LIVE UNITED

United Way
United Way of Central Maryland

2017

Work Life Benefits

VISION:
Provide comprehensive first class benefits.
Provide security no matter what stage in life.

GOALS:
Offer competitive benefits.
Maintain competitiveness in the nonprofit market.
Continue benefits comparable with peer United Way organizations.

WE BELIEVE:
In offering our employees a balanced benefit program that addresses their diverse needs;
In attracting and retaining high quality employees to UWCM; In communicating the details and costs of benefits to our employees.

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Employee Benefits Guide 2017

CBIZ

Welcome!

United Way of Central Maryland takes pride in offering a comprehensive and competitive benefits package to full-time employees. United Way of Central Maryland (UWCM), through partnership with advisors & carriers, offers you an employee benefits program that allows choice and flexibility. Employees are eligible for all health benefits, beginning on their first day of the month following date of hire.

It is important that you take the time to review all of the plan options available to you. We believe in protection of our employees who carry our mission. Therefore, consider each program and/or service along with the associated cost carefully.

Options selected upon enrollment remain in place through the end of the plan year (July 31st) unless you experience a qualified status change. The plan year for UWCM is August 1st through July 31st of the following calendar year.

CONTENTS

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official plan document shall prevail as accurate. Please refer to the plan specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules or otherwise decided by United Way of Central Maryland.

CBIZ®

What's New in 2017

What's Changing?

- Medical: New Traditional HMO plan option available through CareFirst
- New Enhanced Voluntary Vison plan option available through Carefirst
- Addition of Health Advocate service paid for by UWCM and available at no cost to you
- Medical Health Savings Account: Increased HSA contribution limit for Self-Only

Passive Enrollment Period

2017 –2018 Benefits Open Enrollment is a "passive" enrollment period. This means if you do not want to make any changes to your benefits for 2017, your current elections will "roll over" for the 2017 plan starting on **August 1, 2017,** with the exception of the Health Care and/or Dependent Care Flexible Spending Account (FSA)**.** Any new enrollments and changes will require a paper enrollment forms that will be available on our open enrollment portal.

All employees are encouraged to use this annual opportunity to review their benefit elections and their beneficiary elections for Life Insurance products to make sure their family needs are met for the upcoming year.

Keep your current ID cards! No new ID cards will be issued unless you are making a change to your benefits.

Eligibility

You are eligible for benefits if you are a regular full-time UWCM employee who works at least 20 hours per week. Coverage begins on the first day of the month following your date of hire.

ELIGIBLE DEPENDENTS INCLUDE

- Married spouses
- Dependent children to age 26

Note on Spousal Eligibility:

If your spouse is offered insurance through his/her employer, he/she is not eligible to enroll as your dependent. A signed affidavit is required.

ELIGIBILITY FOR DEPENDENT COVERAGE

Medical	Dependents covered up to age 26
Dental	
Vision	
Supplemental Life Insurance for Dependent Children	

Life Changing Events

You can make changes to your medical, dental, vision, Flexible Spending Account and Health Savings Account elections during the year only if you have an IRS approved "qualified status change." You must make a change within 31 days of the event.

You can change your benefits within 31 days if you experience one of the following life changes:

⇒ Marriage, divorce, or legal separation
⇒ Birth or adoption of child
⇒ Death of a covered dependent
⇒ Job status change (Full-time to Part-time or vice versa)
⇒ Your spouse becomes eligible for medical benefits through new employment
⇒ Your spouse becomes unemployed and loses benefit coverage
⇒ A significant change in your spouse's health coverage attributable to your spouse's employment
⇒ Ineligibility of your covered dependents due to:
    - Marriage
    - Change in dependent status
    - Attainment of non-qualifying age (medical, dental, vision, and life insurance coverage)

Medical - Same Great Benefits!

UWCM has partnered with CareFirst, to provide you and your family with high quality healthcare. Your medical plan covers a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations. UWCM has designed an open access plan, meaning that you have the ability to choose your provider within the BlueChoice network, without requiring referrals. Depending upon the type of service, whether it be a routine office visit, a trip to the emergency room, or any other medical service under the plan, your plan shares the cost of care with you in different ways. Please see the below summary for specific plan details.

