FY27 BENEFITS GUIDE

July 1, 2026 – June 30, 2027



Washington County Public Schools

WCPS | BENEFITS

If you 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.
Refer to your legal notices packet for more details.

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OVERVIEW

Washington County Public Schools understands that your benefits are important to you and your family. Included in this guide are summary explanations of the benefits, as well as contact information for each provider. It is important to remember that only those benefit programs for which you are eligible, and have enrolled in, apply to you.

We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, preauthorization requirements, participating networks, and services that may be limited or not covered (exclusions).

This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans, but rather a quick reference to help answer most of your questions. Please see the carrier benefit summaries for more details. We hope this guide will give you an overview of your benefits and help you be better prepared for the enrollment process.

EMPLOYEE ELIGIBILITY

Eligible employees are provided an opportunity to participate in the employer sponsored benefits program the first of the month following the date of employment and annually during Open Enrollment. This eligibility applies to permanent employees working 15 hours or more per week or if you are a permanent employee on an approved Leave of Absence. Please refer to the following guidelines regarding eligibility and election changes.

DEPENDENT ELIGIBILITY - MEDICAL, DENTAL, & VISION

A dependent is defined as a covered employee's legal spouse and a dependent child of the employee or employee's spouse. Dependent children may be covered through the end of the month in which they turn age 26. A dependent child is defined as:

- A biological child
- A step-child
- A legally adopted child
- A child placed for adoption / foster care
- A child for whom legal guardianship has been awarded to the covered employee or the employee's spouse
- Children of any age who become mentally or physically disabled before reaching the age limit

DEPENDENT PROOF

If you choose to cover dependents, you must provide proof of relationship within 31 days of the effective date. Documents include; a copy of a marriage certificate, birth certificate, adoption paperwork, court decree of legal guardianship/custody, QMSCO, Social Security documentation, Medicare or a physician disability verification, etc.

Covering ineligible dependents is a violation of the Internal Revenue Code, as well as WCPS eligibility requirements. If you find that you are currently covering an ineligible dependent under a WCPS benefit plan, please notify the Human Resources Benefits team immediately at 301.766.2810 or email the office at **benefits@wcps.k12.md.us.**

CHANGES

Compliance with Section 125 of the IRS code requires WCPS to follow specific rules regarding timeframes for changes in enrollment.

- **Annual Open Enrollment —** Annual Open Enrollment gives you the opportunity to review available benefit plan options and make any changes for the following plan year. Changes can be made to medical/prescription, dental, and vision. Any change you make stay in place for the entire plan year if you pay premiums and remain eligible.

- **Anytime:** Changes can be made to your 403(b) and 457(b) plans anytime through the year. You can also change your supplemental life insurance, voluntary AD&D insurance and long-term disability. If electing life insurance, AD&D or long term disability outside of your initial eligibility period, you may be subject to an Evidence of Insurability form for coverage approval.

QUALIFYING EVENTS

Coverage elections made at Open Enrollment cannot be changed until the next annual Open Enrollment period. The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Event." A Qualifying Event allows you to make a change to your benefit elections within 31 days of the event.

Examples of Qualifying Events include, but are not limited to:

- Marriage
- Divorce
- Birth, adoption, or legal custody of a dependent child
- Loss or gain of other group insurance
- Death

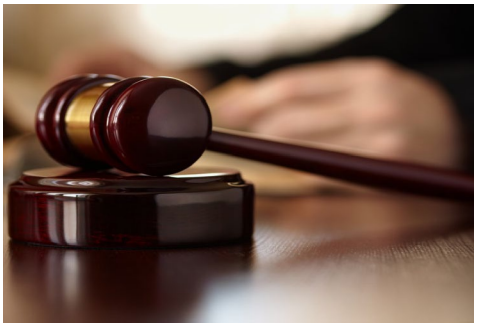
If you experience a Qualifying Event, contact your Human Resources Benefits team and submit all required documents within 31 days of the event.

MEMBER RESPONSIBILITY

Before you enroll, make sure you understand the plans and ask questions. After you enroll, you should always check your first paycheck stub to make sure that the correct amount is being deducted and all of the benefits you elected are included.

Any corrections must be made within the first 31 days of enrollment. You should also verify that all beneficiary information is up to date.







OVERVIEW

SPECIAL ENROLLMENT

The group health plan offers additional special enrollment opportunities, which are:

- You or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility.
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

EMPLOYEE BENEFIT COST

Costs of the offered benefits are shown on the Full-Time and Part-Time Employee Rate sheets. Costs are determined on an annual and fiscal year basis. Employee contributions for certain benefits can vary by bargaining unit, so please refer to your negotiated agreement for details.

WHAT HAPPENS TO MY BENEFITS IF I NEED TO BE OFF WORK FOR AN EXTENDED PERIOD OF TIME?

Sometimes events in our life prevent us from being on the job for periods of time. This can impact our pay and your benefits. If you need to be off from work for more than five days and it's not for vacation leave, then you should contact the Human Resources Benefits team immediately for guidance. Each employee's situation can be different based on the reason for leave, Family and Medical Leave (FMLA) eligibility, and the benefits in which you are enrolled. While it is recognized that advanced notice is not always possible, contacting the Human Resources Benefits team as soon as you become aware of the possibility of an absence will be beneficial to you so you can prepare accordingly.

MEDICAL

Cigna is our exclusive medical healthcare provider. You have the choice of two medical plans, allowing you to choose the benefit plan that best meets your benefit and budgetary needs.

These plans do not require a referral to seek care from a specialist. You may seek care directly from any contracted Cigna physician. Before scheduling an appointment with a physician, you should confirm their current participation status with the Cigna network.

You can locate a physician by contacting Member Services or go to Cigna website at www.myCigna.com.

PLAN YEAR DEDUCTIBLE:

The Plan Year Deductible is a specified dollar amount that you must pay for certain covered services per plan year. There are individual and family deductibles. Once an individual or a family deductible has been satisfied, then coinsurance applies, if applicable. Coinsurance is your share of the costs of a health care service. It is the amount a member pays after the deductible has been met.

PLAN YEAR OUT-OF-POCKET MAXIMUM:

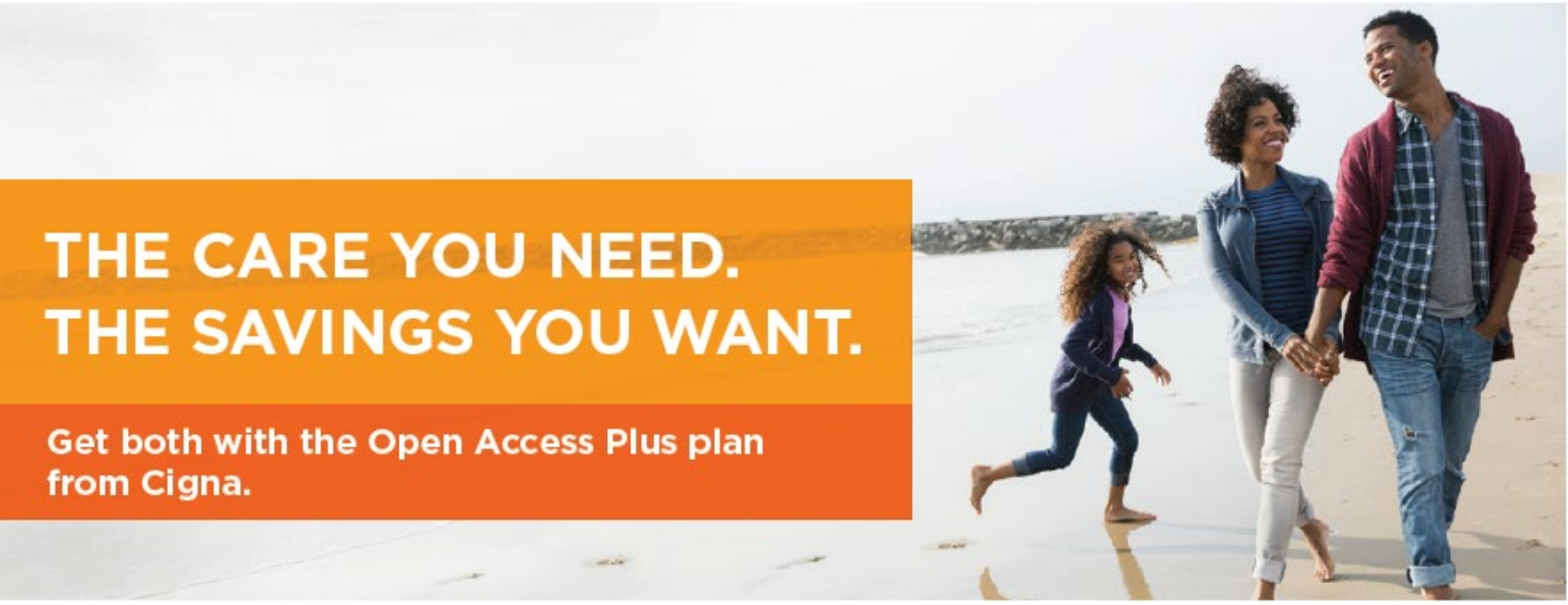
The Plan Year Out-of-Pocket Maximum is the amount of covered expenses, (including deductible, coinsurance, and co-payments) that must be paid by you, either individually or combined as a covered family.

