2024-2025

HOOD COLLEGE

EMPLOYEE BENEFITS GUIDE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 24-25 for more details.

CONTACT INFORMATION

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

Medical - Group# 76-411748
UMR
www.umr.com
(800) 826-9781

Prescription Drug—Account# HOODCOLLEGE
Rx Benefits/Optum Rx
www.optumrx.com/mycataramanrx
(800) 334-8134

Health Savings Account—Employer ID# 76411748
Optum Bank
www.optumbank.com
(800) 243-5543

Dental – Policy# 00921323
UHC Dental
www.uhcdental.com
(877) 816-3596

Vision – Policy# 00921323
UHC Vision
www.myuhcvision.com
(800) 638-3120

Basic Life and AD&D, Supplemental Life - Policy# GL164190
Reliance Standard
www.reliancestandard.com
(800) 345-3544

Long-Term Disability - Policy#LTD132959
Reliance Standard
www.reliancestandard.com
(800) 345-3544

Flexible Spending Accounts (FSA)
Plan # 7670--411748
UMR
www.umr.com
(800) 826-9781

Employee Assistance Program (EAP)
BHS
www.bhsonline.com
(800) 327-2251
Portal.BHSonline.com Username: HOOD

ShieldAtWork
Legal Services/ID Theft
shieldatwork.com
(800) 654-7757

HealthAdvocate
(866) 395-8622
members.healthadvocate.com/ha/#

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.

Your Benefits Team
Hood College
Amanda Harris (301) 696-3590
aharris@hood.edu

Take control of your benefits by having them right by your side. Download the apps today.

App Store Google Play

UMR Medical & HSA

- Find in-network providers
- View your ID card
- Track your deductible and copays
- View claims
- HSA account integration
- Complete your CHRA for Wellness rewards

OptumRx: Manage your Prescriptions

- Real-time benefit and drug coverage information
- Drug pricing for home delivery and retail pharmacies
- Refill reminders

App Store Google Play

TeleDoc—Physical & Behavioral Health

App Store Google Play

- 24/7 appointments in lieu of Urgent Care
- Talk to licensed therapists for your mental health needs

Flexible Spending Account

- Check your balance
- Reimburse yourself
- Submit claims

Consumer Accounts with UMR

App Store

Google Play

TIAA Retirement Plan

App Store

Google Play

- Monitor account activity
- Track fund performance

BHS Employee Assistance Program

- Confidential, in-moment support
- Various tools to aide in work -life balance

App Store

Google Play

Medicare Resources

SHIP

- Find a local Medicare counselor
- Services are free and confidential

MEDICAL INSURANCE

HOW TO GET STARTED

1 **SELECT YOUR MEDICAL PLAN**

- ☐ **OPTION 1: POS**
- ☐ **OPTION 2: EPO**
- ☐ **OPTION 3: QHDHP/HSA**

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 regular full-time equivalent (FTE) employee working at least 18.75 hours per week (.5 or greater FTE) to be eligible for benefits.

Will I receive a new Medical ID card?

You will receive an ID card in the mail if you are newly electing medical coverage, or if you made election changes

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

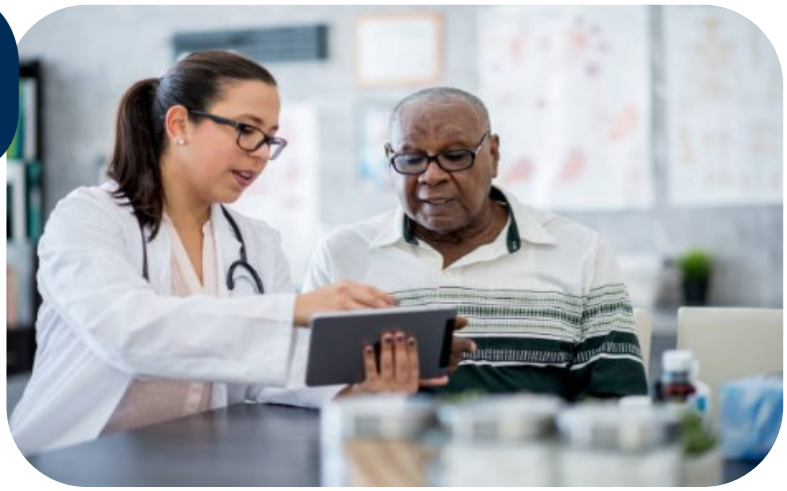
A policy-year basis: July 1 - June 30.