Medical Benefits Description

Plan Design	CareFirst Blue Choice HMO Open Access High Deductible Health Plan	Carefirst Blue Choice HMO Open Access Traditional Health Plan
Deductible:	In-Network Only	In-Network Only
- Single	$1,500	$500
- Family	$3,000	$1,000
Out of Pocket Maximum:		
- Single	$3,000	$2,500
- Family	$6,550	$5,000
Pharmacy Out of Pocket Maximum:		
- Single	Integrated with Medical	$3,500
- Family	Integrated with Medical	$7,000
Coinsurance:	100%	100%
Office Visits:		
- Primary Care Physician	$10 Copay After Deductible	$30 Copay After Deductible
- Specialist	$20 Copay After Deductible	$40 Copay After Deductible
- Lab and x-ray (free standing)	No Charge After Deductible	No Charge (Deductible Waived)
- Vision	$10 exam / Plan Year; Discount on material	$10 exam / Plan Year; Discount on material
Preventive Service	**Deductible not Apply**	Deductible not Apply
- Well Child	No Charge	No Charge
- Adult	No Charge	No Charge
Hospitalization:		
- Inpatient	$250 per Admission After Deductible	No Charge After Deductible
- Outpatient Surgery - Facility	No Charge After Deductible	No Charge After Deductible
- Urgent care	$20 Copay After Deductible	$40 Copay After Deductible
- Accident/Medical Emergency (Copay Waived if Admitted)	$100 Copay After Deductible	$100 Copay After Deductible
Prescription Drugs:	Medical & Rx Integrated	
- Pharmacy Deductible	Integrated with Medical	$200 Deductible
- Generic	$15 Copay	$15 Copay
- Brand	$35 Copay	$35 Copay
- Non-Formulary	$60 Copay	$60 Copay
- Mail Order (up to 90 days)	2 x copay	2 x copay
Primary Physician	No Referral	No Referral
Physician Network	Blue Choice (Local Network)	Blue Choice (Local Network)
Lifetime Maximum	Unlimited	Unlimited

HSA Information

- You must be enrolled in a qualified High Deductible Health Plan
- Members do not "lose it" at the end of the plan year; dollars roll over year after year earning tax-free interest to pay for future medical expenses or possibly retirement.
- Encourages consumerism; stretch dollars with research and knowledge.
- Dollars are eligible to pay for medical, dental, vision and over the counter (with Rx) expenses.
- Other qualified expenses include acupuncture and out-of-network costs.
- Members save premium costs as high deductible health plans' premiums are lower than traditional health plan premiums.
- Investment options exist allowing for control of healthcare dollars.
- Member is responsible for paying the deductible if claims occur before HSA deposits (typically only an obstacle during the first year enrolled).
- If a High Deductible Health Plan is elected but an HSA Bank Account is not opened and funded, members can and will experience increased out-of-pocket costs.
- The IRS reserves the right to request proof of medical necessity; save all receipts when using your HSA Bank Account (likelihood same as tax return audit).

Question: How much can I contribute to my HSA each year?

- Each year, the IRS determines contribution limits.
  - ◊ These limits include any dollars made on deposit, either by a member or an employer (or both).

- 2017 limits:
  - ◊ $3,400 for individual coverage
  - ◊ $6,750 for dependent/family coverage
  - ◊ All members ages 55-65 allowed additional $1,000 per year catch-up provision above annual limit.

- 2018 limits:
  - ◊ $3,450 for individual coverage
  - ◊ $6,900 for dependent/family coverage
  - ◊ All members ages 55-65 allowed additional $1,000 per year catch-up provision above annual limit.

Distributions: The Rules of HSA Withdrawals

- Distributions are tax free when used for "qualified medical expenses".
  - ◊ Expenses for the member and any dependents claimed on tax return, even if those dependents are NOT covered by the HSA Compatible Health Plan.

- Your HSA Account cannot be used for claims or bills that occurred before the account was opened.
- You can take your HSA contributions with you if you leave UWCM.
- Withdrawals for ineligible expenses are taxable plus 20% penalty (unless age 65 or older).

Visit BB&T's website https://www.bbt.com/banking/savings/health-savings-account.page for more information. Please note the limitations of who cannot contribute to an HSA.

