HOUSING AUTHORITY of BALTIMORE CITY

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2021 Retiree Benefits Guide

Contact Information – HABC Retiree Benefits Program			
Name	For Questions About...	Phone	Website/Email
HABC – Human Resources	▪ Enrollment ▪ Eligibility for benefits ▪ Family status changes ▪ General benefits questions & information	410-396-3251	email: Benefits@habc.org
Medical Plans			
Kaiser Permanente	▪ Kaiser Permanente Health Maintenance Organization (HMO) Select ▪ Kaiser Permanente Medicare Advantage	800-777-7902 (Baltimore area) 301-468-6000 (D.C. metro area)	www.kp.org
CareFirst	▪ CareFirst BlueChoice Opt Out Plus Open Access POS ▪ CareFirst Standard Medicare Complementary	833-824-8643	www.CareFirst.com
Dental Plans			
CareFirst	CareFirst BlueDHMO (Dental Health Maintenance Organization)	844-495-0653 or 410-847-9060 (8:30 am – 5 pm)	www.CareFirst.com
CareFirst	CareFirst Regional Preferred Dental (PPO)	866-891-2802	www.CareFirst.com
Vision Plan			
CareFirst	CareFirst/Davis Vision	800-783-5602	www.CareFirst.com
For questions about prescription coverage, contact your medical plan listed above.			

Your Benefit Plan Options			
	For Retirees *Without* Medicare	**For Retirees *With* Medicare Parts A & B**	
		But *Without* Separately Purchased Part D Prescription Drug Coverage	**And *With* Part D Prescription Drug Coverage**
Medical	▪ Kaiser Permanente HMO Select *(with Rx coverage)* ▪ CareFirst BlueChoice Opt Out Plus Open Access POS *(with Rx coverage)*	▪ CareFirst Standard Medicare Complementary *(with Rx coverage)* ▪ CareFirst BlueChoice Opt Out Plus Open Access POS with Medicare *(with Rx coverage)*	▪ CareFirst Standard Medicare Complementary *(assumes you buy Part D Rx coverage separately)* ▪ CareFirst BlueChoice Opt Out Plus Open Access POS with Medicare (*assumes you buy Part D Rx coverage separately)* ▪ Kaiser Medicare Advantage *(automatically includes Part D Rx coverage)*
Dental	▪ CareFirst BlueDHMO ▪ CareFirst Regional Preferred Dental (PPO)		
Vision	CareFirst/Davis Vision		

Open Enrollment FAQs	
When is Open Enrollment?	▪ Open Enrollment for the 2021 plan year will be held February 22 – March 12, 2021.
Will Benefits Fairs be held this year?	▪ No. Due to COVID-19, we will not hold the Benefits Fairs, or Open Enrollment meetings, this year. For information about your benefits or help with enrolling, call Human Resources at 410-396-3251, or email benefits@habc.org.
What do I need to do?	▪ Read this benefits guide and other available enrollment materials. ▪ Review/choose the plans you want for yourself and your eligible dependents. ▪ Review/choose the Primary Care Physician(s) for yourself and your eligible dependents if you enroll in an HMO or a POS plan. ▪ **If you are <u>not</u> changing your plan, level of coverage, or dependents covered**, you do not have to fill out an enrollment form. ▪ **If you <u>are</u> changing your plan, level of coverage, or dependents covered,** fill out your enrollment form and return it to Human Resources by March 12, 2021.
How do I enroll?	Complete an enrollment form and return it to Human Resources by March 12, 2021. The enrollment form is enclosed with this guide. If you need a new form, call HABC's Human Resources Department at 410-396-3251 or email benefits@habc.org.
Who do I contact if I have questions?	Call Human Resources at 410-396-3251, or email benefits@habc.org.

TABLE OF CONTENTS

Welcome

Welcome to HABC's retiree health benefits program! This program gives you access to quality medical, dental, and vision coverage ***at prices that you and HABC can afford.***

Same Plan Options for 2021

We are pleased to report your choice of plans will remain the same for the 2021 plan year (April 1, 2021 - March 31, 2022) with no significant changes. As with most years, there will be a few changes to certain copays.

Also, some of the monthly rates you pay for coverage will change. See page 3 for the rates effective April 1, 2021.

You do not need to enroll unless you want to make a change to your benefit elections for the new plan year.

Read through this guide to learn more about the benefits available for the 2021 plan year. As always, if you have questions, feel free to email **benefits@HABC.org** or call Human Resources at **410-396-3251**. Or, contact the plans directly (see the front of this guide for contact information).

How to Use This Benefits Guide

This guide gives an overview of the different benefit plans available to you. For all of the plans, we've included benefit comparison charts, which highlight some of the benefits provided in each plan. At the end of the Medical section, you'll also see "Choosing a Medical Plan," which lists some factors you may want to consider when choosing a plan for yourself and your family.

Use this guide to help you enroll in and learn about your health care benefits. We encourage you to read it carefully, along with other benefits information you receive from HABC and our insurance carriers. You can also access Open Enrollment materials on the HABC website, www.habc.org.

Health care benefits are very important for you and your family, so take some time to learn about the different options that HABC offers.

This guide is intended for HABC retirees who would like to enroll in or make changes to their benefits for the upcoming plan year (April 1, 2021 - March 31, 2022). This is your once-a-year opportunity to make changes to your benefit elections, unless you experience a qualified family status change (see page 6 for more information).

Who Is Eligible

You are eligible for health care coverage as a retiree if you are at least 55 years old with 10 years of service.

Your eligible dependents for health care benefits include:

- Your spouse; and
- Your unmarried dependent child(ren):
  - Up to age 26, regardless of student status; or
  - Over age 26 if mentally or physically disabled, as long as you provide proof that the disability began within 31 days after the dependent reached age 26.

If you are adding a dependent(s) to your coverage, you will need to provide a copy of the dependent's birth certificate (for children), marriage certificate (for spouse), and Social Security cards (or a copy or photo of the cards) for all dependents being added. Based on your dependent's relationship to you, you may also need to provide a copy of a custody agreement, decree of adoption, or guardianship order.

Your Cost for Benefits

You and HABC share the cost of your benefits. HABC will bill you on a monthly basis for your share of the cost (the premium). See the following tables for your monthly benefit plan rates effective April 1, 2021.

Note: In addition to your monthly premium, you may need to pay a portion of your medical expenses through copays, coinsurance amounts, and amounts over what your plan allows if you go out of network (see pages 15 – 19 for more information).

Are you a single parent covering more than one child?

If you select Kaiser, you can enroll in the Parent & One Child category. However, if you select CareFirst, you need to enroll in the Family category if you are covering more than one child.

Your 2021 Monthly Benefit Plan Rates (Effective April 1, 2021)

Retirees ***Without*** Medicare

	Individual	Parent & One Child*	Employee & One Adult	Family
Medical Plans with Carrier Prescription Drug Coverage				
Kaiser Permanente HMO Select	$394.82	$750.11	$829.12	$1,184.45
CareFirst – Blue Choice POS	$528.46	$1,004.09	$1,215.47	$1,585.39
Dental Plans				
CareFirst BlueDHMO	$6.86	$13.21	$13.21	$19.23
CareFirst Dental PPO	$11.19	$21.26	$25.76	$31.34
Vision Plan				
CareFirst/Davis Vision	$0	$0	$0	$0

**Kaiser Permanente allows multiple children in the Parent & One Child category. CareFirst requires a parent with more than one child to enroll in the Family category.*

Continued on next page.