After the individual/family out-of-pocket maximum has been satisfied in a plan year, payment for in-network covered services requiring co-payment and coinsurance for that covered individual/family will be payable by Cigna at the rate of 100% for the remainder of the plan year, subject to any other terms, limitation, and exclusions.

WCPS MEDICAL PLANS			
	Open Access Plus		Open Access Plus IN
	In & Out of Network		In Network Only
Network Access	In-Network	Out-of-Network	In-Network
Plan Year Deductibles (CYD)	**Your Responsibility**		**Your Responsibility**
Individual / Family	$750 / $1,500	$750 / $1,500	$750 / $1,500
Out-of-Pocket Maximum	**Your Responsibility**		**Your Responsibility**
Individual Out-of-Pocket Maximum (Medical / Rx)	$2,000 / $4,000	$4,000 / N/A	$2,000 / $4,500
Family Out-of-Pocket Maximum (Medical / Rx)	$4,000 / $8,200	$8,000 / N/A	$4,000 / $9,000
Professional Services			
Primary Care Physician (PCP) Visit	$20 Copay	Ded. then 30%	$20 Copay
Specialist Office Visits	$30 Copay	Ded. then 30%	$30 Copay
Preventive Care Visit	No Charge	No Benefit	No Charge
Urgent Care and Emergency Room			
Urgent Care Facility	$50 Copay	$50 Copay	$50 Copay
Emergency Room (waived if admitted)	$20 Physician / $100 Facility	$20 Physician / $100 Facility	$20 Physician / $100 Facility
Diagnostic Services			
X-Ray	Ded. then 10%	Ded. then 30%	Ded. then 10%
MRI, MRA, CT & PET Scans (Outpatient)	Ded. then 10%	Ded. then 30%	Ded. then 10%
Hospital / Facility Services			
Inpatient Hospital	Ded. then 10%	Ded then 30%	Ded. then 10%
Outpatient Hospital / Surgical Facility	Ded. then 10%	Ded then 30%	Ded. then 10%
Pharmacy Services			
Generic	$10 Copay		
Preferred Brand	$40 Copay		
Non-Preferred Brand	$60 Copay		
Specialty	$75 Copay		
Cigna 90Now	**Generic / Preferred Brand / Non-Preferred / Specialty**		
Retail Cigna 90 (90-day supply)	$20 / $80 / $120 / $150		
Mail Order Pharmacy (90 day supply)	$20 / $80 / $120 / $150		

This is a high-level overview. Please review the plan documents for more information.

CIGNA COVERAGE HIGHLIGHTS



Offering flexible access to thousands of providers – plus programs and services to support your whole health needs – the Open Access Plus (OAP) plan is designed to make it easier for you to get the quality care you need and the savings you want.

Here's how it works.

› In-network savings
You have the freedom to use any provider or facility of your choice, whether they are in the Cigna OAP network or out of the network. Just know that staying in-network will help keep your costs down and avoid any additional paperwork.

› No-referral specialist care
A primary care provider (PCP) is recommended but not required. If you need to see a specialist for any reason, you don't need a referral to see an in-network health care provider. If you choose an out-of-network specialist, your care will be covered at the out-of-network level and you may be responsible for any preauthorization's needed.

› Care coordination
Our robust medical management program provides you and your family a valuable resource for one-on-one support and guidance to the right programs and services.

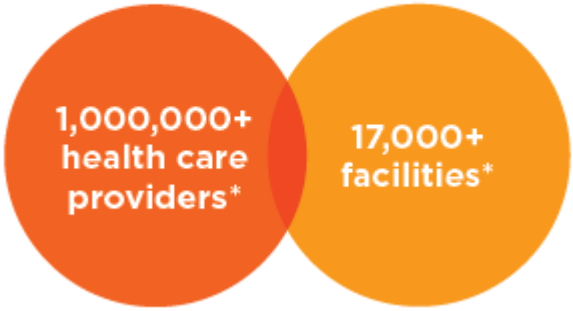
› Hospital stays
In an emergency, you have coverage. However, requests for nonemergency hospital stays (other than maternity stays) and some types of outpatient care must have prior authorization or be preauthorized. This lets Cigna determine if the services are covered by your plan.

If your provider is in the Cigna OAP network, he or she will arrange for prior authorization. If you use an out-of-network provider, you must make the arrangements.

› Out-of-pocket costs
Depending on your plan, you may have to pay an annual amount (deductible) before your plan begins to pay for covered health care costs. You may also need to pay a copay and/or coinsurance (a portion of the covered charge) for covered services. Then, your plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100% for the rest of your plan year.

If you receive out-of-network care, your costs will be higher. Out-of-network providers and facilities may also bill you for charges that are not covered by the plan. Charges not covered by the plan do not contribute to your deductible or out-of-pocket limits.

Great care anywhere. Where you live, work or travel



Added convenience and support

› Virtual Care
Connect 24/7 with board-certified providers and pediatricians for minor medical conditions. You can also schedule online appointments for licensed counselors or psychiatrists for behavioral or mental health conditions. You and your covered family members can get care from anywhere via video or phone.**

› Cigna Health Information Line
With the Cigna Health Information Line, clinicians are just a phone call away – 24/7, and at no extra cost. They can help you understand health issues you might be experiencing, and help you to make informed decisions – whether it's reviewing home treatment options, following up on a provider's appointment, or choosing and finding the right care in the right setting.

› Live, 24/7/365 customer service
Customer service representatives are here for you where and when you need us – over the phone, via chat at **myCigna.com** or on the myCigna® App.

› The myCigna website and app
On **myCigna.com** and the myCigna App, you have easy access to personalized tools to help you take control of your health and your health care spending. From your computer or mobile device, you can:
– Manage and track claims
– See cost estimates for medical procedures
– Compare quality information for providers and hospitals
– Track your account balances and deductibles
– Use the easy health and wellness tools
– Print a temporary ID card



Want to check if your provider is in the Cigna OAP network before you enroll?

Just go to **Cigna.com** and click on "Find a Provider, Dentist or Facility" and then click on "Plans through your employer or school" to search the provider directory.

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* Based on Cigna internal provider data for OAP service area as of 2/2020. Subject to change.

** Not all plans include coverage for behavioral services. Check your plan documents for details. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A primary care provider referral is not required for this service. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents.

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myCigna

So many ways to help manage your health.

Get to know the full value of myCigna.



Now it's easier than ever to manage your health and make the most of your health plan with myCigna®.* From programs that help improve your health to tools that help manage your health spending, there's so much you can do.

