Plan Year 2021-2022

OPEN ENROLLMENT BENEFIT GUIDE

Washington County
MARYLAND

Welcome to the 2021-2022 Benefits Plan Year!

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

Options selected during open enrollment remain in place for the full plan year.

YOUR BENEFITS CONTACT

Brittany Price, Benefits Coordinator
bprice@washco-md.net
(240) 313-2358

CONTACT INFORMATION

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

Medical
Aetna
www.aetna.com
(800) 547-5569

Prescription Drug
CVS Caremark
www.caremark.com
(855) 297-2177

Dental
Delta Dental
www.deltadentalins.com
(800) 932-0783

Vision
United Healthcare Vision
www.myuhcvision.com
(800) 672-7723

Basic Life and AD&D
Voya
Contact your Benefits Team

Long-Term Disability
Voya
Contact your Benefits Team

Flexible Spending Accounts (FSA)
CBIZ
https://myplans.cbiz.com
(800) 410-2249
Email: cbizflex@cbiz.com

Employee Assistance Program (EAP)
BHS (Business Health Services)
(800) 327-2251
Portal.BHSonline.com

TABLE OF CONTENTS

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

MEDICAL INSURANCE

1 HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

- ☐ **LOW OPTION (Aetna Select)**
- ☐ **HIGH OPTION (Open Choice)**

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

FREQUENTLY ASKED QUESTIONS

? Will I receive a new Medical ID card?

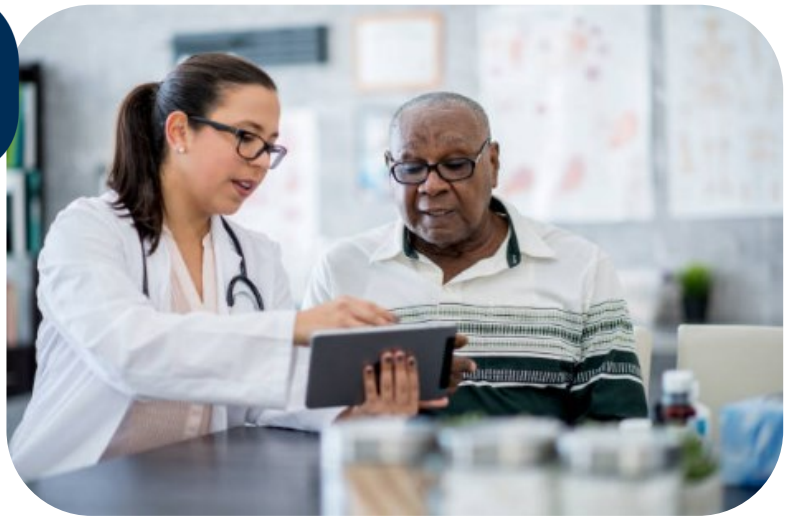
You will receive an ID Card in the mail if you are making changes to your medical coverage.

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

A policy-year basis: July 1, 2021 - June 30, 2022

? How long can I cover my dependent children?

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



YOUR HEALTH PLAN OPTIONS

As a full-time employee of Washington County Commissioners, you have the choice between two medical plan options: Low Option and High Option.

If a deductible applies to your plan, your deductible will run from July 1, 2021 – June 30, 2022.

These plans cover a broad range of healthcare services and supplies. Please refer to the following pages for specific details on the medical plans available to you and your family.

LOW OPTION HIGHLIGHTS:

- No deductible when using in-network providers
- Does not require referrals when seeking care from a specialist
- Does not provide out-of-network coverage.

HIGH OPTION HIGHLIGHTS:

- No deductible when using in-network providers
- Does not require referrals when seeking care from a specialist
- A POS plan with in-network and out-of-network coverage. A deductible applies when for out-of-network coverage.