How long can I cover my dependent children?

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

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

Your medical insurance benefit will begin on the 1st day of the month following date of hire or date of hire if hired on the first of the month.



YOUR HEALTH PLAN OPTIONS

As an eligible .5 or greater FTE employee of Hood College, you have the choice between three medical plan options: POS, EPO and QHDHP/HSA.

For each, your deductible will run from July 1 – June 30.

Two of the plans give you the option of using out-of-network providers, you can save money by using in-network providers because UMR/UHC 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 UMR's UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

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

POS AND EPO PLAN HIGHLIGHTS:

- Lower deductibles when using in-network providers
- Do not require referrals when seeking care from a specialist

QHDHP/HSA HIGHLIGHTS:

- A POS plan with in- and out-of-network coverage
- Do not require referrals when seeking care from a specialist
- When enrolling in this plan, you will be able to establish a Heath Savings Account
- More information contained herein

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 UHC Choice Plus network by calling the toll-free number on the back of your medical ID card, or by visiting www.umr.com. You can also call the UMR Nurse Line at (877) 950-5083.

PRIMARY CARE

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

TELEHEALTH

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

CONVENIENCE CARE

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

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.

TELEHEALTH $$

Retail Telehealth, or a "virtual visit", lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! UMR partners with Teladoc to bring you care from the comfort and convenience of your home or wherever you are.

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.

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

TELEHEALTH

TELADOC

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. General medicine, Dermatology and Behavioral Health are a few of the services.

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

If you are enrolled in the HDHP/HSA, your cost will be associated with the applicable service that you are selecting. If you are enrolled in the EPO or POS there will be no cost to you for these services.

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. Your 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.

Sign up now to be ready to use Teladoc.

For EPO and POS plans, Teladoc is free.

For HDHP, Teladoc is free after deductible is met. Prior to deductible being met, the following fees per Teladoc service apply: up to $54 for general medical, up to $95 for mental health, up to $235 for psychiatry, and up to $85 for dermatology.

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

YOUR MEDICAL INSURANCE PLAN OPTIONS AND COSTS

Medical Insurance Plan Options and Costs

UMR/Rx Benefits Optum Rx	POS Plan Employee Cost Per 26 Paychecks	EPO Plan Employee Cost Per 26 Paychecks	HDHP/HSA Plan Employee Cost Per 26 Paychecks
Wellness Rates*			
Employee	$264.66	$74.95	$29.47
Employee & Spouse	$534.45	$227.66	$150.89
Employee & Child(ren)	$430.64	$183.43	$121.57
Family	$600.17	$267.64	$172.12
2024-2025 Rates			
Employee	$273.89	$84.18	$38.70
Employee & Spouse	$543.68	$236.89	$160.12
Employee & Child(ren)	$439.87	$192.66	$130.81
Family	$609.40	$276.87	$181.35
	In-Network	**In-Network**	**In-Network**
Deductible (calendar year) Individual / Individual +1/ Family	$100 / $300 / $600	$750 / $1,500 / $2,000	$2,500 / $3,750 / $5,000
Out-of-Pocket Maximum** Individual / Ind + 1 / Family	$2,000 / $4,000 / $6,000	$2,500 / $5,000 / $7,500	$4,000 / $6,000 / $8,000
Office Visit Primary Care Physician Specialist	$30 copay $45 copay	$30 copay after deductible $40 copay after deductible	100% after deductible
Preventive Care	100% covered; deductible waived	100% covered; deductible waived	100% covered; deductible waived
Lab and X-ray / Imaging	100% covered	100% covered after deductible	100% covered after deductible
Urgent Care	$50 copay	$40 copay	100% after deductible
Emergency Care Hospital	$350 copay, waived if admitted	$150 copay after deductible, waived if admitted	100% after deductible
Outpatient Hospital	$300 copay	90% after deductible	100% after deductible
Inpatient Hospital Services	90% after deductible	75% after deductible	100% after deductible
Prescription Drug Retail *(30-day supply)* Mail Order *(90-day supply)* *Copays apply toward out-of-pocket maximum*	$20 / $50 / $75 / 50% max $100 $40 / $100 / $150	$20 / $50 / $75 / 50% max $100 $40 / $100 / $150	After deductible, $15 / $35 / $60 / 50% max $100 $30 / $70 / $120
	Out-of-Network	**Out-of-Network**	**Out-of-Network**
Deductible Individual / Individual +1 / Family	$500 / $1,000 / $1,500	N/A	$3,500 / $5.250 / $7,000
Out-of-Pocket Maximum** Individual / Ind +1 / Family	$4,000 / $6,000 / $8,000	N/A	$5,000 / $$7,500 / $10,000