View, print and send ID cards	Find in-network doctors, hospitals and medical services	Compare quality of care information, including patient reviews from Cigna Healthcare℠ customers
Manage and track claims	See cost estimates for medical procedures	Use the click-to-chat feature to connect with a live Cigna Healthcare rep

Feel better protected Cigna Healthcare is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on myCigna.

Visit myCigna today. Not registered yet? Start here.**

Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.

App Store Google Play **Download the myCigna App for your mobile device.** Disponible en Español.

cigna healthcare

CIGNA TELEHEALTH

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®



It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

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3 easy steps to connect to care

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

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

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



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®

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1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

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CIGNA SUPPORT PROGRAMS

YOU'VE GOT A GOAL. AND YOU'VE GOT WHAT IT TAKES TO REACH IT.

Whether your goal is to lose weight, quit tobacco or lower your stress levels, you have the power to make it happen. Cigna Lifestyle Management Programs can help – and all at no additional cost to you. Each program is easy to use and available where and when you need it. And, you can use each program online or over the phone – or both.*

Weight Management

Reach your goal of maintaining a healthy weight – all without the fad diets. Create a personal healthy-living plan that will help you build your confidence, be more active and eat healthier. And, you'll get the support you need to stick with it.

Tobacco Cessation

Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy (patch or gum).

Stress Management

Get help lowering your stress levels and raising your happiness levels. Learn what causes you stress in your life and develop a personal stress management plan. And, get the support you need to help you cope with stressful situations – both on and off the job.

Take the first step.

Call 800-Cigna24 or visit myCigna.com

Over the phone*

- One-on-one wellness coaching
- Convenient evening and weekend hours
- Program workbook and toolkit

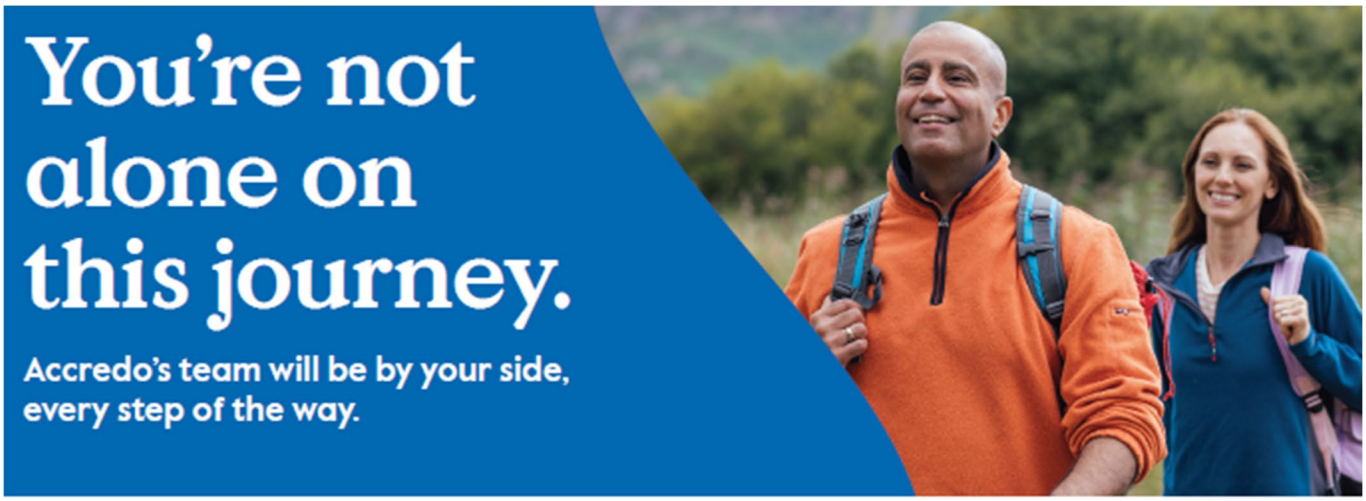
Online

- Convenient support
- Self-paced program
- Educational materials, interactive tools and resources

Together, all the way.®

Cigna®

CIGNA PHARMACY



Whether you've been going through treatment for years or just got diagnosed, managing a complex medical condition can be, well, complex. Accredo® specialty pharmacy[1] is focused on supporting complex conditions like yours.

They're not one person behind a counter, they're a whole team behind you

Accredo's team of specialty trained pharmacists, nurses and clinicians work together to give you the personalized care and support you need to manage your therapy. They'll:

- **Provide personalized care services**, including counseling and training on how to use your medication
- **Help you understand your medication and condition** – they have teams that are focused on supporting specific complex conditions
- Keep track of **how you're doing** with your treatment and **work with your doctor** to make sure you're getting the care you need
- **Talk regularly** with your caregivers and doctor
- **Answer** your questions – call as often as you need to, we'll talk as long as you need to
- Talk about **side effects** and possible interactions
- Help you take your medication in a way that **works best for you**
- Work with your doctor to **help get your medication pre-approved** so your plan will cover its cost
- Help you **find ways to pay for your medications** – such as applying for third-party copay assistance programs and other payment options



What's a specialty pharmacy?

A specialty pharmacy is a state-licensed pharmacy that's focused on supporting patients living with a complex medical condition. They:

- Provide specialized patient care and services that most retail pharmacies can't
- Fill and deliver specialty medications directly to the patient's home or doctor's office

cigna healthcare

Get quick, safe delivery of your medication

Accredo will deliver your specialty medication to your home, workplace or doctor's office[2] – or even to a vacation location – to make sure you have it when and where you need it

- **Fast shipping, at no extra cost**[3] – even for medications that need special handling, such as refrigeration
- Packaging designed to **protect your privacy** and **stand up to bad weather** and warm temperatures
- **Easy refills and free reminders** to help make sure you don't miss a dose – you can also refill certain prescriptions **by text**[4]
- **Extra supplies** (such as syringes and a sharps container) at no extra cost to you
- Easily manage your medications and track your orders **online**[5]

Manage your medications online

Log in to the **myCigna**® App[6] or **myCigna.com**® and click on the Prescriptions tab. Select My Medications from the dropdown menu and click the button next to your medication name. We'll automatically connect you to your online Accredo account.



What's a specialty medication?

Specialty medications are used to treat complex medical conditions. They have to be:

- Carefully handled, packaged and stored
- Given in a certain way (typically injected or infused)
- Kept at a certain temperature or they'll go bad
- Monitored to watch for side effects and to make sure they're working

Get started with Accredo

Ask your doctor's office to send your prescription to Accredo electronically. Or you can call Accredo and they'll contact your doctor's office to get your prescription.

877.826.7657

Monday–Friday | 7:00 am–10:00 pm CST

Saturday | 7:00 am–4:00 pm CST

Cigna.com/specialty

cigna healthcare

CIGNA PHARMACY

Having options can help make the things you do on a regular basis a little easier – such as refilling your prescriptions. With the Cigna 90 Now℠ program, you decide how and where you fill your maintenance medications.

Choose how much you want to fill.

- **30-day supply.** You have the option of switching to a 90-day (or 3-month) supply at any time.
- **90-day (or 3-month) supply.**[1] You'll make fewer trips to the pharmacy for refills (four times a year instead of every month). And you're more likely to stay healthy – with a 90-day supply on hand, you're less likely to miss a dose.[2]

What are maintenance medications?

They're the medications you take on a regular basis to treat an ongoing health condition, such as asthma, diabetes, high blood pressure or high cholesterol.

Choose where you want to fill.

Retail pharmacies

There are thousands of pharmacies in your network – including local independent pharmacies, grocery stores, retail chains and wholesale warehouse stores. To find an in-network pharmacy near you, log in to the **myCigna® App**[3] or **myCigna.com®**.

- Every pharmacy in your network can fill **30-day** prescriptions.
- Select retail pharmacies can fill **90-day** prescriptions. For example, **Walgreens® Pharmacy** is approved to fill 90-day supplies. If you choose to fill this amount, make sure you use an approved pharmacy.

Home delivery with Express Scripts® Pharmacy[4]

Home delivery is a convenient option when you're taking a medication on a regular basis. It's simple, safe – and saves you trips to the pharmacy.