Your 2021 Monthly Benefit Plan Rates, continued

Medical Coverage for Retirees ***With*** Medicare Parts A & B but ***Without*** Separately Purchased Part D Prescription Drug Coverage

	Individual	Parent & One Child	Employee & One Adult	Family
Medical Plans with Carrier Prescription Drug Coverage				
CareFirst – Blue Choice POS with Medicare	$146.18	N/A	$292.36	N/A
CareFirst Standard Medicare Complementary *(with Carrier Rx)*	$204.81	N/A	$409.62	N/A

Medical Coverage for Retirees ***With*** Medicare Parts A & B and ***With*** Part D Prescription Drug Coverage

	Individual	Parent & One Child	Employee & One Adult	Family
Medical Plans				
CareFirst BlueChoice POS with Medicare *(assumes you buy Part D Rx coverage separately)*	$28.11	N/A	$56.22	N/A
CareFirst Standard Medicare Complementary *(assumes you buy Part D Rx coverage separately)*	$81.63	N/A	$163.26	N/A
Kaiser Medicare Advantage* *(automatically includes Part D Rx coverage)*	$59.46	N/A	$118.92	N/A

**Rate subject to change each year on January 1.*

Dental and Vision Coverage for all Medicare Retirees

	Individual	Parent & One Child*	Employee & One Adult	Family
Dental Plans				
CareFirst BlueDHMO	$2.59	$4.99	$4.99	$7.26
CareFirst Dental PPO	$4.22	$8.02	$9.72	$11.83
Vision Plan				
CareFirst/Davis Vision	$0	$0	$0	$0

**Kaiser Permanente allows multiple children in the Parent & One Child category. CareFirst requires a parent with more than one child to enroll in the Family category.*

Note: Vision coverage is provided to all retirees and their eligible dependents through CareFirst/Davis Vision at no cost to you.

Annual Open Enrollment

Due to COVID-19, we will *NOT* hold Open Enrollment Benefit Fairs this year.

If you need help with enrollment or have questions, please contact Human Resources at benefits@habc.org or 410-396-3251.

Every year, HABC holds an Open Enrollment period during which eligible retirees may enroll in or make changes to their health care benefits. HABC announces the Open Enrollment dates in advance and distributes information to help you make the right decision about benefits for you and your family.

Typically, HABC holds a series of Benefits Fairs during the Open Enrollment period. However, **this year, due to COVID-19, we will not hold the Benefits Fairs.** For information about your benefits, please review this guide. For questions or help with enrolling, call Human Resources at 410-396-3251, or email benefits@habc.org. You may also call the insurance companies directly (see the front of this guide for contact information).

If you do not want to make a change for 2021, you do not need to enroll. Your current benefits will automatically remain in place with any applicable changes to monthly premiums, copays, coinsurance, etc., for the new plan year.

IMPORTANT

If you are enrolling for new benefits or changing your coverage level, you must complete an enrollment form and submit it to Human Resources.

Enrollment Form

If you wish to enroll for or make changes to your benefits, you need to fill out an enrollment form and submit it to:

HABC Human Resources
Benton Building
417 East Fayette Street, Suite 940
Baltimore, Maryland 21202

Your enrollment form is enclosed with this guide. If you need another form, please contact Human Resources at 410-396-3251.

Completed forms are due before the last day of the Open Enrollment period (March 12, 2021).

For qualified family status changes, completed forms are due within 30 days of the change.

Changing Your Benefit Elections

Once you enroll for your benefits, they stay in effect for the entire plan year (April 1 – March 31). However, you may change your coverage level at any time during the year if you have a qualified family status change and you submit the appropriate forms within 30 days of the family status change.

Some examples of qualified family status changes include:

- Getting married or divorced;
- Having a baby;
- Adopting a child;
- A death in your immediate family that affects your coverage; or
- Gaining or losing benefits because of a change in your spouse's employment.

If you experience a qualified family status change, you must notify Human Resources within 30 days from the date the change took place.

Questions?

If you have questions, please call Human Resources at 410-396-3251.

Your Medical Options

Under the HABC benefits program, you can choose from the following medical plans:

If You are Under Age 65

- Kaiser Permanente HMO Select
- CareFirst BlueChoice Opt Out Plus Open Access POS

If You are Age 65 or Over or have Medicare

- Kaiser Permanente Medicare Advantage
- CareFirst BlueChoice Opt Out Plus Open Access POS
- CareFirst Standard Medicare Complementary Plan

Be Well!

Free Preventive Care in All Plans

All of HABC's medical plan options offer preventive care benefits – such as routine physicals, well-child care, and routine OB/GYN care – ***at no cost*** when you coordinate care through your Primary Care Physician (PCP).

Free Wellness Resources

All of our medical plans also offer a wealth of online wellness information and tools, including health assessments. Visit www.CareFirst.com (CareFirst) or www.kp.org (Kaiser) for more information.

About HMOs

Some people prefer HMOs because most services are covered in full, or only require a small copay. With an HMO, you select a Primary Care Physician (PCP) who will provide most of your care and refer you to a specialist when needed. If you always have your PCP coordinate your care, there are usually no deductibles to meet, and little to no other out-of-pocket costs. To enjoy the ease and low cost of an HMO, ***your PCP must coordinate your care; otherwise, there is no coverage***.

PCPs can be family practitioners, general practitioners, internists, or pediatricians. You can choose a different PCP for each member of your family.

About Point-Of-Service Plans

A POS plan gives you two ways to receive health care services — in-network or out-of-network. ***Each time*** you need care, you decide where you want to receive it. You can go to your PCP or other in-network providers and keep your costs as low as possible. Or, you can go to out-of-network providers and pay more out of your pocket.

Your Medical Plan Options if You are Under Age 65

If you are under age 65, you have two medical plan options:

- Kaiser Permanente HMO Select, and
- CareFirst BlueChoice Opt Out Plus Open Access POS.

Kaiser Permanente HMO Select

With Kaiser Permanente HMO Select, **you select a Primary Care Physician (PCP) who will provide most of your care and refer you to specialists when needed.** If you always use your PCP to coordinate your care, there are usually no deductibles to meet, and little or no other out-of-pocket costs. You pay a $10 copay for doctor's office visits. Preventive care, including physical exams, routine OB/GYN care, and well-child care, is covered in full.

PCPs can be family practitioners, general practitioners, internists, or pediatricians. You may choose a different PCP for each member of your family.

To Find a Kaiser Select Provider:

1. Go to: kp.org
2. Click on "Doctors and Locations"
3. Under Search Type select "Doctors" or "Locations"
4. Under Region select "Maryland/ Virginia/ Washington D.C."
5. **If you are already a Kaiser Permanente member**, select either:
   - "Members: choose Kaiser Permanente physicians" or
   - "Members: choose affiliate or network physicians"

   Note: you must sign in to choose your doctor.

   If you are not a Kaiser Permanente member, select either:
   - "Meet Kaiser Permanente primary care physicians, obstetrician/ gynecologists, or specialists" or
   - "Search our affiliated and network physicians/provider"

   You can find doctors by specialty and/or location.

The Kaiser HMO Select Plan offers you choice in where you receive care. You can get:

- Exclusive, member-only care at any of the 34 Kaiser medical centers, or
- Care from the Kaiser Select Network of private practice community providers, all located outside of Kaiser Centers. There are 12,000 of these providers in the mid-Atlantic region.

When you choose private practice providers from the Kaiser Select Network, talk with them about how their healthcare team is organized to support your care. Remember that you can still go to Kaiser Permanente medical centers for urgent care, prescriptions, lab tests, and more. Please refer to the Select Physician Directory or visit kp.org/doctor for a list of Select Network primary care physicians, OB/GYNs, specialists, and hospitals.

For information about the Kaiser HMO Select Plan, go to kp.org. Or, you can call Kaiser Customer Service toll-free at 800-777-7902 in the Baltimore area or 301-468-6000 for the D.C. Metro area.