***Eligibility for Wellness Rates is contingent on completion of the Clinical Health Risk Assessment in UMR and one preventive exam/ screening by April 30,2024.**

**Out-of-Pocket maxes are integrated for medical and Rx.

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

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

HEALTHADVOCATE

Navigating healthcare takes a human touch, data-driven health insights, and technology that engages. HealthAdvocate has been helping Americans navigate the complexity of the healthcare system for over 19 years. We offer a full range of clinical and administrative services as well as behavioral health and wellness programs supported by medical claims data science and a technology platform that uses machine learning to drive people to engage in their health and well-being.

HEALTH SAVINGS ACCOUNT (HSA)

Two ways you can put money into your HSA: (1) Regular payroll deductions on a pre-tax basis and (2) lump-sum contributions of any amount, anytime, up to the maximum limit.

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

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

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Contribute up to **$4,150** Single, or **$8,300** Family

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 qualified tax dependents for their eligible tax expenses—even if they're not covered by your medical plan.

What is a Health Savings Account?

OPTUM Bank® Member FDIC

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 contribution limit. Contributions are based on a calendar year. The contribution limits for 2024 are $4,150 for Single and $8,300 for Family coverage. If you're age 55 or older, you are allowed to make extra contributions each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- 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.

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

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

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

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

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

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

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

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

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 UMR. You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from UMR 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 www.umr.com.

FLEXIBLE SPENDING ACCOUNTS

SELECT FSA ACCOUNTS

2

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Flexible Spending Account**
- ☐ **Limited Purpose 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. A **limited purpose FSA** is a healthcare spending account that can only be used for eligible vision and dental expenses. Unlike a healthcare **FSA**, however, an LPFSA can be held at the same time as a Health Savings Account (HSA).

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

Click here for the full list of Healthcare FSA Eligible Expenses

What is a Flexible Spending Account?

2024 Maximum Contributions

Health Care Flexible Spending Account	$3,200 max
Dependent Care Expense Account	$5,000 max

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 Hood College. 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.

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

UHC DENTAL IS THE DENTAL CARRIER FOR 2024-2025.

The dental plan is a PPO that offers 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 UHC'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.

What is Dental Insurance?

FIND A DENTIST

To find a dental provider in your area, visit the website at: www.uhcdental.com

Network: National Options PPO 30

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

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

Dental Insurance Plan Options and Costs

UHC Dental Plan	High Plan		Low Plan	
	Employee Cost Per 26 Paychecks		Employee Cost Per 26 Paychecks	
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$22.85 $40.41 $27.87 $53.60		$19.00 $30.36 $21.42 $36.23	
PPO	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual / Family	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,000	$1,000	$1,000
Diagnostics/Preventive Services	Carrier pays 100% (no deductible)	Carrier pays 100% (no deductible)	Carrier pays 80%	Carrier Pays 80%
Basic Services	80%	80%	50%	50%
Major Services	50%	50%	50%	50%
Ortho Maximum	$1,000	$1,000	Not covered	Not covered

VISION INSURANCE

4 REVIEW YOUR VISION PLAN

UHC VISION IS THE VISION CARRIER FOR 2024-2025

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.

FIND A PROVIDER

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

Network: UHC Vision

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

What is Vision Insurance?

Vision Insurance Plan Options and Costs

UHC Vision Plan	Employee Cost Per 26 Paychecks	
Employee Employee & One Employee & Family	$3.28 $5.86 $8.00	
	In-Network	**Out-of-Network**
Examination Copay	100% covered	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	Up to $150	Reimbursement Up to $45
Contact Lenses in lieu of lenses/frame*	Covered up to $150 retail allowance	Reimbursement $150
Medically Necessary Contacts	100% covered	Reimbursement Up to $210

LIFE INSURANCE AND AD&D

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

5

REVIEW YOUR LIFE AND DISABILITY POLICIES

- ☐ **Basic Life and AD&D**
- ☐ **Voluntary Life**
- ☐ **Long-Term Disability**
- ☐ **Short-Term Disability**

BASIC LIFE AND AD&D

Hood College provides 1x your annual earnings to a maximum of $125,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

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

DID YOU KNOW? Hood College provides you Basic Life and AD&D AT NO COST TO YOU.