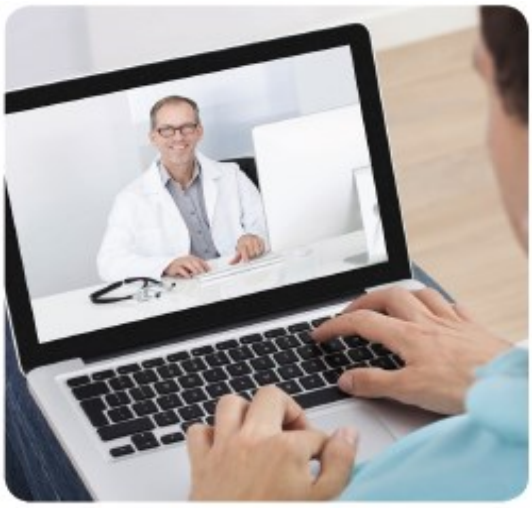
CareFirst Video Visit

When your PCP isn't available, CareFirst Video Visit allows you to connect with a doctor on a smartphone, tablet or computer. Video Visits cost the same as your PCP sick office visit copay (up to a maximum of $60).

CareFirst Video Visit is intended for the treatment of uncomplicated, non-emergency health concerns.

www.carefirstvideovisit.com

Know Before You Go



Get treatment for common health issues

CareFirst Video Visit is intended for the treatment of uncomplicated, non-emergency** health concerns including, but not limited to:

- Bronchitis
- Cough/sore throat
- Sinus infection
- Diarrhea
- Fever
- Pinkeye
- Cold/flu
- Respiratory infection

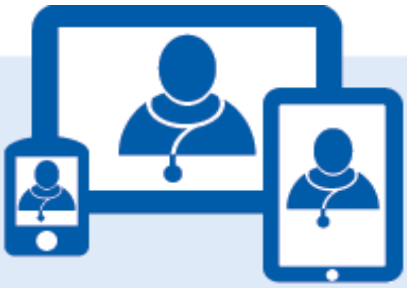
Video Visit doctors provide consultation, diagnosis and even prescriptions (when available and appropriate). They are all U.S. board-certified, licensed, credentialed and have profiles so you can see their education and practice experience.

When to use Video Visit

- Your doctor's office is closed
- You are on business travel or vacation
- You have children at home and can't bring them to the doctor's office

Register today so you'll be ready when you want to visit. There are two easy ways:

1. Visit **www.carefirst.com/needcare** and click on any of the *Video Visit* links, or
2. Download the CareFirst Video Visit app from your favorite app store



CareFirst Video Visit. The doctor will see you now!

**The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.*

***In the case of a life-threatening emergency, you should always call 911 or your local emergency services. CareFirst Video Visit does not replace these services.*

Total Well-being

As part of our commitment to the health and wellness of our employees, we have instituted a Wellness Incentive. This incentive is designed to encourage an ongoing relationship between you and your Primary Care Physician (PCP) to promote a healthy lifestyle and ensure that any health problems are detected early and monitored on a regular basis. Our goal is that you will visit your PCP for your annual physical. By providing proof of your annual visit you will receive a $100 incentive.

In order to receive this incentive you must perform the following steps:

1. Go to CareFirst.com and register for “My Account” (if you have not already), then go to “My Assessments/ Health Assessment” to complete your Health Assessment. After you have finished, you will see a page titled “Your Report.” Print that page to be submitted with this completed form.
2. On that same webpage, go to the option titled “Physician Summary.” Print that report to be shared with your PCP.
3. Make an appointment with your PCP for your annual physical and share the Physician Summary report with your PCP.
4. Have your Primary Care Physician (PCP) complete the information below. Upon completion, this form should be turned into the Human Resources Office. After Human Resources receives your form, you will be paid the $100 incentive in your following paycheck.

The physical must occur in the plan year. You are eligible to receive ONE incentive payment each year.

Blue Rewards is CareFirst’s exclusive incentive program where you can earn rewards for taking steps toward getting and staying healthy.