Note: In the Kaiser Permanente HMO Select Plan, single parents with more than one child are covered under the Parent-Child rate.

Video Visit

With Kaiser's Video Visit, you can meet with a doctor face-to-face from almost anywhere using your smartphone or computer. Call 1-800-777-7904 (TTY 711) at any time to make an appointment. Appointments are often available the same day or the next day. You can receive care for minor health conditions, such as coughs, colds, skin infections, and sleep problems and receive medication refills. There is no cost for Video Visits with Kaiser doctors. For technical support, call 1-844-800-0824, Monday through Friday, 8:30 a.m. to 5:30 p.m. EST.

Email Your Doctor

You can send your doctor's office a non-urgent question at any time. Go to Kaiser's secure Message Center or use the Kaiser Permanente app. You'll typically get a reply within two business days. Email is appropriate for non-urgent medical advice and follow-up care. There is no additional cost for emailing your doctor.

Try yoga, cardio, and bootcamp – at home

Kaiser members get a special rate on ClassPass to make it easier for you to exercise at home. With ClassPass you get:

- On-demand video workouts at no cost
- Reduced rates on livestream and in-person fitness classes

Get started at kp.org/exercise

Feeling Overwhelmed?

Adult Kaiser members can download two popular apps – Calm and myStrength – at no cost. These apps can help you:

- Manage depression,
- Reduce stress,
- Improve sleep,
- And more!

Get started at kp.org/selfcareapps

CareFirst BlueChoice Opt Out Plus Open Access POS

The BlueChoice Opt Out Plus Open Access POS Plan, administered by CareFirst, gives you two ways to receive health care services — in-network and out-of-network. ***Each time*** you need care, you decide where you want to receive it. You can go to any in-network provider and keep your costs as low as possible. Or, you can go to an out-of-network provider and pay more out of your pocket.

The plan's network has over 40,000 participating PCPs, nurse practitioners, specialists, hospitals, pharmacies, and diagnostic centers in the mid-Atlantic region.

Patient-Centered Medical Home

Did you know that, as a CareFirst member, you have access to a Patient-Centered Medical Home (PCMH) program? The PCMH program provides your PCP with a more complete view of your health needs to ensure you get access to, and receive, the most appropriate care in the most affordable settings.

While the POS Plan ***does*** require you to select a primary care physician, ***you do not need referrals from your PCP***; you can go directly to any in-network provider and you will receive the in-network level of benefits. However, establishing a relationship with one doctor is the best way to receive consistent, quality healthcare. Your PCP provides routine and preventive care, maintains your personal medical history, pre-authorizes your treatment for certain conditions and facility services when necessary, and files claims for you.

To find a PCP or to see if your doctor is in-network, go to www.CareFirst.com and select "Find a Doctor." The Member Services Department is available toll-free by calling 833-824-8643 from 8 a.m. to 9 p.m. EST Monday through Friday to assist you with questions.

You can also obtain personalized information regarding your health insurance coverage online. Visit www.CareFirst.com and click on "Log In or Register." Following a brief registration process, you will have details on your claims, benefits, eligibility, and out-of- pocket costs – right at your fingertips. You can access CareFirst on the go with their mobile app, which you can download from www.CareFirst.com or from an app store.

If You Go In-Network

If you use in-network providers, the plan covers most services at 100%, after a $10 PCP copay or a $15 specialist copay.

If You Go Out-of-Network

If you receive care from an out-of-network provider, you'll have to pay a deductible of $300 per person (maximum of $600 per family) per calendar year before the plan begins paying benefits. Then, the plan generally pays 80% of the allowed benefit, and you pay the remaining 20%. The amount the plan pays may be based on the usual and customary rate that is typically charged for a given service by the providers in your area. Note that when you go out of network, the provider can bill you for any uncovered balance.

For information on prescription drug benefits, see the Prescription Drug Benefits section on page 21 of this guide.

Video Visits

CareFirst Video Visit securely connects you with a board-certified doctor, day or night, through your smartphone, tablet, or computer. You can use video visits for urgent care or schedule appointments for other services. Note that video visits are for treating non-emergency issues.

Register Now!
Register for Video Visit today so you'll have it when you need it! Visit carefirstvideovisit.com or download the CareFirst Video Visit app from your favorite app store.

Your Medical Plan Options if You are Age 65 or Over or Have Medicare

When you become eligible for Medicare, you have three options to choose from:

- CareFirst Standard Medicare Complementary Plan,
- CareFirst BlueChoice Opt Out Plus Open Access POS, and
- Kaiser Permanente Medicare Advantage HMO.

Medicare Always Pays First

If you are retired and enrolled in Medicare Parts A and B, your HABC medical plan will coordinate with Medicare. Regardless of which medical plan you are in, Medicare will pay benefits first and your HABC plan will pay second.

The following pages give an overview of your options.

CareFirst Standard Medicare Complementary Plan

HABC offers a Standard Over 65 Medicare Complementary Plan through CareFirst BlueCross BlueShield, which includes prescription drug coverage. This CareFirst plan coordinates with Medicare to provide benefits. Medicare pays benefits first. Then, the plan pays a portion of your expenses after you first meet the deductible, as long as your doctor accepts Medicare coverage. The Member Services Department is available toll-free by calling 833-824-8643.

The CareFirst plan gives you the option to receive care from a CareFirst participating provider or a non-participating provider. Most doctors and hospitals in the area participate in CareFirst. But, you receive benefits even if you use a non-participating provider.

The plan usually covers 80% of the allowed charge for a service, after you first meet the Medicare Part B annual deductible of $203 per individual (2021). How the plan works, though, depends on whether you receive care from a CareFirst participating provider or a non-participating provider.

CareFirst Standard Medicare Complementary Plan

If you receive care from a CareFirst participating provider…	**If you receive care from a non-participating provider…**
• You must first meet the (2021) $203 annual Medicare Part B deductible* (per individual) before the plan begins paying benefits; • You pay the coinsurance or copay; • Your claims are filed for you; and • Your provider is paid directly by CareFirst.	• You must first meet the (2021) $203 annual Medicare Part B deductible* (per individual) before the plan begins paying benefits; • You ***may*** have to pay all expenses when you receive care and be reimbursed later by the plan; • You must file your claims on a timely basis; and • CareFirst reimburses you—not your provider—for a portion of the covered expenses. You are responsible for all costs above CareFirst's payment.

**Note the 2021 Part A hospital deductible is $1,484 for each benefit period*

Kaiser Medicare Advantage

The Kaiser Medicare Advantage Plan was developed to coordinate with Medicare. It includes prescription drug coverage and is virtually identical to the under 65 Kaiser HMO option. The main difference is that Kaiser Medicare Advantage members must use Kaiser medical centers for Kaiser Permanente to cover the care. The community network is not available if you are eligible for Medicare. However, with this plan, you may use your red, white, and blue Medicare card to see any Medicare provider without referrals. If you do, you will be responsible for the Medicare deductible and coinsurance after the provider files directly to Medicare.

Kaiser Medicare Advantage is an integrated care plan with a Medicare Cost contract. It includes Medicare Part D prescription coverage. The best care and savings are realized by using the Kaiser Permanente medical centers and the physicians within the plan. For more details about the Kaiser HMO, see page 8.

CareFirst BlueChoice Opt Out Plus Open Access POS

The CareFirst BlueChoice Opt Out Plus Open Access POS Plan is virtually identical to the Under 65 option. The main difference is that the 65 and over plan will coordinate with Medicare. For more details about the CareFirst BlueChoice Opt Out Plus Open Access POS option, refer to page 10.

If you choose an HMO or POS plan, make sure you select a PCP who is a Medicare physician.