Medical Insurance Plan Options and Costs

AETNA	Low Option	High Option
	Employee Cost Per Paycheck	Employee Cost Per Paycheck
Employee Employee & Spouse Employee & Child Employee & Family	$27.54 $53.98 $50.12 $77.66	$48.96 $95.96 $89.11 $138.07
	In-Network	In-Network
Deductible (calendar year) Individual / Family	$0/ $0	$0/ $0
Out-of-Pocket Maximum Individual / Family	$2,000 / $6,000	$2,000 / $6,000
Office Visit Primary Care Physician Specialist	100% after $30 copay 100% after $35 copay	100% after $35 copay 100% after $40 copay
Preventive Care	100% covered	100% covered
Lab and X-ray	100%	100%
Urgent Care	100% after $35 copay	100% after $35 copay
Emergency Care Hospital Ambulance transportation	$200 copay, waived if admitted 100%	$200 copay, waived if admitted 100%
Outpatient Surgery	100% after $35 copay	100% after $40 copay
Inpatient Hospital Services	100% after $100 copay	100% after $100 copay
	Out-of-Network	**Out-of-Network**
Deductible Individual / Family	N/A	$250/ $750
Out-of-Pocket Maximum Individual / Family	N/A	$3,000 / $9,000

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 31 days of the event.

Hearing Aid Coverage

Hearing Aids are covered at 100% for 1 pair, every 5 years

Follow this Process for Hearing Aid Coverage

Call Hearing Care Solutions (1-866-344-7756) or Amplifon (1-877-301-0840) when you are ready to start the process. You will only have coverage if you go through one of these two providers. Once you call, they will make an appointment for you with a local provider that participates in their network.

When you go to your appointment, the provider will give you a hearing test and provide recommendations on hearing aids following the hearing test.

Once you have made your choice, contact the provider to order the hearing aids. The provider can bill our insurance directly so you will not have to pay anything up front. If the provider tries to bill you for the hearing aids, please contact me at bprice@washco-md.net for assistance.

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. Be sure to check that the facility is in the Aetna network by calling the toll-free number on the back of your medical ID card, or by visiting https://www.aetna.com/.

PRIMARY CARE

- Routine, primary/ preventive care
- Non-urgent treatment
- Chronic Disease Management

TELEDOC

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus Problems

CONVENIENCE CARE

- Common infections (Ear infections, pink eye, strep throat & Bronchitis)
- Pregnancy tests
- Flu Shots
- Rashes
- Screenings
- Vaccines

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections
- Mild Asthma Attacks
- Back Pain or strains

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- 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 9-1-1

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.

TELEDOC

Teladoc lets you see and talk to a doctor from your mobile device or computer wherever you are. Teledoc's U.S. board-certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults. The cost to use this service is less than a PCP Copay.

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 Caremark, 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 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.

Primary Care vs. Urgent Care vs. ER

TELEDOC

TELADOC

If you enroll in either health plan, you can connect with a licensed physician via phone or video anytime, anywhere through Teladoc.

Teladoc's U.S. board certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults.

Conditions commonly treated through a virtual visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

Registering with Teladoc is quick and easy online. Visit the Teladoc website at Teladoc.com, click "Set up account" and provide the required information.

You may also call Teladoc for assistance over the phone at (800) Teladoc (835-2362).

Once your account is set up, you can call and request a consult any time you need care.