Earn rewards by completing four steps:

Know Before You Go

- **FirstHelp offers members access to**
  - Round-the-clock medical advice
  - A registered nurse 24/7
  - 1-800-535-9700

- **With FirstHelp**
  - Health care advice is immediate
  - Nurses have information on all health care options
  - Information about Emergency facilities, urgent care, clinics, primary care providers and other health care resources is available to members

"Advice isn't just needed from 9 to 5…
Our 24/7 Health Care Advice Line is here to help"

Blue365

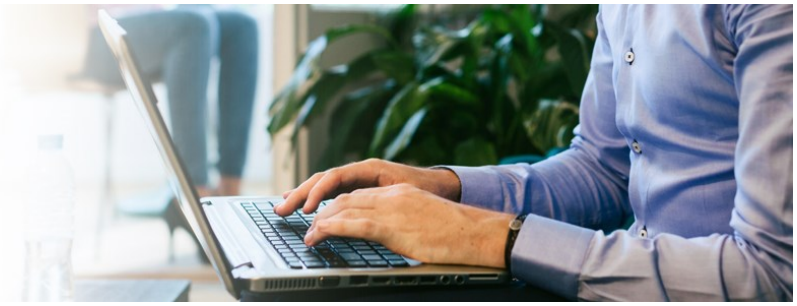
Exclusive health and wellness deals and discounts from top national and local retailers:

- Gym memberships
- Fitness gear
- Family activities
- Healthy eating options

www.carefirst.com/blue365

My Account: Wherever You Are

- Complete your well-being assessment and Blue Rewards steps
- View claims and Explanation of Benefits (EOBs)
- Find a doctor, facility or pharmacy
- Check your benefits and deductibles
- View, order and print ID cards
- Estimate medical expenses



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Voluntary Vision Benefits

Eligible employees may sign up for the enhanced vision coverage, which allows participants to get an examination and lenses every 12 months and frames every 24 months. Participants have the option of receiving care from a network provider or out-of-network provider; however, if you use an out-of-network provider you will incur higher out-of-pocket expenses. For additional information please visit www.carefirst.com.

	CareFirst	
Network	Davis Vision	
Copayments	In-network	Out-of-network
- Examination (benefit period)	$10 Copay	$45 allowance
- Materials - lenses and frames	$20 Copay	see schedule below
Frequency of Service		
- Vision Exam, Lenses, Contacts*	12 Months	
- Frames	24 Months	
Lenses (pair)		
Basic Single Vision	$20 Copay	Up to $52 Allowance
Basic Bifocal	$20 Copay	Up to $82 Allowance
Basic Trifocal	$20 Copay	Up to $101 Allowance
Frames	select frames covered in full; $130 allowance for non-covered frames, plus 20% discount	Up to $60 Allowance
Contact Lenses	(in lieu of glasses) Up to $130 Allowance, plus 15% discount No copay if Medically Necessary	Up to $127 Allowance Up to $285 if Medically Necessary
Laser surgery	up to 25% off retail or 5% off promotion	not covered

Dental Benefits

Good dental health is important to your overall wellbeing. At the same time, we all need different levels of dental treatment. The Dominion National Plan provides affordable coverage based on the type of service obtained –**Preventive, Basic, Major Restorative, or Orthodontia.** To locate a provider visit *www.dominionnational.com*

	Dominion National		
	Access ePPO	Choice PPO	
	In Network Only	In Network	Out of Network
Deductible (Calendar Year)			
- Individual	$25	$50	$50
- Family	$75	$150	$150
Calendar Year Benefit Maximum:	$2,000	$1,000	$1,000
Maximum Rollover:	$1,500	$1,000	
Coinsurance:	Fee Schedule		80th percentile of UCR
- Type A - Preventive	Up to 100%	100%	80%
- Deductible Waived for Preventive	Yes	Yes	Yes
- Type B - Basic Restorative	Up to 80%	80%	65%
- Type B - Endodontics, Periodontics & Oral Surgery	Up to 80%	80%	65%
- Type C - Major Restorative (Including Implants)	Up to 50%	50%	40%
Orthodontia: Child(ren) to age 19 only	Individual discount program may be purchased separately. See information on Ortho Select.	50% up to $1,000 Lifetime Maximum	
Locate a Dentist	www.dominionnational.com	www.dominionnational.com	N/A
Dental Network	ePPO Access	Choice PPO	N/A
Claim Forms Required?	No	No	Yes

*Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Note that when using out-of-network services, members may incur any charges exceeding the 80th percentile of the allowed amount. UCR = Usual, Customary and Reasonable.

