses, *instead of* prescription glasses or contacts	Not covered

FIND A VISION PROVIDER

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

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

LIFE INSURANCE AND AD&D

5. REVIEW YOUR LIFE INSURANCE POLICY

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

BASIC LIFE INSURANCE

Washington College provides 1½x your annual earnings to a maximum of $85,000 in Basic Life insurance.

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

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

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

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

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

If you do not enroll in the Voluntary Life and AD&D plan during your initial enrollment period, **you will be required to complete an Evidence of Insurability (EOI) form and be approved by Reliance. The EOI form and link are in the Paycom benefit documents.**

The only exception to this is, if you are currently enrolled in Washington College's voluntary life, then at open enrollment you can increase coverage up to 5 increments of $10,000, not to exceed the guaranteed issue amount of $200,000. Spouse coverage can be increased by one increment of $10,000, up to the guarantee issue amount of $30,000.

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

Reliance	Rates per $10,000 of coverage		
	Age	Employee	Spouse*
Voluntary Life	<25	$0.335	$0.335
	25-29	$0.380	$0.380
	30-34	$0.475	$0.475
	35-39	$0.525	$0.525
	40-44	$0.570	$0.570
	45-49	$0.805	$0.805
	50-54	$1.180	$1.180
	55-59	$2.125	$2.125
	60-64	$3.205	$3.205
	65-69	$6.075	$6.075
	70-74	$9.790	$9.790
	75+	$9.790	$9.790
	Child(ren) to age 26	$0.28 per paycheck per $2,500 coverage	

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

DID YOU KNOW? Washington College provides you Basic Life insurance AT NO CHARGE.

DISABILITY INSURANCE

6. REVIEW YOUR DISABILITY COVERAGE

- LONG-TERM DISABILITY
- ELECT PRE OR POST TAX

LONG-TERM DISABILITY INSURANCE

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

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

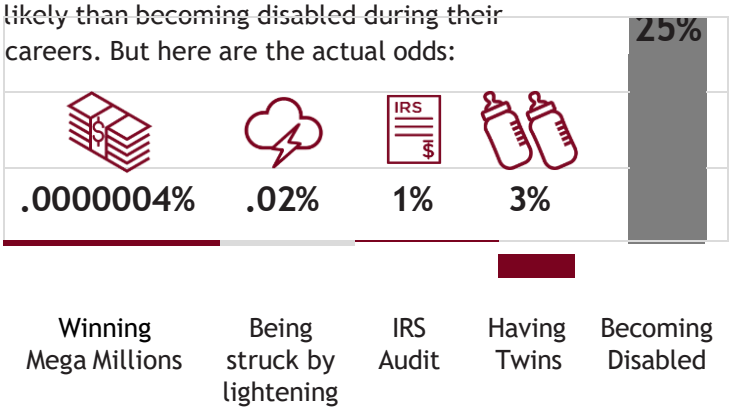
Long-Term Disability insurance offered through Reliance is provided at no cost to you. The plan benefit is 60% of basic monthly earnings up to a maximum of $ 6,000 per month maximum.

The benefits begin after a 180 day waiting period.

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

WHAT'S MORE LIKELY?

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



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

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

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

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

RETIREMENT

7. RETIREMENT

- ELECT YOUR 403(B) CONTRIBUTION

OUR 403(B) PLAN IS MANAGED BY TIAA

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

ELIGIBILITY

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

EMPLOYEE CONTRIBUTIONS

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

EMPLOYER CONTRIBUTONS

Currently, the College is not providing contributions or match to the retirement plan.
The College contribution will be reviewed prior to the start of each

VESTING

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

TIPS ON HOW TO SAVE SMART FOR RETIREMENT:

- Start **NOW**. Don't wait. Time is critical
- Start small, if necessary. Even small contributions can make a big difference given enough time and the right kind of investments
- Save regularly. Make saving for retirement a habit
- Roll over retirement account money if you change jobs
- Don't dip into retirement savings

TIP

2025 CONTRIBUTION LIMIT: $23,500*
ADDITIONAL $7,500* ALLOWED FOR EMPLOYEES AGE 50 OR OLDER

Starting in 2025, there's a higher catch-up contribution limit for employees aged 60, 61, 62and 63 who participate in the plan. The higher catch-up contribution limit is $11,250.*

***PLEASE NOTE: THESE AMOUNTS MAY CHANGE FOR 2026**
Check with HR in January if these limits are important to your saving.

NEXT STEPS

- Use an enrollment/change form to set up your contribution
- Log into tiaa.org/washcoll to register as a new user or log into your account
- Review and update your investment elections and beneficiaries

WELLNESS & ADDITIONAL BENEFITS

Cigna Healthcare Wellness Experience

Cigna's new voluntary program is powered by Personify Health, formerly Virgin Pulse, the first and only personalized health platform company. Enroll from your myCigna.com account. Start a journey focused on getting active, eating healthy, sleeping well or finding emotional balance. Personalized fitness challenges, digital journeys and wellness tools, along with real time insights help drive healthy routines for lasting change.