VOLUNTARY LIFE

ELIGIBILITY
Employees: You are eligible when actively-at-work on a full-time basis as defined by your employer, except if you are working on a temporary or seasonal basis.

Dependents: You must be insured for your Dependents to be covered.
Dependents are:

- Your legal spouse who is not legally separated or divorced from you
- Your unmarried financially dependent children* age 14 days to 21 years (to 26 years if full-time student).

*Natural and adopted children; stepchildren and foster children in your custody.

Supplemental Life:
Choose from a minimum of $10,000 to a maximum of $500,000 in $10,000 increments.

Dependent Life:
Spouse: Choose from a minimum of $5,000, a maximum of $500,000 in $5,000 increments

Dependent Child(ren):
14 days to age 21 years: $2,000 to $10,000 increments of $2,000 (up to age 26 if a full-time student)

GUARANTEED ISSUE
(Initial eligibility period only: When you are first eligible and there are no medical questions)

Employee:
Guarantee Issue: $150,000

Employee can elect up to $50,000 not to exceed EOI.
If you're already enrolled for an amount at GI or higher, the $50k is not relevant. You will need an EOI regardless.

If you're enrolled for $120k already, then, the "free/non-EOI" enrollment of an additional $30k without needing an EOI would be allowed.

Spouse:
Guarantee Issue: $30,000

The same rules for the employee above apply, except you will only be allowed a $10k increase without EOI up to $30k GI.

Child:
All child amounts are guaranteed issue.

Link to EOI: DocuSign

What is Life and AD&D Insurance?

LONG-TERM DISABILITY

What is Disability Insurance?

Long-Term Disability insurance is offered through Reliance Standard and is provided at no cost to you. The plan benefit is 66.6667% of basic monthly earnings up to a maximum of $8,000 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and excludes commissions, bonuses, overtime pay, shift differential pay, or any other earnings.

There is a 150 day elimination period.

This coverage is offered through Reliance Standard.

CONTRIBUTION REQUIREMENTS
Coverage is employer paid.

VOLUNTARY SHORT-TERM DISABILITY Policy#VPS328902

COVERAGE
Disability income protection insurance provides a benefit for short term disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY
Employees with a .5 or greater FTE

BENEFIT AMOUNT
You may elect a weekly benefit equal to 60% of your covered earnings, from a minimum of $50 up to a maximum benefit of $1,500 per week.

DAY BENEFITS BEGIN
Injury (accident) and Sickness (illness): benefits begin on 15th consecutive day of disability.

MAXIMUM BENEFIT DURATION
Benefits for one period of disability will be paid up to a maximum of 20 weeks.

CONTRIBUTION REQUIREMENTS
Coverage is employee paid.

LIMITATIONS
Pre-Existing Condition Limitation

Link to EOI: DocuSign

Example STD Benefits and Costs

Age	Salary	Rate	Weekly Benefit	Per Pay Deduction
18-34	40,000	$0.650	$461.54	$13.85
35-49	50,000	$0.500	$576.92	$13.31
35-49	60,000	$0.500	$692.31	$15.98
50-54	70,000	$0.620	$807.69	$23.11
55-64	80,000	$0.800	$923.08	$34.08

VOLUNTARY COVERAGES

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

6 REVIEW YOUR VOLUNTARY COVERAGES

- ☐ Critical Illness Insurance
- ☐ Accident Insurance

What is Critical Illness Insurance?

CRITICAL ILLNESS INSURANCE

COVERAGE
Voluntary critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductible and prescriptions to transportation and child care.

ELIGIBILITY
Employees: All eligible employees.
Dependents: You must be insured in order for Dependents to be covered.

Dependents are:
- Your legal spouse or your Spouse must be under age 70 at date of application. Coverage terminates at age 75.
- Your dependent children from birth to 26 years.

BENEFIT AMOUNT
Employee: Choose from a benefit of $5,000 to a maximum of $20,000 in $5,000 increments.
Spouse: Choose from a benefit of $5,000 to a maximum of $20,000 in $5,000 increments, not to exceed 100% of approved employee amount.
Dependent child(ren): 25% of approved employee amount up to a maximum of $5,000.

GUARANTEED ISSUE:
Employee: $20,000
Spouse: $20,000
Child: All child amounts are guaranteed issue

CONTRIBUTION REQUIREMENTS
100% employee paid

FEATURES
Coverages for health include carcinoma in situ, heart attack, life threatening cancer and stroke.