Orthodontia Discount Program

DOMINION NATIONAL

Orthodontic
program for adults and children

Program Features

NO Deductibles
NO Waiting Periods
NO Pre-authorization Paperwork
NO Lifetime Maximums
NO Pre-existing Condition Exclusions
NO Claim Forms

Ortho Discount Program

- Quality care at predetermined fees
- Choose any in-network orthodontist from one of the largest discount dental networks in the Mid-Atlantic[1]
- Family members may select different orthodontists
- All network orthodontists are licensed, regulated and must meet Dominion's Credentialing and Quality Assurance Program standards

Who is eligible?

Everyone is eligible to enroll. The program is available on a per member basis.

What is my cost?

You will pay a one-time charge per member for three years of access to reduced fees.

Existing Dominion PPO Member	$49
Not an Existing Dominion PPO Member	$99

Is this a dental insurance plan?

No. This is not an insurance plan. It is a reduced fee-for-service program designed specifically for individuals. Members pay a predetermined reduced fee for listed services provided by contracted providers. Dominion does not pay contracted providers for services.

How do I enroll?

- Complete the enclosed enrollment card.
- You must receive care from a participating Discount Network orthodontist to receive discounts on services. You can find a current list of orthodontists online at DominionNational.com/find-a-dentist.
- After your effective date, simply call the participating orthodontist and make an appointment.
- You may pay a one-time payment by either credit card or check.
- Return the completed application and payment to Dominion National; P.O. Box 75314; Charlotte, NC 28275-5314.
- An ID card will be mailed to you on or before your first day of eligibility.
- If your application and payment are received by the 25th of the month, your program will be effective on the first day of the following month.

Can I make changes online?

Yes. Dominion provides members with secure online access to:

- ID card requests
- Program information
- Dentist search
- Contact information
- Member services requests and general correspondence

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Find a Participating Dentist

How to select a DHMO dental provider:

DHMO members must select a participating dentist prior to making a dental appointment. Except for out-of-area emergency care, you must receive treatment at the dental office you selected. Family members may use different participating dentists.

Option 1: Create your online account through Dominion's Member Portal at https://DominionMembers.com. Once you have logged in, simply go to your "Member Summary" and select the "Change Dentist option.
Option 2: Call Dominion at (888) 518-5338.

How to find a PPO dental provider:

1. Go to www.DominionNational.com/find-a-dentist.

2. Utilize the searchable features to find general dentists and specialists near your home or office. You may filter your search by city, state or zip code, dentist name and type or language(s) spoken. **You must select plan type Dominion USA in the dropdown menu in order to determine the corresponding work.**

3. Once you have entered in the search criteria, click "Find" and your results will be displayed. Search results provide detailed contact information including office and eMail addresses, office and emergency phone numbers, dentist status (accepting new members), hours of operation, handicap accessibility, language(s) spoken and directions to the dental office.

Rollover Benefit/ Find a Dentist

- Allows you to roll over a portion of your unused spending to increase your maximum benefit limit next year, and beyond.

- You can save and accumulate part of your unused benefit dollars and use it for the future.

The chart below is a four-year example of how *Maximum Rollover* is applied based on a member's annual maximum amount of $1,000.

	Year One	Year Two	Year Three	Year Four
Your annual maximum amount	$1,000	$1,000	$1,000	$1,000
Rollover amount from previous year	N/A	$350	$350	$150
Benefit dollars available	$1,000	$1,350	$1,350	$1,150
Your total claims paid*	$400 (less than $500)	$800 (over $500)	$1,200** (over $500)	$300 (less than $500)
Cleaning or oral exam during year	Yes	Yes	Yes	Yes
Rollover amount	$350	$0	$0	$350
Accumulated *Maximum Rollover* total	$350	$350	$150	$500

The benefit dollars available to this member in Year Five would be $1,500.