Here's how the coordination with Medicare works:

1. After you receive care, you or your provider submits a claim to Medicare.
2. Medicare pays its portion of the bill.
3. You or your provider then submits your claim to your HABC medical plan.
4. Your HABC medical plan pays its portion.
5. You pay any remaining balance.

Medical Plan At-a-Glance Charts

The following charts show benefits coverage for certain services under the plans. For a complete list of covered services, please contact the plan or HABC Human Resources.

Under 65 Options

Kaiser Permanente HMO Select *(available to retirees under 65)*	
Covered Services	**In-Network** (Kaiser Centers or community private practice providers that participate in the Kaiser network)
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum*	Individual: $3,500 Family: $9,400
Maximum Lifetime Benefits	Unlimited
Doctor's Sick Visit	100%, after $10 copay
Preventive Care	100%
Routine Physicals	100%
Routine OB/GYN Care	100%, all other care $10 copay
Inpatient Hospitalization (room, board, ancillary)	100%
Surgery	**Inpatient:** 100% **Outpatient:** 100%, after $10 copay
Outpatient Services	100%, after $10 copay
Diagnostic Testing, Lab, and X-ray	100%
Emergency Care	100%, after $50 copay
Inpatient Mental/ Nervous & Substance Abuse	100%; Unlimited number of days when deemed medically necessary and clinically appropriate by mental health practitioner
Outpatient Mental/ Nervous & Substance Abuse	Individual: $10 copay (no limit) Group: $5 copay (no limit)
Rehabilitation Therapy (physical, speech, occupational)	$10 copay per visit. Up to 30 visits per episode for each type of therapy.
Prescription Drugs** ***(See page 21 for more information.)***	**Kaiser Pharmacy** ***(up to a 60-day supply 1 copay; 90-day supply 1.5 copays):*** Generic/Tier 1: $10 copay Preferred Brand/Tier 2: $20 copay Non-Preferred Brand/Tier 3: $35 copay **Non-Kaiser Pharmacy** ***(up to a 60-day supply 1 copay; 90-day supply 1.5 copays):*** Generic/Tier 1: $20 copay Preferred Brand/Tier 2: $40 copay Non-Preferred Brand/Tier 3: $55 copay **Mail order maintenance drug** ***(60-day supply 1 copay; 90-day supply 1.5 copays):*** Generic/Tier 1: $10 copay Preferred Brand/Tier 2: $20 copay Non-Preferred Brand/Tier 3: $35 copay
Dental	N/A
Vision	Exam: $10 copay Frame and lenses: Ages 19+: $75 combined hardware allowance (1 pair/ year); up to age 19: no charge for 1 pair/year; Contacts (in lieu of glasses): $25 allowance per year (all ages)

** The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit. **Both of our medical plans include prescription drug coverage, so you don't need to enroll in a separate prescription drug plan. This chart provides highlights of the medical plans offered for the 2021 plan year. For more information, you may contact Human Resources for the Summaries of Benefits & Coverage (SBCs).*

Under 65 Options (continued)

CareFirst BlueChoice Opt Out Plus Open Access POS Plan *(available to retirees under or over 65)*		
Covered Services	**In-Network**	**Out-of-Network***
Calendar Year Deductible	None	Individual: $300 Family: $600
Calendar Year Out-of-Pocket Maximum**	Individual: $2,100 Family: $6,500	Individual: $2,000 Family: $4,000
	Note: Prescription drug copays count toward the pharmacy out-of-pocket maximum: Individual: $3,500; Family: $7,000	
Maximum Lifetime Benefits	Unlimited	Unlimited
Doctor's Sick Visit	$10 PCP copay/$15 specialist copay	80%, after deductible
Routine Physicals	100%	Not covered
Well-child Care	100%	80%, no deductible
Routine OB/GYN Care	100%	80%, after deductible
Inpatient Hospitalization* (room, board, ancillary)**	Covered in full	80%, after deductible
Surgery* **	**Inpatient**: Covered in full **Outpatient**: Covered in full	80%, after deductible
Outpatient Services	$10 PCP copay/$15 specialist copay	80%, after deductible
Diagnostic Testing	Covered in full	80%, after deductible
Emergency Care	100%, after $25 copay (waived if admitted)	Paid as in-network if a bonafide emergency
Inpatient Mental/Nervous & Substance Abuse* **	Covered in full	80%, after deductible
Outpatient Mental/Nervous & Substance Abuse	Facility Practitioner: Covered in full Private Practice: $10 copay	80% after deductible 80% after deductible
Rehabilitation Therapy	100% after $15 copay (up to 30 visits per condition per calendar year)	80% after deductible (up to 30 visits per condition per calendar year)
Prescription Drugs† ***(See page 21 for more information.)***	**Participating retail pharmacy (up to a 34-day supply):** • Generic/Tier 1: $10 • Preferred brand/Tier 2: $20 • Non-preferred brand/Tier 3: $35 • Preferred Specialty/Tier 4: you pay 50% up to $100 maximum • Non-preferred Specialty/Tier 5: you pay 50% up to $150 maximum **Mail order (90-day supply):** • Generic/Tier 1: $20 • Preferred brand/Tier 2: $40 • Non-preferred brand/Tier 3: $70 • Preferred Specialty/Tier 4: you pay 50% up to $200 maximum • Non-preferred Specialty/Tier 5: you pay 50% up to $300 maximum	**Non-participating pharmacy:** Member submits claim to CVS Caremark, which is reimbursed at the average wholesale price (AWP). Member is responsible for copay and any charges over AWP (no deductible).
	Prescription drug copays count toward the pharmacy out-of-pocket maximum: Individual: $3,500; Family: $7,000	

Coverage for out-of-network care is based on the usual and customary fee for a particular service. You may be billed for any uncovered balance if you go out of network. The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit.***Services at an inpatient facility require pre-authorization. †Both of our medical plans include prescription drug coverage, so you don't need to enroll in a separate prescription drug plan. This chart provides highlights of the medical plans offered for the 2021 plan year. For more information, you may contact Human Resources for the Summaries of Benefits & Coverage (SBCs).*

Over 65 Options

	Medicare Parts A and B	CareFirst Standard Medicare Complimentary *(only available to retirees over 65)*
Covered Services	**These two plans coordinate together to provide benefits**	
Calendar Year Deductible	Part A: See "Inpatient Hospital," below Part B: $203 per person (for 2021)	$100
Calendar Year Out-of-Pocket Limit	Varies per service	N/A
Lifetime Maximum	Varies per service	Unlimited
Doctor's Office Visit	Pays 80% of approved amount, after Part B deductible	Pays 80% of Medicare Part B deductible and coinsurance after deductible
Preventive Care (mammograms)	Pays 80% of approved amount, after Part B deductible	Pays 100% of Medicare Part B deductible and coinsurance after deductible
Preventive Care (prostate cancer screening)	Pays 80% of approved amount for men over age 50, after Part B deductible	Pays 80% of Medicare Part B deductible and coinsurance after deductible
Routine Physicals	If your Medicare Part B coverage began after 1/1/05, Medicare pays 100% after deductible for a one-time exam within the first six months you have Part B	Pays 100% of deductible and coinsurance up to $100 maximum per exam
Routine GYN care	Pays 80% of approved amount every 3 years or annually for women at high risk for cervical cancer. Part B deductible waived	Pays 100% of Medicare coinsurance
Inpatient Hospital (including Inpatient Mental/Nervous and Substance Abuse; covers room, board, and ancillary services)	• Pays 100% after $1,484 Part A deductible for days 1-60 • Pays 100%, after $371 per day Part A coinsurance for days 61-90 • Pays 100%, after $742 per day Part A coinsurance for days 91-150	Pays 100% of Medicare Part A deductible and coinsurance for Medicare-provided stay Pays 80% for other inpatient services including days in excess of Medicare day maximums
Outpatient Services	Pays 80% of approved amount, after Part B deductible	Pays 100% of Medicare Part B deductible and coinsurance
Diagnostic Testing	Pays 80% of approved amount, after Part B deductible	Pays 80% of Medicare Part B deductible and coinsurance after deductible