Check out this video to preview your wellness experience.

WASHINGTON COLLEGE—JOHNSON FITNESS CENTER

The Fitness Center is available to employees, spouses/partners and children. Contact HR to register family members and obtain an ID for gym access at Public Safety. Fitness Center Hours:

Monday—Thursday, 6am—10pm; Friday, 6am—7pm; Saturday / Sunday, 10am—4pm

Prioritize your Wellbeing

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

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 per the policy criteria and guidelines. See the policies and forms on MyWashColl and contact HR with any questions.

IDENTITY THEFT ASSISTANCE

InfoArmor Identity Protection is provided through Reliance. InfoArmor provides powerful monitoring and security tools, plus full-service remediation and reimbursement. Services include Dark web monitoring, Lost wallet assistance and fraud-related loss reimbursement. Enroll in your benefit today by calling 1-855-246-7347, or visit www.reliancestandard.com/infoarmor.

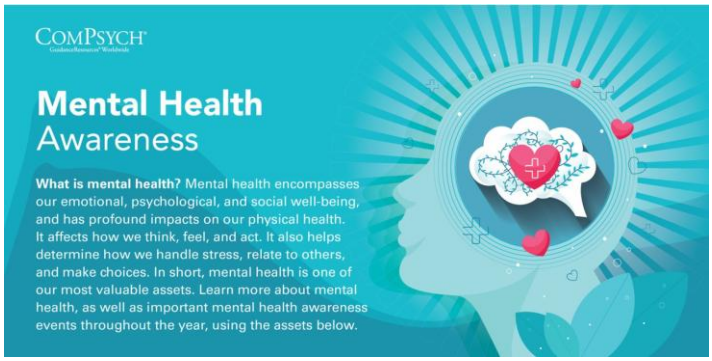
Cigna members can also register for free identity monitoring services. Visit myCigna.com for additional details.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

ComPsych ID: COM589

What Is An EAP?



DISCOUNTED MEALS

Employees can purchase breakfast, lunch and/or dinner at a discounted rate at Hodson Dining Hall. Current rates are: $5.25 for breakfast; $7 for lunch; $9 for dinner.

VIDEO RESOURCES

MEDICAL PLANS

- Traditional PPO vs. HDHP
- Options for Care
- Managing Prescription Drug Costs
- Preventative Care

INSURANCE 101

- Key Benefit Terms
- Understanding your EOB
- Navigating Medicare

TAX ADVANTAGE SAVINGS ACCOUNTS

- Health Savings Accounts
- Flexible Spending Account
- Dependent Care Account

ANCILLARY COVERAGES

- Dental Insurance
- Employee Assistance Program

WELLBEING

- Prioritize Your Wellbeing

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

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

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

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

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

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

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

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

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

MEDICAL TERMS

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

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

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

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

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

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Washington College About Your Prescription Drug Coverage and Medicare

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

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

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

2. Cigna has determined that the prescription drug coverage offered by the Washington College health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

IMPORTANT NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Washington College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 15, 2025
Name of Entity/Sender:	Washington College
Contact--Position/Office:	Human Resources
Address:	300 Washington Ave, Chestertown, MD 21620
Phone Number:	410-778-7260

IMPORTANT NOTICES

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

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

IMPORTANT NOTICES

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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA - Medicaid and CHIP (Hawki)	**KANSAS - Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: 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://kidshealth.ky.gov/Pages/index.aspx 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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

IMPORTANT NOTICES

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. 5218
NEW JERSEY - Medicaid and CHIP	**NEW YORK - 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: 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**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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

IMPORTANT NOTICES

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

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)

IMPORTANT NOTICES

INITIAL COBRA NOTICE

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

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

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

IMPORTANT NOTICES

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Washington College HR Department 410-778-7298

This notice is a summary. For a full description of all of Washington College's benefit plans, please refer to the Summary Plan Descriptions.

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

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

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

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

IMPORTANT NOTICES

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

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

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

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).

IMPORTANT NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

IMPORTANT NOTICES

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

IMPORTANT NOTICES

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Washington College		4. Employer Identification Number (EIN) 52-0591691	
5. Employer address 300 Washington Ave		6. Employer phone number 410-778-7260	
7. City Chestertown	8. State MD	9. ZIP code 21620	
10. Who can we contact about employee health coverage at this job? Washington College Benefit Manager			
11. Phone number (if different from above)	12. Email address HR@washcoll.edu		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Regular full-time employees scheduled to work thirty hours per week or more.
    Variable hour or part-time employees who qualify for coverage under ACA lookback rules (work on average of 30 hours per week in the measurement period).
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    spouse, domestic partner and children up to the age of 26.
    Contact Human Resources for additional information regarding domestic partners and possible eligibility for disabled children over the age of 26.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

IMPORTANT NOTICES

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☒ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Washington College

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.