By choosing home delivery, you can:

- **Easily manage** your medications from your phone or online
- Get standard shipping **at no extra cost**[5]
- Fill up to a **90-day supply** at one time
- Talk to **helpful pharmacists**, 24/7
- Sign up for **free automatic refills** or refill reminders so you don't miss a dose
- Use a **flexible payment plan** to make it easier to pay for your medication

To learn more, go to **Cigna.com/homedelivery**.

How to fill a 90-day supply.



Ask your doctor for a 90-day prescription (with refills).

Ask their office to send it electronically to an approved in-network retail pharmacy or to Express Scripts® Home Delivery.

Get your 90-day supply of medication. You'll fill again in 3 months.

How to fill a 30-day supply.



Ask your doctor for a 30-day prescription.

Ask their office to send it electronically to any in-network retail pharmacy.

Get your 30-day supply of medication. You'll fill again in a month.

DENTAL

WCPS offers Dental coverage through United Concordia. United Concordia offers a PPO network which affords employees and their families the best coverage at the lowest cost. This plan still allows you and your family to utilized out of network providers at an affordable cost. Please keep in mind that utilizing out-of-network providers may subject you to balance billing.

If you enroll in dental coverage, we encourage you to establish a user ID and password on United Concordia's website to review your benefits, claims, and to browse through the wealth of wellness information. They even have an app for kids to use to monitor their time brushing their teeth.

Review more dental plan information at https://www.wcpsmd.com/departments/benefits/dental.

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible (Policy Year July –June)	$100 per person; $200 family limit Excludes Preventive Services and Orthodontics	
Annual Benefit Maximum (Policy Year July—June)	$1,500 Excludes Preventive Services and Orthodontics	
Covered diagnostic and preventive dental services no longer apply to your annual plan maximum. This will allow you to have more annual max. dollars available for other basic or major dental services.		
Preventive Dental Services: exams, bitewing x-rays, all other x-rays, cleanings & fluoride, treatments; sealants, space maintainers, palliative treatment	100%; no deductible	
Basic Dental Services: basic restorative (fillings) – includes posterior, composites, simple extractions, repairs of crowns, inlays, onlays, bridges & dentures endodontics, nonsurgical periodontics, surgical periodontics complex oral surgery, general anesthesia	80%	
Major Dental Services: inlays, onlays, crowns, prosthetics (bridges, dentures	80%	
Orthodontia Services (child and adult)	50% to $1,500 lifetime maximum	
Claims Reimbursement	Advantage Plus	Advantage Maximum Allowable Charge (MAC)

Dependent Children covered to end of month in which they attain age 26.

Reimbursement is based on UCCI's schedule of maximum allowable charges (MACs). Network dentists agree to accept UCCI's allowances as payment in full for covered services. Non-Network dentist may bill the member for any difference between UCCI's allowance and their fee (also known as balance billing). United Concordia Dentist's standard exclusion and limitations apply.
This is a high-level overview. Please review the plan documents for more information.

UnitedConcordia.com **1-800-332-0366**

Find A Dentist - https://www.unitedconcordia.com/find-a-dentist/#/

United Concordia dental



Get the max out of your dental plan

Create a *MyDentalBenefits* account

It's the online hub where you can check your coverage details, see claims and payments, print extra ID cards and more.

Scan to create your *MyDentalBenefits* account

Set up an account after your plan's effective date. When you're ready, simply visit **UnitedConcordia.com/GetMDB**. Make sure to have your member ID or social security number handy.

Visit in-network dentists

You'll save money by staying in network for your dental care. Just visit **UnitedConcordia.com/FindADentist** to locate an in-network dentist near home or work.

Scan to find an In-network dentist

Download the United Concordia Dental app

The app lets you access your ***MyDentalBenefits*** info from your smartphone or tablet. You can log in with the same user ID and password.

Get our Chomper Chums® app for kids

No more nagging—children love brushing alongside their favorite Chomper Chum. A built-in timer ensures they brush, floss and rinse for a full two minutes.

Sign up for tips via email

Each month, we'll send pointers to help you understand your dental plan and keep your mouth healthy. Sign up for emails when you create your ***MyDentalBenefits*** account.

Go paperless

Sign up to get an email when you have a new Explanation of Benefits. View or print it from your ***MyDentalBenefits*** account.

Learn more at UnitedConcordia.com/GetStarted

VISION

Vision coverage is offered through EyeMed. Using EyeMed's Insight PPO network will afford employees and their fami- lies the best coverage at the lowest cost. Utilizing providers outside of the EyeMed network still provides reasonable coverage.

If you should elect coverage, we encourage you to enroll on EyeMed's website at www.eyemed.com to review your ben- efits, claims, and to locate participating doctors.

For supplementary information about the vision plan such as the contact mail order program and discounts on LASIK procedures, please visit https://www.wcpsmd.com/departments/benefits/vision.

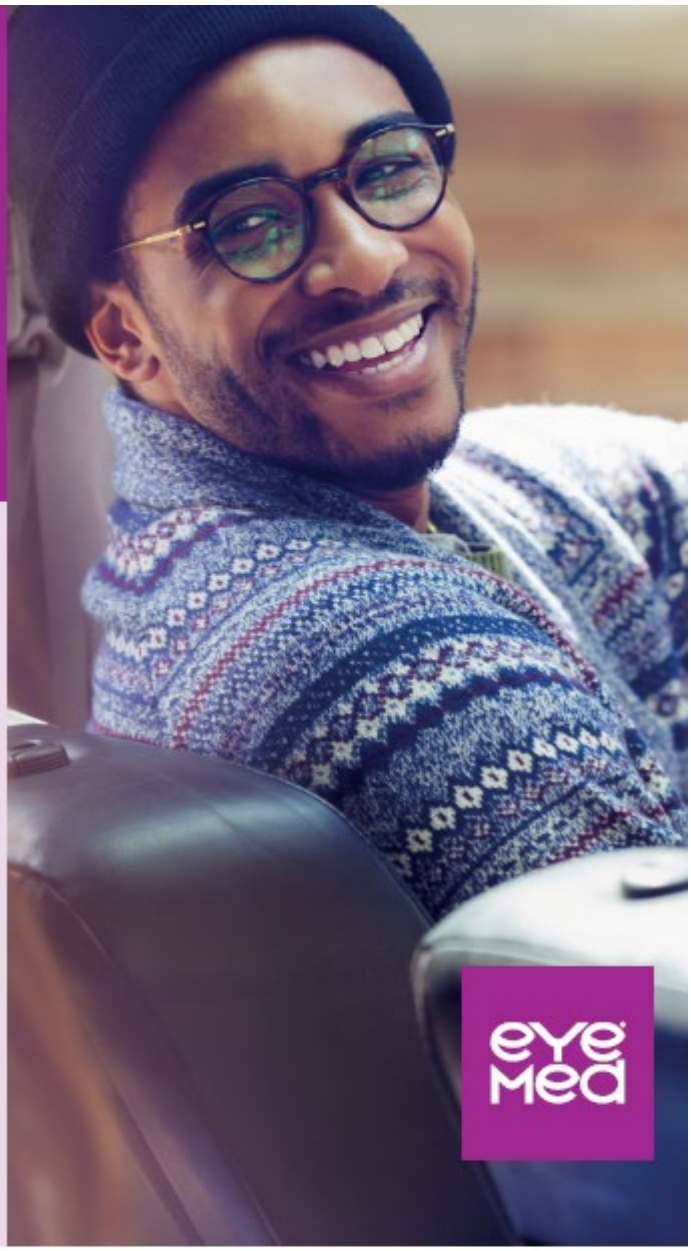
SERVICE	IN-NETWORK (ANY EYEMED PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
EYE EXAM — ONCE EVERY PLAN YEAR		
	$15 copay; covered in full	Up to $52
LENSES — ONCE EVERY PLAN YEAR		
Single Vision Lenses	$25 copay; covered in full	Up to $34
Lined Bifocal Lenses	$25 copay; covered in full	Up to $50
Lined Trifocal Lenses	$25 copay; covered in full	Up to $66
Lenticular Lenses	$25 copay; covered in full	Up to $100
FRAMES —ONCE EVERY OTHER PLAN YEAR		
	$0 copay; 20% off balance after $130 allowance	Up to $91
CONTACT LENSES —ONCE EVERY PLAN YEAR IF YOU ELECT CONTACTS INSTEAD OF LENSES/FRAMES		
Contacts—Conventional	0 copay; 15% off balance over $130 allowance	Up to $130
Contacts—Disposable	$0 copay; plus balance over $130 allowance	Up to $130
Contacts—Medically Necessary	$0 copay; paid in full	Up to $210
Fit and Follow up– Standard	$20 Copay	Up to $20
Fit and Follow up—Premium	$20 Copay; 10% off retail price, then $40 allowance	Up to $20

This is a high-level overview. Please review the plan documents for more information.



Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.



Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from—independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts*

Members already save an average 76% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

*Discounts are not insurance. Available at participating providers.
[1] Based on weighted average of sample transactions. EyeMed Insight network/$10 exam copay/$10 materials copay/$150 frame or contact lens allowance. 2021 EyeMed Commercial BOB stats.



Create a member account at eyemed.com/member

Everything is right there in one spot. Check claims and benefits, see special offers, estimate costs and find an eye doctor—search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed App (Google Play or App Store).

This information is available broadly and is not plan or state specific.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

PDF-2301-M-851



Basic Life & AD&D and Supplemental Life and AD&D

BASIC LIFE & AD&D

WCPS offers a variety of life insurances to fit the needs of you and your family provided by Ochs, Inc. Some of the premiums for these insurances are fully paid by WCPS and some are employee paid.

For full time employees, WCPS pays for 1 time your annual salary in Basic Life Insurance and Basic Accidental Death and Dismemberment (AD&D). Part time employees may purchase this level of coverage.

SUPPLEMENTAL LIFE & AD&D

Full and Part time employees may purchase Supplemental Life and Voluntary AD&D insurance in addition to the company-provided coverage. You may also purchase life insurance for your dependents.

During your initial 31-day eligibility period, you may elect Supplemental Life insurance up the Guaranteed Issue of $350,000 without providing evidence of insurability (EOI):

Elect the following		
Employee Supplemental Life*	1-3x annual base pay (round to the next higher $1,000)	• Maximum coverage: $800,000 (combined with Basic) • Guaranteed Issue: $350,000 • Employees are eligible to increase to the GI amount during Annual Enrollment without completing EOI
Dependent Life	Packaged Option: Spouse: $10,000 Each eligible child: $5,000	• All dependent coverage is guaranteed • Children eligible from live birth to age 26 • Spouse not eligible if they are eligible for EE coverage • Child may only be covered by one parent
Voluntary Accidental Death and Dismemberment (VAD&D)	$50,000, $100,000 or $200,000	All coverage is guaranteed

*Electing or increasing coverage requires evidence of insurability (EOI), if outside of initial eligibility window.

ADDITIONAL FEATURES

Early benefit payments if diagnosed as terminally ill— if an insured person becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100% of the face amount (basic and supplemental combined)

No premiums if you become disabled — if you become totally disabled prior to age 60 and continues until the earlier of retirement, recovery or age 65 according to the terms of your certificate, life insurance premiums may be waived.

Take your coverage with you — If you are no longer eligible for coverage as an active employee you may port your group life insurance (ported coverage end at age 75) or you may convert your life coverage to an individual policy.

This is a high-level overview. Please review the plan documents for more information.

DISABILITY INSURANCE

LONG TERM DISABILITY

WCPS offers long term disability coverage (LTD) to all full-time permanent employees. WCPS pays some or all of the premium for this coverage based upon your bargaining group. Please reference the full-time rate sheet for details.

Eligibility – Active, full-time employees working a minimum of 30 hours per week are eligible upon hire, and electing at this time will not require an Evidence of Insurability (EOI) form. Adding this benefit at a later time will require the EOI form. Please see the cost page for more information on eligibility.

Monthly Benefit – This plan pays a benefit of up to 60% of your monthly covered earnings to a maximum of $10,000. Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

Definition of Disability – Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation, and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your indexed earnings. We will require proof of earnings and continued disability.

Covered Earnings – Covered earnings means your wages or salary, not including commissions.

Elimination Period – You must be disabled for 90 calendar days. Any sick pay will be treated as an offset to the policy.

Benefit Duration – Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period shown below, or until you no longer qualify for benefits, whichever occurs first.

Your benefit period begins on the first day after you complete your elimination period. And, should you remain disabled, your benefits continue according to one of the following schedules, depending on your age at the time you become disabled.

Age at Disability	Age 61 or younger	62	63	64	65	66	67	68	69+
Duration of Benefits (months)	To age 65 or the date the 42nd monthly benefit is payable, if later	42	36	30	24	21	18	15	12

This is a high-level overview. Please review the plan documents for more information.



PROGRAMS INCLUDED AT NO ADDITIONAL COST

Legal, Financial and Grief Resources

Access professional services for a variety of needs – from legal matters and financial situations to coping with loss – through comprehensive web and mobile resources, as well as consultations. Will prep templates are included in this service.
Administered by TELUS Health - Professional and timely support services for a variety of needs

Travel Assistance Services

This service offers online pre-trip resources and 24/7/365 support for emergency travel assistance, medical and security evacuation services when traveling 50 or more miles away from home.
Administered by RedpointWTP LLC

Legacy Planning Resources

Provides you with a variety of online information and resources to help with multiple aspects of legacy planning, including endof-life and funeral planning, final arrangements, directives and survivor assistance.

Empathy

A comprehensive support system for loss, offering bereaved families holistic guidance and care for administrative, emotional, legal, and financial challenges they face after a loved one passes. .

Employee Assistance Program from TELUS Health

A 24/7 line which provides solutions to employees that may include meeting with a counselor for up to three face-to-face visits.

Identity Theft Assistance Services from IDX

Provides expert guidance if your employees or their family members suspect they are victims of identity theft.

This is a high-level overview. Please review the plan documents for more information.

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

PAYING FOR HEALTH CARE

WCPS offers an FSA as a way to set aside pre-tax dollars to pay for eligible expenses. Employees can choose to participate in either a medical or dependent care account each calendar year.

Flexible Benefit Administrators (FBA) administers WCPS's flexible spending accounts (FSA's).

Annual open enrollment for FSAs is held in May for a July 1 start date.

If you are unfamiliar with FSA's and how they work, we encourage you to watch the short video and review the employee guide for a good explanation of how they can be beneficial to you. The informative employee guide and video can also be found on the WCPS benefits webpage at https://www.wcpsmd.com/departments/benefits/flexible-spending-accounts.

	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)
Which medical plans are compatible with a health FSA?	In and Out of Network Plan or In Network Only
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses)
When can I use the funds?	All funds you elect for Medical FSA are available July 1
Can I roll over funds each year?	WCPS and FBA have made changes to the Health Care FSA allowing the roll over feature for the 2026-2027 plan year. Effective July 1, 2027, you will be able to roll over $680 of unused funds for the next plan year.
How do I pay for eligible expenses?	With your Flexible Benefits Administrator's debit card (you can also submit claims for reimbursement online at **fba.wealthcareportal.com**)
How much can I contribute each year?	Up to $3,400 (2026)
Can I change my contributions throughout the year?	No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year



DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

PAYING FOR DEPENDENT CARE

You can contribute pre-tax dollars into a dependent care FSA to pay for eligible child or elderly care expenses.