Wellness (Health Screening) Benefit of $50.

PRE-EXISTING CONDITION LIMITATION
A pre-existing condition is an sickness or injury experienced before enrollment in a health insurance plan.

Benefits would not be payable to a pre-existing condition unless the Critical Illness is diagnosed after the coverage period (12 months) from the insured's effective date of coverage.

Link to EOI: DocuSign

Employee Bi-Weekly Premiums

Benefit Amount	Age 0-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75-79	Age 80-84	Age 85+
$5,000	$0.55	$0.90	$1.08	$1.57	$2.40	$3.53	$4.75	$6.53	$9.42	$14.19	$23.24	$29.10	$44.91
$10,000	$1.11	$1.80	$2.17	$3.14	$4.80	$7.06	$9.51	$13.06	$18.83	$28.38	$46.48	$58.20	$89.82
$15,000	$1.66	$2.70	$3.25	$4.71	$7.20	$10.59	$14.26	$19.59	$28.25	$42.58	$69.72	$87.30	$134.72
$20,000	$2.22	$3.60	$4.34	$6.28	$9.60	$14.12	$19.02	$26.12	$37.66	$56.77	$92.95	$116.40	$179.63

ACCIDENT INSURANCE

COVERAGE

Voluntary accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment (if included). These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare.

ELIGIBILITY

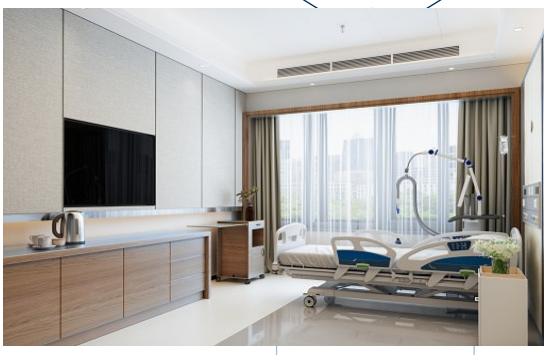
Employees: All eligible employees.
Dependents: You must be insured in order for Dependents to be covered.

Dependents are:

- Your legal spouse or your domestic partner. Spouse must be under age 70 at date of application.
- Your dependent children from birth to 26 years.

CONTRIBUTION REQUIREMENTS

100% employee paid



BI-WEEKLY PREMIUM

Coverage	Plan A	Plan B
Employee	$4.93	$7.24
Employee & Spouse	$7.92	$11.59
Employee & Children	$9.62	$13.99
Employee & Family	$12.77	$18.56

BENEFITS

Benefits	Plan A	Plan B
Emergency Treatment	$150	$225
Fractures	To $2,500 for Non-Surgical To $5,000 for Surgical repair	To $3,750 for Non-Surgical To $7,500 for Surgical repair
Physician Visit	$50 Initial; $50 Follow-up	$75 Initial; $75 Follow-up

Wellness (Health Screening) Benefit	Plan A	Plan B
Wellness (Health Screening) ***(This benefit gets paid by just submitting proof of health screening)***	$50	$75

[What Is Accident Insurance?]

RETIREMENT

7 OUR 403 (B) IS MANAGED BY TIAA

The contributions to the 403(b) plan are deducted pre-tax from your paycheck. You can contribute up to the IRS limit of your eligible pay,

Hood College provides a 1.5% Non-Elective Contribution for all eligible employees and matches up to an additional 3.5% per the example below

Employee	College
0%	1.5%
1%	1.5%
2%	2%
3%	3%
4%	4%
5%	5%
Greater than 5%	5%

Both the Retirement Annuity Program (RA) and Group Supplemental Retirement Annuity (GSRA) allow for Traditional pre-tax or Roth after-tax contributions.

TIAA Retirement Annuity Program (RA):

- Half-time or greater FTE employees are eligible to enroll
- Eligible participating employees can contribute a percentage of their salaries (up to IRS limits)
  - Up to $23,000 for 2024
  - Additional $7,000 if over age 50
- Hood contributes a matching percentage, up to 5%

Group Supplement Retirement Annuity (GSRA)

- Open to FTE, <.5 FTE or Adjunct employees
- Allows for pre-tax contributions, but does not have a Hood College contribution

OTHER BENEFITS

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The BHS EAP offers a free, confidential service provided to covered employees and their dependents. BHS provides assistance to employees and household members for a variety of mental health and other family issues such as financial, identity recovery assistance, daily living services and child and elder care.