Over 65 Options (continued)

	Medicare Parts A and B	CareFirst Standard Medicare Complimentary *(only available to retirees over 65)*
Emergency Care	Pays 80% of approved amount, after Part B deductible	Pays 100% of Medicare Part B deductible and coinsurance for services received within 72 hours of accident/injury Pays 80% of Medicare Part B deductible and coinsurance after 72 hours after deductible
Outpatient Mental/Nervous & Substance Abuse	Pays 80% of approved amount, after Part B deductible	Pays 80% of Part B deductible and coinsurance after deductible
Rehabilitation Therapy	Pays 80% of approved amount, after Part B deductible	Pays 100% of Medicare Part B deductible and coinsurance
Prescription Drugs ***(See page 21 for more information.)***	Not covered, unless you enroll separately in a Medicare prescription drug plan	**At a participating pharmacy (30-day supply):** • Generic/Tier 1: $10 copay • Preferred brand-name/Tier 2: $20 copay • Non-preferred brand-name/Tier 3: $35 copay • Preferred Specialty/Tier 4: you pay 50% up to $100 maximum • Non-preferred Specialty/Tier 5: you pay 50% up to $150 maximum **At a non-participating pharmacy:** Member submits claim to CVS Caremark, which is reimbursed at the average wholesale price (AWP). Member is responsible for copay and any charges over AWP (no deductible). **At a mail order pharmacy (90-day supply):** • Generic/Tier 1: $20 copay • Preferred brand-name/Tier 2: $40 copay • Non-preferred brand-name/Tier 3: $70 copay • Preferred Specialty/ Tier 4: you pay 50% up to $200 maximum • Non-preferred Specialty/Tier 5: you pay 50% up to $300 maximum ***Prescription drug copays count toward the pharmacy out-of-pocket maximum:*** Individual: $3,500 Family: $7,000

Over 65 Options (continued)

Kaiser Permanente Medicare Advantage HMO *(only available to retirees over 65)*	
This plan coordinates with Medicare	
Covered Services	**In-Network (Kaiser Centers)**
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum	Individual: $3,400
Maximum Lifetime Benefits	Unlimited
Doctor's Sick Visit	100%, after $10 copay
Medicare Covered Preventive Care	100%
Routine Physicals	100%
Routine OB/GYN Care	100%
Inpatient Hospitalization (room, board, and ancillary services)	100%
Surgery	**Inpatient:** 100% **Outpatient:** 100%; office visit copay may apply
Outpatient Services	100%, after $10 copay
Diagnostic Testing	100% (including laboratory services, X-rays, CAT, PET, and MRI scans)
Emergency Care	100%, after $50 copay
Inpatient Mental/Nervous & Substance Abuse	100%; Unlimited number of days when deemed medically necessary and clinically appropriate by mental health practitioner
Outpatient Mental/Nervous & Substance Abuse	$10 copay (no limit)
Rehabilitation Therapy (physical, speech, occupational)	$10 copay
Prescription Drugs *(See page 21 for more information.)*	**At a Kaiser pharmacy (up to a 60-day supply)** Generic or Brand-name: $10 copay **Non-Kaiser pharmacy (up to a 60-day supply)** Generic or Brand-name: $15 copay **Mail order pharmacy (90-day supply)** Generic or Brand-name: $5 copay
Dental	Kaiser enhanced plan (see schedule of benefits, available from Human Resources)
Vision	$10 copay Vision hardware discounts: $100 allowance towards glasses, frames, lenses, or contacts at Kaiser Permanente vision centers (no age restrictions)

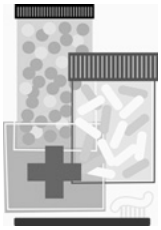
Choosing a Medical Plan

Because no one plan is right for everyone, HABC offers you a choice of medical plans. You may want to choose a plan because it has low premiums, because it offers specific coverage you'd like, or because your doctor is in the network. Different people have different preferences and needs. Below are some questions you may want to ask yourself to help you decide which plan is right for you and your family:

- How important is your relationship with your current doctor? In which plan's network does he or she participate?
- Is there something you like about a plan that outweighs having to choose a new doctor from a network?
- What is your overall health? Do you expect any major medical bills next year?
- Are the plan's doctors and hospitals close to where you live or work?
- Do you need to lower your out-of-pocket costs for health care? Look at both the monthly premiums and the amounts you pay when you receive care (copays, deductibles, etc.).
- Which plan offers the most flexibility to meet your needs?

Wellness Resources: Each of the medical plans offers resources and tips to help you and your family get healthy and stay healthy. Refer to your medical plan information for more details. Websites for the medical plans are listed on the inside front cover of this guide.

Your Prescription Drug Benefits



HABC does not offer a "stand-alone" prescription drug plan option. Your prescription drug benefits depend on whether you are eligible for Medicare and which medical plan you enroll in.

- **If you are *not* yet eligible for Medicare**, you will receive prescription drug benefits through the HABC medical plan that you enroll in.
- **If you *are* eligible for Medicare**, prescription drug coverage through your HABC medical plan depends on whether you enroll in a separate Medicare Part D prescription drug plan.
  - If you do *not* enroll in a separate Medicare Part D prescription drug plan, your HABC plan *will* include prescription drug coverage.
  - **If you *do* enroll in a separate Medicare Part D prescription drug plan, your HABC plan will *not* include prescription drug coverage.** The only exception to this is the Kaiser Medicare Advantage plan, because that plan includes Medicare Part D drug benefits.

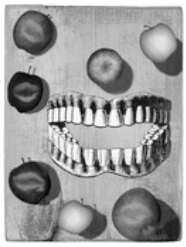
See the "Medical Plan At-a-Glance Charts" beginning on page 15 for the prescription drug benefits and copays in each plan.

How Your Prescription Drug Benefits Work

Your copays for prescription drug benefits depend on which type of drug you receive and which medical plan you are in. The chart below describes the different types of drugs—generic, preferred brand-name, non-preferred brand-name, and specialty drugs. **Each plan's formulary (list of covered drugs) is updated regularly and is subject to change.** If you have any questions about your plan's formulary list or your prescription drug coverage, please call the member services department of your health care provider.

Type of Prescription Drug	Description
Generic *(Sometimes known as Tier 1)*	Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts.
Preferred Brand-Name *(Sometimes known as Tier 2)*	A preferred brand-name drug is a commonly prescribed medication that has been selected based on its clinical effectiveness and safety. There may or may not be generic equivalents for some preferred brand-name drugs.
Non-Preferred Brand *(Sometimes known as Tier 3)*	A non-preferred brand-name drug has a higher copay than a preferred brand-name drug. There may or may not be generic or preferred brand-name equivalents for some non-preferred brand-name drugs.
Preferred Specialty Drugs *(Referred to as Tier 4 Drugs by CareFirst)*	Certain specialty drugs are covered by both the CareFirst plan and the Kaiser Permanente plan, but CareFirst separates these drugs into a separate category and you pay a percentage of the cost, rather than a specific copay.
Non-Preferred Specialty Drugs *(Referred to as Tier 5 Drugs by CareFirst)*	Certain specialty drugs are covered by both the CareFirst plan and the Kaiser Permanente plan, but CareFirst separates these drugs into a separate category and you pay a percentage of the cost, rather than a specific copay.