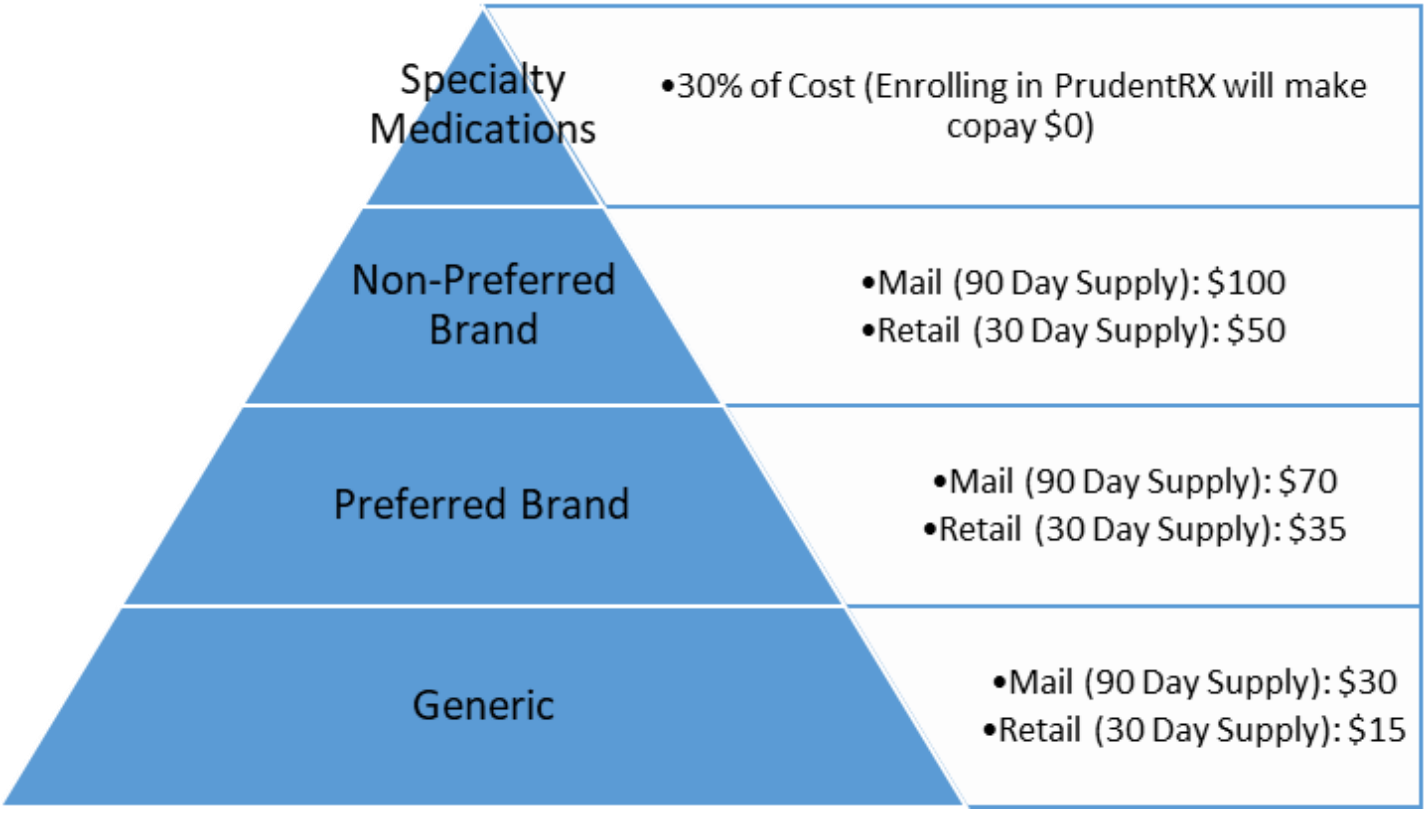
7 REASONS TO REGISTER WITH TELADOC

1. Teladoc provides confidential, convenient, and affordable healthcare 24/7/365.
2. You can speak with a licensed doctor about non-emergency health issues anywhere, whether you're at home, at work, or on vacation.
3. The average wait time to speak with a doctor is 10 minutes.
4. Teladoc doctors can diagnose and treat cold and flu symptoms, upper respiratory infections, ear infections, skin problems, allergy symptoms and more.
5. Teladoc doctors can also send a prescription straight to your pharmacy of choice when medically necessary.
6. You dependents are eligible to receive care from Teladoc, including adult children up to age 26.
7. You can connect with Teladoc by phone, web, or mobile app.

(800) Teladoc (835-2362) **www.teladoc.com**

PRESCRIPTION INSURANCE

PRESCRIPTION COVERAGE IS INCLUDED WITH YOUR MEDICAL PLAN ELECTIONS



- As of July 1, we will be going to a 4-tier copay structure for Prescription Coverage.
- The cost of specialty medications will be 30% of the cost of the drug.
- **If you enroll in PrudentRX, the cost for the employee will be $0. The only way that someone will have to pay 30% is if they elect not to enroll in PrudentRX.**
- Enrolling in PrudentRX will be a simple process. PrudentRX will contact you directly prior to July 1 if this affects you. You will only have to enroll if you currently are taking a specialty medication. This can also be done at the pharmacy in the future if you are prescribed a new specialty drug after July 1.

DENTAL INSURANCE

2 REVIEW YOUR DENTAL PLAN

FIND A DENTIST

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

DELTA DENTAL IS THE DENTAL CARRIER FOR THE 2021-2022 PLAN YEAR.