	DEPENDENT CARE FSA
What is it?	An account that allows you to set aside pre-tax dollars from each paycheck to pay for eligible child or elderly care expenses while you and your spouse work full time
Why should I consider it?	You can lower your taxable income to save some money while you take care of your daycare expenses
What expenses are eligible?	Daycare expenses for your children under age 13 or dependents who are mentally or physically incapable of caring for themselves (including elderly dependents)
When can I use the funds?	Funds are available as you contribute to the account with each paycheck
Can I roll over funds each year?	No, you will lose any funds remaining in your account at the end of the year
How do I pay for eligible expenses?	With your Flexible Benefit Administrators debit card (you can also submit claims for reimbursement online at fba.wealthcareportal.com)
How much can I contribute each year?	$7,500 for the family



Important Note Both the health care and dependent care FSAs have a use-it-or-lose-it rule. You will lose any unused funds at the end of the year except for the health care funds roll over amount.

Your healthcare finances are at your fingertips with the Flexible Benefit Administrators mobile app!

The Flexible Benefit Administrators mobile app provides ultimate convenience and 24/7 access directly from your tablet or mobile device.



Features

Download on iTunes

Download on Google Play

- **Access accounts** – Check balances, view transaction history, and more.
- **Manage claims** – Submit new claims, upload receipts and check claims status.
- **Track and pay expenses** – Track medical claims and other expenses, plus pay bills electronically.
- **Access cards** – Manage card details, access your PIN, and initiate card replacement for lost or stolen cards.
- **Receive alerts** – View important account messages.
- **Update your profile** – Update personal information, including your email and mobile phone.

Get Started Today!

Simply search Flexible Benefit Administrators Mobile in iTunes or Google Play store, select "Install", and log-in online if previously registered or register. Registration requires an employee ID (generally your SSN), employer ID/ benefit debit card number, and valid email address to begin.

FlexibleBenefit ADMINISTRATORS
Ph: 800-487-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

FSA Enrollment Form

Employee Information

Employee ID: | Date of Birth:

Employer Name: | Dept/Location: (Optional)

First Name: | Middle Initial: | Last Name:

Employee Home Address:

City: | State: | Zip:

Home Phone #: | E-Mail:

Help us go green! If provided, we will use your email as our primary method of contact.

Employment Date: | Plan Effective Date: | ☐ Male ☐ Female

Employer Information *(Employer to complete the information below.)*

Date of 1st Payroll Deduction: | ☐ 12 Month Plan Year

Employee Plan Effective Date: | ☐

Employee Elections *(Employee to complete the information below)*

A. Group Medical Premiums *(If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.)*

	Annual Election		# of Payroll Deductions		$ Per Pay Check
B. Health FSA		/		=	
Employer Contribution		/		=	
C. Dependent Care		/		=	
Employer Contribution		/		=	
D. Limited FSA		/		=	
Employer Contribution		/		=	
E. Administration Fee (if any)		/		=	
TOTALS	$ 0.00				$ 0.00

☐ **No, I do not want to enroll**. If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer's plan allows).

☐ **Yes, I want to enroll** . The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

Signature: | Date:

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EMPLOYEE ASSISTANCE PROGRAM

Free, Confidential Support for You and Your Family
The Employee Assistance Program (EAP) provides confidential resources and professional support to help you manage personal, family, financial, legal, and work-life challenges. Services are available at no cost to employees and eligible family members.

EAP Services Include

- **Emotional & Mental Wellbeing**
  - Short-term counseling for stress, anxiety, depression, relationships, grief, and other life challenges
  - In-person, virtual, and telephonic support
- **Financial & Legal Assistance**
  - Budgeting, debt management, retirement planning, and financial coaching
  - Referrals for legal matters including wills, estate planning, family law, and real estate
- **Work-Life Support**
  - Childcare and eldercare resources
  - Adoption and special needs assistance
  - Referrals for everyday life services and community resources
- **Health & Wellness Navigation**
  - Medical advocacy and healthcare referrals
  - Assistance understanding healthcare resources and benefits
- **Life Coaching**
  - Goal setting, personal growth, career development, and work-life balance support

You're Not Alone
Whether you're facing a personal challenge, planning for the future, or simply looking for guidance, the EAP is available to help you and your family navigate life's challenges with confidence.

Access Support Anytime
24/7 Member Portal & Mobile App
Virtual counseling appointments
Self-help tools and wellbeing resources
AI-powered support through Izzy
Contact Information
📞 **800-451-1834**
🌐 **allonehealth.com/portal**
🔑 **Company Code: wcpseap**

Download the AllOne Health App

ALLONE HEALTH

RETIREMENT PLAN

WCPS offers a mandatory and a voluntary participation retirement program. Review the chart below for details.

The Maryland State Retirement & Pension System has helpful videos, pamphlets, & calculators found on the https://sra.maryland.gov/ website.

TSA Group is the Supplemental Plan Administrator, who oversees the financial vendors. Log into their site for vendor options, and to begin or increase your contributions.

	Pension Plan	403(b)	457(b)
Vendors	Maryland State Retirement and Pension System	Administrator: TSA Consulting Group (TSACG) • Equitable • MetLife • PlanMember Services • Voya	Administrator: TSA Consulting Group (TSACG) • Equitable • MetLife • PlanMember Services • Voya
Participation Requirements	Mandatory	Voluntary	Voluntary
Eligibility	All employees working 2-75 hours per day or more	• Administrators & Supervisors (A&S) • Teachers • Education Support Personnel (ESP) • Substitutes	• Administrators & Supervisors (A&S) • Teachers
Enrollment Window	Must enroll at hire or first eligibility	May enroll anytime	May enroll anytime
Contribution Rate	Required 7% of pre-tax earnings	Employee election of pre-tax or post-tax earnings	Employee election of pre-tax earnings
Annual Deferral Limits - 2026	N/A	$24,500 Age 50 or over an additional $8,000	$24,500 Age 50 or over an additional $8,000
Vesting - eligible for a future benefit	Hired prior to 7/1/2011 - vested after 5 years of service Hired after 7/1/2011 – vested after 10 years of service	Immediately vested	Immediately vested
Loans	Not permitted	Permitted	Permitted
Withdrawals	Permitted at retirement (as a monthly benefit) or distributed at severance of employment	Permitted at age 59 ½. Mandatory distributions begin at age 72.	Permitted at severance of employment if no longer employed by plan sponsor. Mandatory distributions begin at age 72.
Rollovers	Permitted at severance of employment	Permitted	Permitted
How to enroll	Enrolled by Human Resources when first eligible	Choose a participating vendor and contact them to establish an account. Visit TSACG website to set up a salary reduction agreement.	Choose a participating vendor and contact them to establish an account. Visit TSACG website to set up a salary reduction agreement.

RETIREMENT CONTINUED

ENROLLING IN A SUPPLEMENTAL RETIREMENT PLAN

Enrolling in a 403(b) or 457(b) plan is an important financial decision. Since it is up to you to choose your investment provider, we recommend you research the options and ask for help from people you trust. See below for a general overview of the steps you can take to start achieving your long-term financial goals. TSA Consulting Group is WCPS's third party administrator for all supplemental retirement plans. This website offers tools and resources that may assist in choosing an investment provider as well as general information on why to invest.

QUICK ENROLL
Visit Quick Enroll at https://www.myquickenroll.com, choose Maryland for the state, and WCPS for the school system. Follow the instructions to complete your enrollment.
*This option does not offer a MetLife plan. To enroll in a MetLife plan, use the standard enrollment method.

STANDARD ENROLLMENT
Follow the step-by-step instructions below to successfully access the TSA website/ART system:

1. Navigate to the website www.tsacg.com.

2. Disable any Internet "Pop-Up Blocker" software before proceeding.

3. The ART system can be accessed via the "ART Login" box located on the right hand side of the home page.

4. Log in with your assigned User ID and Password.

- **If this is your first time logging into the system, your User ID will be your Social Security Number, and your Password will be your Date of Birth (*MMDDYYYY).*** You will then be prompted to set up a new User ID and Password that should be different from the default.
- Call Customer Service at (888) 796-3786 if assistance is needed.

5. Once you establish your account and log in, you can review helpful resources on the site. On the blue ribbon, the topics of Investing and Planning may be especially helpful.

Choose an investment provider. A list of investment providers and their contact information is found on the WCPS website on the Benefits page under the retirement topic. Simply contact an agent for an appointment to set up your account.