Your Dental Options



HABC offers two dental plan options to retirees and eligible dependents—the CareFirst Regional Preferred Dental (PPO) and the CareFirst BlueDHMO. Both plans provide comprehensive dental coverage at an affordable cost, but there are some differences in the plans.

The CareFirst Regional Preferred Dental (PPO) Plan will cost you more than CareFirst BlueDHMO Plan, but the PPO has a larger network of providers, and also allows you to go out-of-network if you wish. Note that, with the PPO, you will receive a higher benefit by using in-network providers.

Your options:

- CareFirst BlueDHMO
- CareFirst Regional Preferred Dental (PPO)

CareFirst BlueDHMO

With the DHMO, ***you must select and receive care from an in-network dentist in order to receive any benefits.*** Refer to your CareFirst Blue ID Card for your selected Participating General Dentist. When you use an in-network dentist, you will pay a $0 copay for diagnostic, preventive, and some restorative care (like fillings). Other covered services are paid according to the Schedule of Benefits and Member Copayments, available from Human Resources. Some of the common copays are shown on the next page.

CareFirst Regional Preferred Dental (PPO)

With the CareFirst Regional Preferred Dental (PPO), you may see any provider you choose. However, you will receive a higher benefit when you visit a participating provider. The plan covers preventive care in full when you see a participating provider or at 80% when you go out-of-network. Other covered services are paid according to the Schedule of Benefits and Member Copayments, available from Human Resources. See the chart on the following page for some of the common copays.

Dental Plan Comparison Chart

	CareFirst Blue DHMO	CareFirst Regional Preferred Dental PPO	
	In-Network Only (No out-of-network option)	**In-Network**	**Out-of-Network**
Calendar Year Deductible	None	$50 (individual) $100 (family)	$50 (individual) $100 (family)
Calendar Year Benefit Maximum	None	$1,500 annual dental maximum $1,500 orthodontic lifetime maximum	
Office Visits	Covered in full	Covered in full	20% of Allowed Benefit, after deductible
Exams	Covered in full	Covered in full	20% of Allowed Benefit, after deductible
2 Cleanings per year	Covered in full	Covered in full	20% of Allowed Benefit, after deductible
Topical Fluoride	Covered in full	Covered in full	20% of Allowed Benefit, after deductible
X-rays	Covered in full	Covered in full	20% of Allowed Benefit, after deductible
Fillings	$0 - $90 copay (depending on extent of repair needed)	20% of Allowed Benefit, after deductible	40% of Allowed Benefit, after deductible
Extractions	$25 - $140 copay	20% of Allowed Benefit, after deductible	50% of Allowed Benefit, after deductible
Periodontics	$40 - $415 copay	20% of Allowed Benefit, after deductible	50% of Allowed Benefit, after deductible
Root Canals	$250 - $390 copay	50% of Allowed Benefit, after deductible	50% of Allowed Benefit, after deductible
Oral Surgery	$25 - $330 copay	50% of Allowed Benefit, after deductible	50% of Allowed Benefit, after deductible
Crowns	$70 - $720 copay	50% of Allowed Benefit, after deductible	50% of Allowed Benefit, after deductible
Dentures & Partials	$160 - $390 copay	50% of Allowed Benefit, after deductible	50% of Allowed Benefit, after deductible
Orthodontics (Braces)	$3,000 copay	50% of Allowed Benefit *(under age 19 only)*	50% of Allowed Benefit *(under age 19 only)*

Your Vision Care Plan

HABC provides vision coverage to all retirees and their eligible dependents at no cost. Benefits are provided through CareFirst/Davis Vision.

The Vision Plan gives you two options for receiving vision care. If you visit an optical provider within the CareFirst/Davis Vision network, you'll receive the highest level of coverage. If you use a provider outside the network, you'll be reimbursed a fixed amount depending on the service you receive. You'll find that your costs are lowest when you use an optical provider within the CareFirst/Davis Vision network.

Be sure to show your provider the CareFirst/Davis Vision card so they don't assume you only have a discount program.

Where to Use Your CareFirst/Davis Vision Benefits

Your CareFirst/Davis Vision benefits are accepted at many area eye care providers. To find a provider near you, call **800-783-5602 or**:

- ✓ Visit www.CareFirst.com
- ✓ Click on "Providers & Facilities"
- ✓ Click on "Find a Doctor or Health Care Facility"
- ✓ Under "Find a Doctor or Health Care Facility" click on "Search Now"
- ✓ Click on "Continue as Guest" (or log in)
- ✓ Enter the zip code where you want to search; click "Continue"
- ✓ Click on "Select a network" and scroll down to select "BlueVision, BlueVision Plus, Pediatric Vision (Davis Vision); click "Continue"
- ✓ Under "Browse by Category," click on "Vision" and select the type of provider/facility you are looking for, or, in the search bar, type in the name of a vision provider or the specialty you are looking for.

If You Go In-Network – CareFirst/Davis Vision

You receive the following vision benefits if you visit an in-network provider:

- Eye exams, lenses, and selected frames are covered in full every 12 months, regardless of your age.
- Contact lenses in lieu of lenses and frames. CareFirst/Davis Vision offers a wide variety of covered contact lenses, including four covered boxes of disposables when obtained from an in-network facility.

Note: Some frames, like designer frames, aren't covered in full. If you choose a frame that isn't covered in full, you will receive up to a $130 allowance.

To locate in-network vision providers, visit www.CareFirst.com. For questions about vision coverage, call the CareFirst/Davis Vision customer service line at 800-783-5602.

If You Go Out-Of-Network

If you receive an eye exam and/or materials from an optical provider who is not in CareFirst/Davis Vision's network, you will need to submit your receipts to the plan to get reimbursed. Send your original, itemized receipt, along with the retiree's Social Security number and the patient's name and date of birth to:

CareFirst/Davis Vision Claims Department
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110.

Even if you go to a vision provider outside of the CareFirst /Davis Vision network, the plan still pays a portion of the cost of services. To locate in-network vision providers, visit CareFirst's website: www.CareFirst.com.

Please verify your coverage with your benefits office or call 1-800-783-5602 or visit www.CareFirst.com.

For details on in- and out-of-network vision benefits, please see the tables on the next page.

Be Sure Your Eye Doctor Knows You Have Davis Vision!

The Davis Vision Plan, which is administered by CareFirst, is a valuable benefit provided to you and your family. When you go to the eye doctor, show them your CareFirst/Davis Vision card! If not, they may think you just have the discount program provided through the CareFirst medical plan.

Be sure to get all the benefits coming to you!

In-Network	You Pay
EYE EXAMINATIONS (once per 12-month benefit period)	
Routine Eye Examination with dilation (per benefit period)	No copay
FRAMES (once per 12-month benefit period)	
Davis Vision Frame Collection	No copay for approximately 400 frames
Non-Collection Frame	Plan pays up to $130, you pay balance minus 20% discount
SPECTACLE LENSES (once per 12-month benefit period)	
Basic Single Vision	No copay
Lenticular (post-cataract)	No copay
Basic Bifocal	No copay
Basic Trifocal	No copay
LENS OPTIONS (ADD TO SPECTACLE LENS PRICES ABOVE)	
Standard Progressive Lenses	$50
Premium Progressive Lenses (Varilux®, etc.)	$90
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Blended Segment Lenses	$20
Polycarbonate Lenses for children, monocular and high prescription	No copay
Polycarbonate Lenses for all other patients	$30
Transition Lenses	$65
Intermediate Vision Lenses	$30
Photochromic Lenses	$20
Scratch-Resistant Coating	$20
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Ultraviolet (UV) Coating	$12
Tinting	No copay
Plastic Photosensitive Lenses	$65
Oversized Lenses	No copay