The dental plan is a PPO that offers coverage options for in and out-of-network. It's to your advantage to utilize a in-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?

Low Option Plan Design and Costs

Delta Dental	Employee Cost Per Pay Check	
Employee Employee & Spouse Employee & Child Employee & Family	$6.19 $11.83 $10.99 $17.02	
	PPO Dentist	**Non-PPO Dentist**
Deductible Individual / Family	$50 / $150	$50 / $150
Annual Maximum	**$1,000**	**$1,000**
Diagnostics/ preventive Services	Carrier pays 80%	Carrier pays 80%
Basic Services	80%	80%
Major Services	50%	50%

High Option Plan Design and Costs

Delta Dental	Employee Cost Per Pay Check	
Employee Employee & Spouse Employee & Child Employee & Family	$7.75 $15.48 $14.39 $22.28	
	In-Network	**Out-of-Network**
Deductible Individual / Family	$50 / $150	$100 / $300
Annual Maximum	**$1,000**	**$1,000**
Diagnostics/ preventive Services	Carrier pays 100% (no deductible)	Carrier pays 80%
Basic Services	90%	70%
Major Services	80%	60%

VISION INSURANCE

UnitedHealthcare®

3 REVIEW YOUR VISION PLAN

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

FIND A PROVIDER

To find an UHC Vision provider in your area, visit the website at www.myuhcvision.com

UHC VISION IS THE VISION CARRIER FOR THE 2021-2022 PLAN YEAR.

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

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers.

What is Vision Insurance?

Low Option Vision Insurance Plan Options and Costs

UHC	Employee Cost Per Pay Check	
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$2.58 $4.17 $4.37 $5.65	
	In-Network	**Out-of-Network**
Examination Copay	$0 copay	Reimbursement Up to $40
Frequency of Service Exam Lenses Frames Contact lenses in lieu of frames	Every 24 months Every 24 months Every 24 months Every 24 months	
Lenses Single Bifocal Trifocal Lenticular	 100% covered 100% covered 100% covered 100% covered	Reimbursement Up to $40 Up to $60 Up to $80 Up to $80
Frames	Covered up to $130 retail allowance	Reimbursement Up to $45
Necessary Contact Lenses in lieu of lenses/frame*	100% covered	Reimbursement Up to $210

High Option Vision Insurance Plan Options and Costs

UHC	Employee Cost Per Pay Check	
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$3.30 $5.23 $5.48 $8.20	
	In-Network	**Out-of-Network**
Examination Copay	$0 copay	Reimbursement Up to $40
Frequency of Service Exam Lenses Frames Contact lenses in lieu of frames	Every 12 months Every 12 months Every 12 months Every 12 months	
Lenses Single Bifocal Trifocal Lenticular	 100% covered 100% covered 100% covered 100% covered	Reimbursement Up to $40 Up to $60 Up to $80 Up to $80
Frames	Covered up to $130 retail allowance	Reimbursement Up to $45
Necessary Contact Lenses in lieu of lenses/frame*	100% covered	Reimbursement Up to $210

Selection Contact Lenses and Non-Selection Contact Lenses also available under the Plan.

FLEXIBLE SPENDING ACCOUNTS

4 SELECT FSA ACCOUNTS

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Flexible Spending Account**

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.

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)

Click here for the full list of Healthcare FSA Eligible Expenses

What is a Flexible Spending Account?

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 County Commissioners. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

DEPENDENT CARE FLEXIBLE SPENDING 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.

2021-2022 Maximum Contributions

Health Care Flexible Spending Account	$2,750 max
Dependent Care Expense Account	$5,000 max

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The BHS EAP is a free, confidential service provided to all Full-Time employees and their household dependents.

Through BHS, employees and household members receive assistance for a variety of mental health and other family issues such as financial, identity recovery assistance, daily living services and child and elder care. There is also a legal plan option that covers many routine legal issues.

This program offers a wide variety of counseling and assessments, referrals, prevention services, education resources, and consultation services which are all designed to assist you and your family.