Choose how much to invest. After establishing an account with the investment provider of your choice, head back to the TSA website and enter the ART system. This is where you will establish the percentage or dollar amount of salary you would like to defer into your new account by choosing *Salary Reduction Agreement*.

Review your pay stubs for the next few pay periods to make sure your new deduction is being withheld.

Be sure to periodically evaluate your investments and contribution amounts to make sure they are still meeting your needs. The investment provider you are working with can assist you with reviewing your account.

RETIREMENT CONTINUED—2026 Plan Summary Information

WASHINGTON COUNTY PUBLIC SCHOOLS, MD 403(B) PLAN AND 457(B) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options available through Washington County Public Schools, MD. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans. Plan administration services for the 403(b) and 457(b) plans are provided by TSA Consulting Group, Inc. (TSACG). Visit the TSACG website (tsacg.com) for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

Eligibility

Most employees are eligible to participate in the 403(b) plan immediately upon employment, however, private contractors, appointed/elected trustees and/or school board members and student workers are not eligible to participate in the 403(b) Plan. Only teachers, administrators, and supervisors are eligible to participate in the 457(b) Plan. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

Employee Contributions

Traditional 403(b) and 457(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)

Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are 591/2 subject to plan document provisions) or a separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. TSACG monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

The 2026 Basic Contribution Limit for each plan is $24,500.

Additional provision allowed if selected by the employer:

Age-Based Additional Amount

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $8,000 to the 403(b) and/or 457(b) accounts.

Enrollment

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and any disclosure forms must be completed and submitted to TSACG. These forms authorize the employer to withhold 403(b) and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. A SRA form must be completed to start, stop or modify contributions to 403(b) and or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please Note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at www.tsacg.com.

Investment Provider Information
A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on the employer's specific Web page at www.tsacg.com.

Plan Distribution Transactions
Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, unforeseen financial emergency withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing.

403(b) and 457(b) Plan Loans
Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider. Prior to taking a loan, participants should consult a tax advisor.

Plan-to-Plan Transfers
A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

RETIREMENT CONTINUED—2026 Plan Summary Information

Rollovers
Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

Distributions
Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations without penalty unless they have attained age 59½ or separated from service in the year in which they turn 55 or older. Generally, a distribution cannot be made from a 457(b) account until you have a severance from employment, reach age 70½, or are deceased. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income.

Exchanges
Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

Hardship Withdrawals
Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. According to IRS Safe Harbor regulations, to be eligible for a hardship withdrawal, a participant must have exhausted all other available financial resources. The eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at www.tsacg.com. After receiving a hardship withdrawal, the participant may not make voluntary contributions to any employer sponsored retirement plan for a period of six months.

Unforeseen Financial Emergency Withdrawal
You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at www.tsacg.com.

Employee Information Statement
Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

There's an App for that!

Keeping your information at your fingertips.

Download and log onto these apps for membership cards, and assistance at your fingertips.

Cigna App for iPhone and Androids

MD Live offers virtual telehealth for medical and mental health appointments with zero copay. Find MD Live by first logging into your MyCigna.com account

UCCI App for iPhone and Androids

FSA App for iPhone and Androids

EyeMed App for iPhone and Androids

AllOne Health for iPhone and Androids



INSURANCE COSTS 2026—FULL TIME EMPLOYEES

WASHINGTON COUNTY PUBLIC SCHOOLS
FULL-TIME EMPLOYEES
INSURANCE RATES FOR JULY 1, 2026 - JUNE 30, 2027

Full Time	Employee Coverage Tier	EE 20 Deductions	EE 26 Deductions	Employee Monthly	WCPS Monthly	Employee Monthly LOA	Employee Yearly	WCPS Yearly
Medical / Rx In and Out of Network	Employee Only	$113.32	$87.17	$188.87	$1,070.29	$1,259.16	$2,266.49	$12,843.44
	Employee + Spouse	$226.65	$174.34	$377.75	$2,140.56	$2,518.31	$4,532.96	$25,686.76
	Employee + Child(ren)	$173.61	$133.55	$289.36	$1,639.68	$1,929.04	$3,472.27	$19,676.20
	Employee + Family	$286.95	$220.73	$478.25	$2,710.10	$3,188.35	$5,739.04	$32,521.23
Medical / Rx In Network Only	Employee Only	$94.94	$73.03	$158.23	$996.72	$1,154.95	$1,898.73	$11,960.60
	Employee + Spouse	$190.94	$146.88	$318.24	$2,004.68	$2,322.92	$3,818.88	$24,056.18
	Employee + Child(ren)	$145.45	$111.88	$242.41	$1,526.99	$1,769.40	$2,908.90	$18,323.92
	Employee + Family	$240.39	$184.92	$400.66	$2,523.84	$2,924.50	$4,807.86	$30,286.02
Dental	Employee Only	$2.71	$2.09	$4.52	$25.63	$30.15	$54.28	$307.58
	Employee + Spouse	$5.43	$4.17	$9.04	$51.25	$60.29	$108.53	$615.03
	Employee + Child(ren)	$5.83	$4.49	$9.72	$55.10	$64.82	$116.68	$661.18
	Employee + Family	$11.47	$8.82	$19.11	$108.29	$127.40	$229.32	$1,299.48
Vision	Employee Only	$2.61	$2.00	$4.34	$4.34	$8.68	$52.11	$52.11
	Employee + Spouse	$4.73	$3.64	$7.88	$7.88	$15.76	$94.51	$94.51
	Employee + Child(ren)	$4.96	$3.82	$8.27	$8.27	$16.54	$99.22	$99.22
	Employee + Family	$7.65	$5.89	$12.75	$12.75	$25.50	$153.04	$153.04

Full-time = 30 or more hours per week

Rates may vary slightly due to system rounding

INSURANCE COSTS 2026—FULL TIME EMPLOYEES

WASHINGTON COUNTY PUBLIC SCHOOLS
FULL-TIME EMPLOYEES
INSURANCE RATES FOR JULY 1, 2026 - JUNE 30, 2027

Supplemental Life, Voluntary AD&D, Dependent Life, Long Term Disability			
Coverage Type	**Cost**		
Basic Term Life Insurance	No cost to employees. 1x annual salary rounded to next higher $1,000		
Basic accidental death and dismemberment (AD&D)	No cost to employees. 1x annual salary rounded to next higher $1,000		
Supplemental life insurance 1x, 2x, or 3x annual base salary rounded to the next higher $1,000	Cost is .234 per thousand per month Calculation - Annual salary (rounded to the next higher $1,000) divided by 1,000 x .234 x 12 divided by the number of deductions (20 or 26)		
Voluntary accidental death and dismemberment Coverage of $50,000, $100,000 or $200,000	12 month pay 26 Deductions	10 month pay 20 Deductions	Monthly Rate
$50,000	$0.46	$0.60	$1.00
$100,000	$0.92	$1.20	$2.00
$200,000	$1.85	$2.40	$4.00
Dependent Life Insurance Spouse $10,000 Child(ren) $5,000	26 Deductions	20 Deductions	Monthly Rate
	$1.36	$1.77	$2.95
Long Term Disability (LTD) Up to 60% of earnings can be paid if approved	**Educational Support Personnel (ESP)** Will pay 100% of the premium but their pay will be increased in the amount of 100% of the premium. **Teachers** Pays 100% of the premium but their pay will be increased in the amount of 75% of the premium Annual salary x.180% x .25 divided by the number of deductions (20 or 26) **Administrators and Supervisors** 25% of the total premium cost deducted from their pay		