In-Network	You Pay
CONTACT LENSES (initial supply; once per 12-month benefit period, in lieu of spectacle lenses)	
Medically Necessary Contacts	No copay with prior approval
Davis Vision Contact Lens Collection	No copay
Other (Non-Collection) Contact Lenses	Plan pays $130, you pay balance minus 20% discount
CONTACT LENSES (MAIL ORDER)	
Mail Order Contact Lens Replacement Online (DavisVisionContacts.com)	Discounted prices
Laser Vision Correction	Up to 25% off allowed amount or 5% off any advertised special

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays $45, you pay balance
Contact Lens Evaluation, Fitting & Follow-up Care	Plan pays $60, you pay balance
Frames	Plan pays $60, you pay balance
Single Lenses	Plan pays $52, you pay balance
Bifocal Lenses	Plan pays $82, you pay balance
Trifocal Lenses	Plan pays $101, you pay balance
Lenticular (post-cataract) Eyeglass Lenses	Plan pays $181, you pay balance
Medically Necessary Contacts	Plan pays $285, you pay balance
Elective Contact Lenses	Plan pays $112, you pay balance
Elective Bifocal Contact Lenses	Plan pays $127, you pay balance

Terms You Should Know

Coinsurance	Your share (percentage) of covered expenses after you meet the deductible.
Copay (Copayment)	A specific dollar amount you pay each time you receive certain types of covered care or supplies. For instance, you might pay a $10 copay for generic drugs and a $15 copay for a doctor's office visit. Copay amounts depend on the plan you choose.
Deductible	The amount you must pay, in some plans, before the plan will pay for certain benefits. The deductible is not reimbursable and benefits paid by a plan do not count toward a deductible. Medical and dental plan deductibles are based on the calendar year rather than the plan year.
Formulary	A list of a plan's covered prescription drugs. The list is reviewed and updated periodically to add new drugs and to ensure all drugs on the formulary are safe and clinically effective. The formulary is divided into tiers, with different cost sharing levels. Each of our plans has its own prescription drug formulary.
Health Maintenance Organization (HMO)	A type of plan that enables you to get care for very little out-of-pocket expense. Usually, benefits are covered at 100% or require a small copay. HMO medical plans require you to receive services from your PCP or in-network providers to whom your PCP refers you.
In-Network	Doctors, hospitals, and other providers that have signed a contract with a health insurance company, agreeing to accept certain rates for care and services. ***With the CareFirst BlueChoice Opt Out Plus Open Access POS Plan***, "in-network" providers are part of the CareFirst BlueChoice network. ***With the Kaiser Permanente HMO Select Plan,*** "in-network" providers include those in Kaiser centers as well as those community private practice providers in the Kaiser Select network.
Out-of-Network	Doctors, hospitals, and other providers that have not signed a contract with a health insurance company.
Plan Year	HABC's benefit plan year runs from April 1 through March 31.

Point-of-Service (POS)	A POS plan gives you two ways to receive care, at two cost levels – in-network and out-of-network. You need to select a primary care physician (PCP) but you are not required to get PCP referrals. Your costs are lowest when you go in-network.
Preferred Provider Organization (PPO)	A Preferred Provider Organization (PPO) allows you to receive care from any provider you choose. However, you will receive a higher level of benefits when you receive care in-network. You do not need to select a PCP and no referrals are required.
Primary Care Physician (PCP)	Both of our medical plans require you to choose a Primary Care Physician (PCP). Your PCP provides or coordinates all of your care and refers you to specialists when needed. With the HMO, care must be provided or coordinated by your PCP. With the POS plan, you do not need PCP referrals to see a provider. With both plans, you can choose different PCPs for each member of your family and you can change PCPs at any time.
Usual and Customary (U&C)	The Usual and Customary fee is the "going rate" for a particular service. The U&C fee is the amount typically charged for a given service by providers in the area.

The following are notices and certifications relating to the HABC benefit plans. Some of these notices are required by the federal government. Please review this document carefully – it contains important information about your employee benefits. You may wish to print a copy of this document and keep it in a safe place in the event you need it in the future.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the HABC Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of the HABC Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

HABC Privacy Officer
Human Resources Department
417 E. Fayette Street, Suite 940
Baltimore MD 21202

If you have any questions, please contact HABC's Human Resources Office at 410-396-3251.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA provides you with certain special enrollment rights pertaining to your health care coverage.

You may choose not to enroll in HABC'Ss medical benefits when you first become eligible because you have coverage through another source. If the other coverage ends, you may be eligible to enroll in HABC's medical benefits, provided you enroll within 30 days of when the other coverage ends.

In addition, if you gain a new dependent through marriage, birth, adoption, or placement for adoption, you may add this dependent to your medical coverage, provided you enroll your dependent within 30 days of the marriage, birth, adoption, or placement for adoption.

HIPAA Privacy Notice

HIPAA and its implementing regulations impose new privacy and security requirements upon the use and disclosure of protected health information. It's the policy of HABC to comply fully with HIPAA's requirements and to protect the privacy of such PHI. Accordingly, all members of HABC's workforce who have access to PHI must comply with HABC policy and procedures on the use and disclosure of PHI.

This notice describes how protected health information about you and your family may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact HABC'Ss Privacy Officer.

Purpose

HABC is committed to protecting health information about you and your family by ensuring that employees who have access to PHI comply with the privacy and security requirements of HIPAA. HIPAA's privacy regulations require HABC to keep PHI about you and your family private, to give you notice of our legal duties and privacy practices, and to follow the terms of this notice. This notice outlines uses and disclosures of PHI that may be made by HABC, as well as your individual rights and HABC'S legal obligations with respect to PHI.

HABC'S Legal Obligations

The federal privacy regulations require us to keep PHI about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

Protected Health Information (PHI)

PHI is information created, received or maintained by HABC'S group health plans that relates to an individual's physical or mental health or condition, the provision of medical care for that individual or the payment for that individual's medical care, which identifies or may be used to identify the individual to whom it relates.

HABC'S workforce includes employees, contractors, volunteers, trainees and other persons whose work performance is under the direct control of HABC. The term "employee" includes all of these types of workers.

Use and Disclosure of Protected Health Information

The following categories summarize ways that HABC may use and disclose PHI. Some of the categories include examples, but every type of disclosure in a category is not listed. The term "you" generically refers to you and your family member(s). Except for the purposes described below, we will use and disclose PHI only with your written permission. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. If you grant permission to use and disclose PHI for a purpose not discussed in this notice, you may revoke that permission, in writing, at any time by contacting the Privacy Officer.

In accordance with HIPAA, HABC may use and disclose PHI for the following purposes:

- For Treatment: HABC may disclose your PHI to a health care provider who renders treatment on your behalf.
- For Payment: HABC may use and disclose PHI so that we or others may bill or receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may use and disclose PHI to assist employees with denied claims.
- For Health Care Operations: HABC may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary for our operation and management purposes. For example, we may use PHI for purposes of assessing health care plan service, quality or performance, for analyzing associated costs or for underwriting, premium rating and other activities relating to plan coverage. However, we will not use your genetic information for underwriting purposes. . We may also use PHI for plan enrollment/eligibility purposes on behalf of an employee, or for assisting an employee with correcting benefits problems and understanding plan coverage/terminology.
- As Required by Law: HABC will disclose PHI when required to do so by federal, state or local law.
- Lawsuits and Disputes: If you are involved in a lawsuit or dispute, HABC may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request or other lawful process.
- Law Enforcement/National Security and Intelligence Activities: HABC may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may also disclose PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- To a Business Associate: Certain services are provided to HABC by third-party administrators known as "business associates." The Plan requires its business associates, through contract, to appropriately safeguard your health information.
- Military and Veterans: If you are or become a member of the U.S. Armed Forces, HABC may release medical information about you as deemed necessary by military command authorities.
- To Avert Serious Threat to Health or Safety: HABC may use and disclose your PHI, when necessary, to prevent serious threat to your health and safety or the health and safety of the public or another person.