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

EDUCATIONAL BENEFITS

Hood College offers a tuition remission benefit, available for coursework at Hood College, for employees and eligible dependents. Please see the staff manual for policy details and program rules.

For Tuition Remission at Hood College, the application for educational benefits must be submitted each semester for which the benefit is requested for an eligible employee, spouse or dependent. Failure to complete and return this form to HR prior to the start of each semester will result in the enrolled individual receiving a tuition bill and/or incurring late fee charges from Hood College.

Hood College participates in the Tuition Exchange program, a third-party entity not affiliated with Hood College. This is not an employee benefit, but it gives eligible dependents of qualifying Hood employees the ability to apply for a competitive Tuition Exchange Scholarship at a participating member institution. Scholarship eligibility and award are determined by the rules established by The Tuition Exchange.

Please visit https://www.tuitionexchange.org/ for more information.

LEGAL ASSISTANCE

ShieldAtWork has a network of dedicated law firms in 50 states. Our 39 provider law firms provide legal protection to more than 1.75 million families any time they need it, even in covered emergency situations, 24/7, 365 days a year. ShieldAtWork lawyers have an average of 22 years' experience in numerous areas. Employees are covered for a wide range of personal legal matters. And with no out-of-pocket costs, no claim forms, no usage limits, and a money-back guarantee, they can feel confident they're better prepared for life's challenges, whether expected or unplanned.

IDENTITY THEFT

Identity Consultation Services Members have unlimited access to identity consultation services provided by Kroll's Licensed Private Investigators. The Investigator will advise members on best practices for identity management tailored to the member's specific situation and should there be an identity theft event, the investigator will recommend that a case be opened for restoration. Members have access to member support agents and 24/7/365 for emergency situations. Kroll's Licensed Investigators will be available to answer questions regarding ID Theft and Fraud issues from 7am to 7pm central time, Monday through Friday excluding major holidays.

Legal and IDShield	Per Pay
IDShield - Employee Only	$4.13
IDShield - Family	$8.75
Legal Only - Family	$8.75
IDShield - EE Only + Legal EE Only or Family	$12.88
IDShield + Legal - Family for both	$15.65

RESOURCE LIBRARY

CLICK THE LINKS TO LEARN MORE!

MEDICAL PLANS

- Primary Care vs. Urgent Care vs. ER
- POS Point of Service
- PPO Overview
- HDHP vs. PPO
- HDHP with HSA Overview

INSURANCE 101

- Benefits Key terms Explained
- How to read an EOB
- What is a qualifying event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What is a Health Savings Account?
- What is a Flexible Spending Account?

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Vision Insurance?
- What is Life and AD&D Insurance?
- What is Disability Insurance?
- What is Critical Illness Insurance?
- What Is Accident Insurance?

GLOSSARY OF MEDICAL 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 to any preventive services.

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 the Affordable Care Act.

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

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

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.

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-pocket maximum.

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 authorization, prior approval or precertification.

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.

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

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.

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.

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Hood 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 Hood 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. Hood College has determined that the prescription drug coverage offered by the UMR 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 Hood 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 Hood College medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

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

You should also know that if you drop or lose your current coverage with Hood 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 Hood 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:	July 1, 2024
Name of Entity/Sender:	Hood College
Contact--Position/Office:	Amanda Harris, Benefits Manager
Address:	401 Rosemont Ave., Frederick, MD 21701
Phone Number:	(301) 696-3590

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. If you would like more information on WHCRA benefits, call your Plan Administrator (301) 696-3556.

INITIAL COBRA NOTICE *[FOR NEW HIRES OR NEW BENEFITS ELIGIBLE ONLY]*

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: Amanda Harris at aharris@hood.edu or (301) 696-3590.

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.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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 **www.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 https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Amanda Harris, (301) 696-3590

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

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% 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.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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.

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: Hood College	**4. Employer Identification Number (EIN):** Inquire at Human Resources if needed
5. Employer Address: 401 Rosemont Avenue	**6. Employer Phone Number:** 301-696-3590
7. City: Frederick	**8. State:** MD **9. ZIP Code:** 21701
10. Who can we contact about employee health coverage at this job? Amanda Harris	
11. Phone number (if different from above):	**12: Email address:** aharris@hood.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: .05 or greater Full time employees, working a minimum 18.75 hours per week on a regular basis. Employees will be effective the first day of the month following date of hire or date of hire if hired on the first 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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 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

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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website:https://mn.gov/dhs/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

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 and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.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

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 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)

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.