Full-time = 30 or more hours per week

Rates may vary slightly due to system rounding

INSURANCE COSTS 2026—PART TIME EMPLOYEES

WASHINGTON COUNTY PUBLIC SCHOOLS
PART-TIME EMPLOYEES
INSURANCE RATES FOR JULY 1, 2026 - JUNE 30, 2027

		Half Time Teachers & ESP		Employees Working 15-19 hours per week	
	Employee Coverage Tier	20 Deductions	26 Deductions	Medical - Monthly Den/Vis 20 deductions	Monthly Cost of Coverage / LOA
Medical / Rx In and Out of Network	Employee Only	$377.75	$290.58	$1,259.16	$1,259.16
	Employee + Spouse	$755.49	$581.15	$2,518.31	$2,518.31
	Employee + Child(ren)	$578.71	$445.16	$1,929.04	$1,929.04
	Employee + Family	$956.51	$735.77	$3,188.35	$3,188.35
Medical / Rx In Network Only	Employee Only	$346.48	$266.53	$1,154.95	$1,154.95
	Employee + Spouse	$696.89	$536.06	$2,322.92	$2,322.92
	Employee + Child(ren)	$530.82	$408.32	$1,769.40	$1,769.40
	Employee + Family	$877.35	$674.88	$2,924.50	$2,924.50
Dental	Employee Only	$9.05	$6.96	$18.09	$30.15
	Employee + Spouse	$18.09	$13.91	$36.17	$60.29
	Employee + Child(ren)	$19.45	$14.96	$38.89	$64.82
	Employee + Family	$38.22	$29.40	$76.44	$127.40
Vision	Employee Only	$2.61	$2.00	$5.21	$8.68
	Employee + Spouse	$4.73	$3.63	$9.46	$15.76
	Employee + Child(ren)	$4.96	$3.82	$9.92	$16.54
	Employee + Family	$7.65	$5.89	$15.30	$25.50

EMPLOYEES WORKING 15-19 HOURS WEEKLY

Medical/prescriptions premiums will not be payroll deducted. Employees will be billed separately for medical/rx premiums on a monthly basis.

Dental and vision premiums will be payroll deducted.

* All rates may vary slightly due to system rounding.

INSURANCE COSTS 2026—PART TIME EMPLOYEES

WASHINGTON COUNTY PUBLIC SCHOOLS
PART-TIME EMPLOYEES
INSURANCE RATES FOR JULY 1, 2026 - JUNE 30, 2027

BASIC LIFE, SUPPLEMENTAL LIFE, BASIC AD&D, VOLUNTARY AD&D, & DEPENDENT LIFE INSURANCE			
Coverage Type	**Cost**		
Basic Term Life Insurance 1x Annual salary rounded to the next higher $1,000 ($10,000 Minimum)	Calculation - Annual Salary (rounded to the next higher $1,000) divided by 1,000 x .099 x 12 divided by the number of deductions (20 or 26)		
Basic Accidental Death & Dismemberment (AD&D) 1x Annual salary rounded to the next higher $1,000	Calculation - Annual Salary (rounded to the next higher $1,000) divided by the number of deductions (20 or 26) divided by 1,000 x .016 x 12		
Supplemental Life Insurance 1x, 2x, or 3x annual base salary rounded to the next higher $1,000	Cost is .234 per thousand per month Calculation - Annual salary (rounded to the next higher $1,000) divided by 1,000 x .234 x 12 divided by the number of deductions (20 or 26)		
Dependent Life Insurance Spouse $10,000 Child(ren) $5,000	26 Deductions $1.36	20 Deductions $1.77	Monthly Rate $2.95
Voluntary Accidental Death & Dismemberment (VADD) Coverage of $50,000, $100,000 or $200,000	12 month pay 26 Deductions	10 month pay 20 Deductions	 Monthly Rate
$50,000	$0.46	$0.60	$1.00
$100,000	$0.92	$1.20	$2.00
$200,000	$1.85	$2.40	$4.00

EMPLOYEES WORKING 15-19 HOURS WEEKLY

Medical/prescriptions premiums will not be payroll deducted. Employees will be billed separately for medical/rx premiums on a monthly basis.

Dental and vision premiums will be payroll deducted.

* All rates may vary slightly due to system rounding.

Contact List

Benefits

www.wcpsmd.com/benefits

benefits@wcps.k12.md.us

301-766-2810

Human Resources

hr@wcps.k12.md.us

301-766-2807

Payroll

payroll@wcps.k12.md.us

Technology Help Desk

*call for IT/Login issues

helpdesk@wcps.k12.md.us

301-766-8911







CONTACT INFORMATION

Resource / Service Provider	Contact	Details
Medical & Prescription (Cigna)	www.cigna.com 1-800-564-7642 (before enrolled) 1-800-244-6224 (after enrolled)	In and Out of Network Plan In Network Only Plan
Dental (United Concordia)	www.ucci.com 1-866-851-7568	PPO
Vision (EyeMed)	www.eyemed.com 1-866-804-0982	PPO
Life Insurance	www.wcpsmd.com/departments/benefits/life-insurance	Basic Life, Basic AD&D, Supplemental Life, Voluntary AD&D, Dependent Life
Long Term Disability	www.wcpsmd.com/departments/benefits/long-term-disability	Long Term Disability
Flexible Spending Account (FSA) (Flexible Benefit Administrators)	https://fba.wealthcareportal.com/Page/Home 1-800-437-3539	Medical Account, Dependent Care Account
Retirement Plan (Maryland State Retirement Agency)	http://www.sra.state.md.us/ 1-800-492-5909	Teacher Pension Plan Employee Pension Plan
Supplemental Retirement Plan (Equitable, MetLife, PlanMember Services, Voya)	Coordinate through TSA Consulting Group www.tsacg.com 1-888-796-3786	403(b) 457(b)
Employee Assistance Program **AllOne Health**	http://wcpsmd.com/benefits/employee-assistance-program-eap	Free to employee and eligible dependents.





LEGAL NOTICES

Patient Protections Disclosure

The Washington County Public Schools Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna at 1-800-244-6224 (after enrolled) / 1-800-564-7642 (before enrolled) or www.cigna.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna at 1-800-244-6224 (after enrolled) / 1-800-564-7642 (before enrolled) or www.cigna.com.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Cigna In and Out of Network Plan (Individual: 100% coinsurance and $200 deductible; Family: 100% coinsurance and $400 deductible)

Plan 2: Cigna In Network Only (Individual: 100% coinsurance and $100 deductible; Family: 100% coinsurance and $200 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 301-766-8991 or boyerkat@wcps.k12.md.us.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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, 2026. 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, 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 4/30/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Washington County Public Schools is committed to the privacy of your health information. The administrators of the Washington County Public Schools Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kathleen Boyer - Coordinator of Human Resources: Employee Benefits at 301-766-8991 or boyerkat@wcps.k12.md.us.

HIPAA Special Enrollment Rights

Washington County Public Schools Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Washington County Public Schools Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kathleen Boyer - Coordinator of Human Resources: Employee Benefits at 301-766-8991 or boyerkat@wcps.k12.md.us.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Washington County Public Schools

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Washington County Public Schools coverage may be affected.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Washington County Public Schools 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 01, 2026**
Name of Entity/Sender:	**Washington County Public Schools**
Contact—Position/Office:	**Kathleen Boyer - Coordinator of Human Resources: Employee Benefits**
Office Address:	**10435 Downsville Pike**
	Hagerstown, Maryland 21740-1732
	United States
Phone Number:	**301-766-8991**

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

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

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Washington County Public Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

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

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

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[1] 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

Washington County Public Schools
Kathleen Boyer - Coordinator of Human Resources: Employee Benefits
10435 Downsville Pike
Hagerstown, Maryland 21740-1732
United States
301-766-8991

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 Kathleen Boyer.

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 Washington County Public Schools		4. Employer Identification Number (EIN) Available upon request
5. Employer address 10435 Downsville Pike		6. Employer phone number 301-766-8991
7. City Hagerstown	8. State Maryland	9. ZIP code 21740-1732
10. Who can we contact about employee health coverage at this job? Kathleen Boyer		
11. Phone number (if different from above)	12. Email address boyerkat@wcps.k12.md.us	

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

- As your employer, we offer a health plan to:

❑ All employees. Eligible employees are:

☑ Some employees. Eligible employees are: Full Time working 30 hrs or more, Part Time working 15 hrs

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are: spouse and dependent children

❑ We do not offer coverage.

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

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

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

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



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