Common Reasons to Call Your EAP			
Relationships	**Transitions**	**Risks**	**Challenges**
Boss/Coworkers	Birth/Death	Burnout/Anger	Daily Responsibilities
Customers	Health/Illness	Depression/ Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal Thoughts	Parenting
Spouse/Kids	Promotion/ Retirement	Substance Abuse	Stress/Conflict

LIFE INSURANCE & AD&D

Life Insurance

- Provided through VOYA
- 100% employer funded
- Coverage is 1X annual salary rounded to next thousand (Maximum of $100,000)
- Increases/decreases with salary

AD&D Policy

- Provided through VOYA
- 100% employer funded
- Coverage is 2X annual salary rounded to next thousand (Maximum of $60,000)
- Increases/decreases with salary

Dependent Life Insurance

- Provided through VOYA
- 100% employer funded
- Coverage is $2000 for an eligible spouse
- Coverage is $1000 for eligible children

SHORT-TERM DISABILITY

Short Term Disability

- 100% employer funded
- For all injuries or illnesses that are not work related
- Mandatory 15-day waiting period from your first day off work
- Must use all sick leave before using short-term disability benefits
- Coverage is 70% of your pay with a maximum of $1600 biweekly for up to 13 weeks
- Benefits, taxes, and other deductions will be taken out of that 70% that you are eligible to receive.
- If you think Short-Term Disability benefits may be needed, contact the Deputy Director of Human Resources or the Benefits Coordinator.

LONG TERM DISABILITY

Long Term Disability

- **Provided through VOYA**
- **Base Plan is 100% employer funded**
- **Base Plan is up to 40% of your salary**

BENEFIT CREDITS

Benefit Credits

- **If you do not take any of our benefits or not covering someone that is eligible under our plan, you could be eligible for Benefit Credits.**
- **Benefit Credit information will be provided within the Open Enrollment email along with the required form.**
- **Eligibility will depend on if you meet all the qualifications under the Policy.**
- **Dropping 1 Tier**
  - **Option of $700 or 3 Additional Vacation Days**
  - **Example: Eligible for Employee & Spouse Coverage but only cover yourself at Employee Only Level (Spouse has insurance at his/her employer)**
- **Dropping 2 Tiers**
  - **Option of $1000 or 5 Additional Vacation Days**
  - **Example: Eligible for Employee & Spouse Coverage but are waiving all coverage options (Spouse covers both of you at his/her employer)**

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Aetna 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 County Commissioners 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:

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.

Aetna has determined that the prescription drug coverage offered by the Washington County Commissioners 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 Aetna 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 Aetna 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 County Commissioners 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 Aetna changes. You also may request a copy of this notice at any time.

Contact: Brittany Price 240-313-2358

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 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 socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	July 1, 2021
Name of Entity/Sender:	Washington County Commissioners
Contact--Position/Office:	Brittany Price, Benefits Coordinator
Address:	100 West Washington Street, Hagerstown, MD 21740
Phone Number:	240-313-2358

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 premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit 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 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 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 January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health- insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://medicaid.georgia.gov/third-party-liability/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

IMPORTANT NOTICES

KANSAS – Medicaid	MONTANA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications- forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852- 3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON-Medicaid**
Website: https://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA -Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311(Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, 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

IMPORTANT NOTICES

FAMILY AND MEDICAL LEAVE ACT (FMLA)

ELIGIBLITY

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50employees within 75 miles of the employee's worksite.

WHAT CAN FMLA BE TAKEN FOR?

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.
- An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.
- An employee does not need to use leave in one block. When itis medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.
- Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

This notice is intended as a brief outline; please HR for more information

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your Plan Administrator 240-313-2358.

IMPORTANT NOTICES

MARKETPLACE COVERAGE OPTIONS

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Washington County Commissioners' HR department.

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

MARKETPLACE COVERAGE OPTIONS CONTINUED

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.

Employer Name: Board of Washington County Commissioners	**Employer Identification Number (EIN):** 52-6001037
Employer Address: 100 West Washington Street, Hagerstown, MD 21740	**Employer Phone Number:** 240-313-2350
Who can we contact about employee health coverage at this job? Brittany Price	**Phone Number:** 240-313-2358 **Email Address:** bprice@washco-md.net

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:

  ☑ Full time employees, working a minimum 30 hours per week on a regular basis. Employees will be effective the 1st day of the month, following date of hire or date of hire if hired on the 1st of the month.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Spouse and children to age 26, regardless of student status

  ☐ 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. Above is 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.

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.