** In this example, "Your total claims paid" cannot exceed the "threshold" amount (of $500) based on the annual maximum amount of $1,000. Reference the second column of the chart below for your plan's "threshold" amount.*

*** In Year Three, the $1,000 annual maximum was exceeded, but the member had enough* Maximum Rollover *dollars accumulated ($350) to cover the additional $200 cost.*

Basic Life and AD&D Insurance

As a full-time employee of UWCM, you are eligible for a variety of company-sponsored benefit plans. UWCM pays 100% of the cost for your Basic Life and Accidental Death & Dismemberment Insurance (AD&D). This amount is equal to 1x your basic annual earnings up to $250,000. Employees must designate a beneficiary

Disability

Disability benefits help protect what you work for. Unum's Group Short Term Disability insurance and Unum's Group Long Term Disability insurance can replace a portion of your salary if you become ill or injured and unable work. It can help you cover your expenses and protect your finances at a time when you're not getting a paycheck and have extra medical bills.

Short-Term Disability (STD): Your STD benefit equals 70% of your weekly earnings up to the maximum allowed benefit. This benefit takes effect on the 15th day of absence due to an accident or illness. The benefit maximum duration is up to 11 weeks.

Long-Term Disability (LTD): Your LTD benefit equals 66.67% of your monthly earnings to a maximum benefit of $8,000 per month. This benefit takes effect on the 91st day of being disabled .

Employee Voluntary Term Life and AD&D Insurance

UWCM offers a Voluntary Life and AD&D Insurance benefit that can be purchased at your expense for you and your dependents. You will pay group rates and the premium is conveniently deducted from your payroll. Employees may elect in up to 5x their basic annual earnings up to a maximum benefit of $500,000 in increments of $10,000. Evidence of Insurability is required for amounts requested in excess of $70,000. You may enroll for supplemental AD&D coverage at the equivalent amount of the elected supplemental life coverage. Reminder: If you do not enroll in Voluntary Benefits at the time of open enrollment, you will need to submit evidence of insurability for any amount you elect.

Critical Illness Insurance

Pays a lump-sum benefit upon diagnosis of a covered cancer or critical illness, such as heart attack (myocardial infarction), end stage renal failure, coronary artery bypass surgery, stroke or major organ transplant. Offers an optional Cancer Treatment and Care Benefit.

Spouse and Dependent Life Insurance

Insurance is available for your spouse in increments of $5,000 up to $500,000 or 100% of your supplemental life election, whichever is less. Evidence of Insurability is required for amounts requested in excess of $25,000 for your spouse any amount elected after your initial enrollment period or any amount if denied in the past.

Coverage for a child is available in increments of $2,000 up to a maximum of $10,000. The dependent child amount cannot exceed 100% of the employee amount. Child life rate applies to one or more covered child(ren), and not per covered child. Evidence of insurability is not required for children. Dependent children are eligible for Life benefits and covered up to the age of 19 if unmarried or up to age 26 if a full-time student.

Accident Insurance

Helps offset the unexpected medical expenses, such as emergency room fees, deductibles and co-payments that can result from a covered accident.

Medical Flexible Spending Account

Although the medical, dental and vision plans pay for many of your health-related expenses, not all health care bills are covered in full. The Medical Flexible Spending Account offers you a tax-free way to pay for many of your out-of-pocket health care costs. Through the Medical FSA you are able to use pre-tax dollars to pay for eligible health care expenses incurred by you or any other person whom you claim as a dependent on your federal income tax return. It is not necessary to be enrolled in the UWCM health plans in order to participate in this plan. This benefit is administered by TASC.

How the Medical FSA works:

1. Estimate the amount of eligible out-of-pocket expenses you will pay in the plan year. **It is important that you estimate carefully. If you do not use all of the money in your accounts by the end of the plan year, you must forfeit any unused balances.** This is referred to as the "Use-It-Or-Lose-It-Rule".
2. Decide how much you want to contribute to your Medical FSA for the entire Plan year (8/1 through 7/31). You may elect up to $2,500 for the Plan year. To enroll in the Medical FSA Plan you will need to complete the appropriate enrollment form. Your election will remain in effect for the entire plan year and can only be changed if you experience a qualified change in status (See Life Changing Events section for information on qualified life events).
3. Once you have been enrolled, contributions are deducted from each paycheck on a pre-tax basis. The money is held in your Medical FSA until you have a qualified expense and file a claim for reimbursement. The money you set aside is not subject to federal income tax, Social Security, Medicare, and, in most cases, state and local taxes. This lowers your taxable income and increases your take home pay.
4. Each time you have an eligible expense you may file for reimbursement or use your Medical FSA Visa debit card. You will need to complete a Medical FSA claim form to file for reimbursement. Receipts may be needed to substantiate claims once you use your Visa debit card. Always keep your receipts.
5. You will be reimbursed with tax-free dollars for the full amount of your expense, up to the amount you elected to contribute for the year. TASC will reimburse by check through the mail, or you may sign up for direct deposit into your bank account.
6. The UWCM Flex Plan year runs from August 1st through July 31st. At the end of the plan year, you will have up to 90 days to submit for reimbursement claims incurred from the previous plan year. This applies to both the MFSA and DCFSA.
7. If you have a balance at the end of the plan year, you may manually move your remaining funds, up to $500 of your Health FSA, to the next plan year.
8. If you terminate employment prior to the end of the plan year, you will have 90 days to request reimbursement for any expenses incurred while you were an employee.