Breach of Unsecured PHI

You must be notified in the event of a breach of unsecured PHI. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. PHI is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm

to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Individual Rights

You have the following rights regarding PHI that HABC maintains about you:

- Right to Inspect and Copy: You have the right to inspect and copy PHI that may be used to make decisions about your care, payment for your care or for your health care operation, including your PHI maintained in an electronic format. If your PHI is available in an electronic format, you may request access electronically and that this be transmitted directly to someone you designate. To inspect and copy this PHI, you must make your request in writing to the Privacy Officer.
- Right to Amend: If you feel that PHI HABC has is incorrect or incomplete, you may ask HABC to amend the information. You have the right to request an amendment for as long as the information is kept by or for HABC. To request an amendment, you must make your request, in writing, to the Privacy Officer. We may deny the request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you request amendment of information that:
    - Was not created by HABC, unless the person or entity that created the information is no longer available to make the amendment;
        - Is not part of the PHI kept by HABC;
        - Is not part of the information that you are permitted to inspect and copy;
        - Is without question accurate and complete.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures," including a disclosure involving an electronic health record. This is a list of the disclosures we made of your PHI that is not one of the uses and disclosures described in this notice. To request this list, you must submit your request, in writing, to the Privacy Officer.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. In addition, you have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not disclose your PHI to your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to disclose the information in certain emergency treatment situations. In addition, you have the right to restrict disclosure of PHI to the health plan for payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. In this case, we are required to implement the restrictions that you request.
- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at certain locations. For example, you can ask that you be contacted only at work or by mail. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask for a paper copy of this notice at any time by contacting the Privacy Officer.

Privacy Officer

Questions, concerns or complaints about the privacy of PHI should be directed to the following:

Kimberly Graham
HABC Privacy Officer
Human Resources Department
417 E. Fayette Street, Suite 940
Baltimore MD 21202

Complaints

If you believe your privacy rights have been violated, you may file a complaint with HABC'S Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with HABC'S Privacy Officer, please direct correspondence to:

Kimberly Graham
HABC Privacy Officer
Human Resources Department
417 E. Fayette Street, Suite 940
Baltimore MD 21202

To file a complaint with the Department of Health and Human Services, please direct correspondence to:

DHHS, Office for Civil Rights
Hubert H. Humphrey Building
Mail Stop 506F
200 Independence Avenue, SW
Washington, DC 20201
Phone: 202-205-8725 or Email: OCRComplaint@hhs.gov

All complaints, whether submitted to the HABC Privacy Officer or the Department of Health and Human Services, must be made in writing.

You will not be penalized or otherwise retaliated against for filing a complaint.

Changes to This Notice

HABC may change the terms of this notice and privacy policies at any time. The revised or changed policies will be effective for all PHI maintained at that time, as well as for PHI received in the future.

Family Status Changes

As outlined in Internal Revenue Code Section 125, HABC offers health care benefits on a tax-free basis. You do not pay federal or state income taxes, or Social Security taxes on the per pay contributions for these benefits. However, because of the tax advantages of tax-free contributions, the Internal Revenue Service (IRS) imposes certain restrictions.

After you enroll — either when you are first eligible or during the annual Open Enrollment period — you may not make changes to your benefits until the next Open Enrollment period. The only exception to this rule is if you experience an IRS-qualifying life status change.

IRS-qualifying life status changes include:

- Your marriage, divorce, or annulment;
- Birth, adoption, placement for adoption, or appointment of legal guardianship of a child;
- Your death or the death of your covered dependent;
- Your or your dependent's loss or gain of employment;
- A change in your or your dependent's employment status due to a switch from full-time to part-time or part-time to full-time;
- A change in your dependent's eligibility;
- A change in your or your dependent's place of residence or work;
- Your requirement to cover your dependent child(ren) according to a judgment, decree, or order resulting from your divorce, legal separation, annulment, change in legal custody, or death of your spouse (that requires health coverage for your dependent child(ren));
- Approved leave of absence;
- Your or your dependent's eligibility for COBRA;
- Your or your dependent's eligibility for Medicare or Medicaid (you may change the current election for the eligible person only);
- Your or your dependent's entitlement to special enrollment rights;
- A significant reduction in coverage or increase in contributions;*
- The addition or elimination of a new coverage option;* and
- A change in your spouse's or dependent's coverage during another employer's annual enrollment when the other plan has a different period of coverage.*

**These IRS-qualified life status changes do not apply to the Health Care Spending Account. You cannot change your spending account contribution once it has been set. To change your contribution amount, you would have to wait until the next annual Open Enrollment period.*

If you or your dependent is eligible, but not enrolled, for health benefits, you are eligible to enroll if you meet either of the following conditions and you request enrollment no later than 60 days after the date of the event:

- You or your dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage.
- You or your dependent becomes eligible for premium assistance, with respect to coverage under the plan, due to coverage with Medicaid or CHIP."

If you experience an IRS-qualified life status change, you may only make benefit changes that are consistent with the life status change. For example, if you get married, you may add your new spouse to your medical coverage, but you cannot switch medical plans until the next annual Open Enrollment period. To make a benefit change as a result of an IRS-qualified life status event, you must do so within 30 days of the life status event; otherwise, you will have to wait until the next annual Open Enrollment period to make the change.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you are covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive 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 coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happen:

- 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 HABC, 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to HABC, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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: HABC Human Resources.

How is COBRA 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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

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 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.

The disability extension is available only if you notify the Plan Administrator in writing of Social Security's determination of disability within 60 days after the latest of the date of Social Security's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. You must provide the notice by notifying the Plan Administrator in writing.

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 of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

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

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

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

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

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

For further information regarding the plan and COBRA continuation, please contact:

Human Resources Department
417 E. Fayette Street, Suite 940
Baltimore MD 21202

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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, ext. 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
CALIFORNIA-Medicaid	
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322; Email: hipp@dhcs.ca.gov	
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid and CHIP (Hawki)**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid	MONTANA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328; Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218
MASSACHUSETTS – Medicaid and CHIP	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MINNESOTA – Medicaid	**NEW YORK – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://medicaid.ncdhhs.gov Phone: 919-855-4100

NORTH DAKOTA – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OKLAHOMA – Medicaid and CHIP	**VERMONT– Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
PENNSYLVANIA – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
RHODE ISLAND – Medicaid & CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH CAROLINA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	**WYOMING – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
TEXAS – Medicaid	
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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 12/31/2021)

Women's Health and Cancer Rights Act

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns' and Mothers' Health Protection Act of 1996

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 normal vaginal delivery, or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity

HABC is complying with recent legislation that removes limits on mental health benefits. For example, there must be equality between medical benefits and mental health benefits as to financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket maximums) and quantitative treatment limitations (such as number of treatments, visits, or days of coverage).

Notice of Creditable Coverage (Important Notice from HABC 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 HABC 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. HABC has determined that the prescription drug coverage offered by the HABC Employee Benefit 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 HABC coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current HABC coverage, be aware that you and your dependents will not be able be able to get this coverage back until the next HABC Open Enrollment period.

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 HABC 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 HABC 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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: 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:	2/7/2021
Name of Entity/Sender:	HABC
Contact:	Human Resources Department
Address:	*417 E. Fayette Street, Suite 940* *Baltimore MD 21202*
Phone Number:	410-396-3251

Summaries of Benefits and Coverage (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available from HABC's Human Resources department. If you would like a paper copy of the SBCs (free of charge), call HABC's Human Resources department at 410-396-3251.

HABC is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.