HSA/FSA Eligible Medical Expenses

- Deductibles/Co-payments
- Acupuncture
- Alcoholism & Drug Abuse Treatments
- Chiropractor
- Contact Lenses & Solutions
- Dental Expenses
- Eye Exams & Eye Glasses
- Hearing Aides & Batteries
- Laser Surgery for Vision
- OTC Drugs (pain relievers, antacids, cold allergy) ***Must be accompanied with prescription for MFSA***
- Orthodontia
- Prescription Sunglasses
- Psychiatric Care
- Smoking Cessation Programs
- Weight Loss Programs-Doctor Prescribed for Obesity

Visit the www.tasconline.com for more details.

Dependent Care Flexible Spending Account (DCFSA)

The Dependent Care Flexible Spending Account (DCFSA) helps you save on out-of-pocket dependent care expenses for services such as child/elder day care that are required in order for you and your spouse to be gainfully employed.

In order to be eligible for the DCFSA you must meet the following guidelines: (1) You are a single parent; or (2) You have a working spouse; or (3) Your spouse is a full-time student; or (4) Your spouse is physically or mentally unable to provide for his/her own care; or (5) You are divorced or legally separated and have custody of your child most of the time, even though your former spouse may claim the child for income tax purposes; **AND** (6) Your child is under the age of 13.

You may use the account to pay for the care of any dependent you claim on your tax return who is under age 13, or mentally or physically incapable of self-care (including elderly dependent parents and disabled children of any age) and regularly spend at least eight hours a day in your home.

How the DCFSA Works:

1. Estimate your eligible dependent care expenses for the entire year. You may contribute up to $5,000 per household per year.
2. Once you have enrolled, contributions are deducted from your paycheck pre-tax, thereby reducing your taxable income. Re-enrollment is required each year.
3. Each time you have an eligible expense you may file for reimbursement through MyTASC. You will be reimbursed up to the amount available in your account at the time of claim. If you do not have sufficient funds in your account to cover the entire claim, you will be reimbursed for the remaining amount of the claim as funds become available in your account.

Visit www.tasconline.com for additional information and resources.

IMPORTANT NOTE: The DCFSA is for out-of-pocket expenses related to dependent day care, and is NOT for dependent health care expenses.

403(b) Retirement Plan

Who is eligible to participate?	Any person employed by UWCM is eligible to participate in the 403(b) Retirement Savings Plan. Once you have a year of service (including other service within the United way system), you will be eligible for an automatic, non-matching UWCM contribution (explained in more detail later).
When does participation begin?	New employees may begin making contributions to the Plan on their first day of work and UWCM begins matching your contributions right away. You will begin receiving an automatic, non-matching contribution from UWCM beginning in the pay period following you 12-month service anniversary
How much can I contribute to the Plan?	You may contribute a flat dollar amount or percentage of pay, up to the IRS limits shown below. Your contributions are tax-deferred; meaning that you don't pay federal, state, or local income taxes on your contributions, or the earnings, until you withdraw them form the Plan. 2017 IRS limits (subject to change each year): Maximum annual tax-deferred contributions- $18,000 for individuals under age 50, and additional $6,000 for individuals age 50 and older Maximum amount of pay on which contributions can be based- $270,000 Total contribution maximum (including you contributions, UWCM matching contributions and UWCM non-matching contributions)- $54,000 for individuals under age 50 and $60,000 for individuals over age 50 You may change the amount your contributions at any time by completing Section 3 (*Change in Contributions*) of the 403(b) Plan election form. Copies of this form are available in Human Resources. The change in contribution will become effective on the pay date following the day Human Resources receives your request for change.
How much will UWCM contribute to my account?	UWCM contributions take two forms: Matching Contributions: UWCM will match 25% of the first 6% of pay you contribute. Matching contributions are placed in your account each pay period that you contribute. Non-Matching Contributions: UWCM will make an automatic, non-matching contribution each payroll period, after you have 12 months of service. Including prior United Way service. You do not have to contribute to the Plan to receive non-matching contributions. The amount of the non-matching contribution will depend on your years of service, as shown next:
How much will UWCM contribute to my account? (continued)	Years of Service — % of Pay Less than 5 — 2% 5 but less than 10 — 3% 10 or more — 4% Subject to the IRS limits explained earlier and depending on your years of services and the amount you contribute, the following shows the total annual contributions to your account:

	Less than 5 years of service			At least 5, but less than 10 years of service		10 or more years of service	
Your Contributions	UWCM Matching Contribution	UWCM Non-Matching Contribution	Total Contributions	UWCM Non-Matching Contribution	Total Contributions	UWCM Non-Matching Contribution	Total Contributions
0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	4.0%	4.0%
1.0%	0.25%	2.0%	3.25%	3.0%	4.25%	4.0%	5.25%
2.0%	0.50%	2.0%	4.50%	3.0%	5.50%	4.0%	6.50%
3.0%	0.75%	2.0%	5.57%	3.0%	6.75%	4.0%	7.75%
4.0%	1.0%	2.0%	7.0%	3.0%	8.0%	4.0%	9.0%
5.0%	1.25%	2.0%	8.25%	3.0%	9.25%	4.0%	10.25%
6.0%	1.50%	2.0%	9.50%	3.0%	10.50%	4.0%	11.50%

Employee Assistance Program (EAP)

When you have questions, concerns or emotional issues surrounding your personal or work life, you can count on Unum to offer help. Unum's work-life balance employee assistance program (EAP) offer unlimited access to master's level consultants by telephone, resources and tools online, and up to three face-to-face visits with a consultant for help with a short-term problem.

Help for personal challenges big and small:

- Locate childcare and eldercare services and obtain matches to the appropriate provider based on your or your family's preferences and criteria.
- Speak with financial experts by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement
- Work through complex, sensitive issues such as personal or work relationships, depression or grief, or issues surrounding substance abuse
- Get a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation.

Guidance for work-related conflicts:

- Have a confidential sounding board and objective view
- Work on communication and problem-solving skills
- Learn how to motivate your employees

Balance can be a call or click away:
(800) 854-1446 (English)
(877) 858-2147 (Spanish)

www.lifebalance.net
user ID and password: lifebalance

Travel Assistance

Pack your worldwide emergency travel assistance phone number and leave travel worries at home. Whenever you travel 100 miles or more from home, whether it be for business or pleasure, be sure to pack your worldwide emergency travel assistance phone number!

Unum offers 24 hour access to:

- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year.

Within the U.S.: 1 (800) 872-1414
Outside the U.S.: +(U.S. access code) 609-986-1234

Legal Services

Legal representation – you may need it more than you realize.

One in three Americans will need a lawyer in the next 12 months.

Reasons include:

- *General advice and consultation*
- *Wills and probate*
- *Family law, including divorce matters*
- *Traffic violations*
- *Document review and preparation*
- *Administrative proceedings*
- *Real estate and housing matters*
- *Criminal matters*
- *Consumer and financial matters*
- *Juvenile matters*

Unfortunately 80% of people who need legal help will not seek it because they don't know their rights, don't know an attorney or think it is too expensive.

You don't have to be one of those people. With the United Legal Benefits Plan, you will have an experienced law firm with attorneys you can trust providing legal protection and representation for you and your family – at a fraction of the normal cost.

Just as in health care, purchasing legal services as part of a group plan significantly reduces the cost of those services. Legal advice or representation that could cost you hundreds or thousands of dollars if paid for individually is affordable with the United Legal Benefits Plan.
In fact, the cost of being a ULB member for an entire year is about the same as what you might spend to talk to a lawyer for about an hour without our plan.

ULB provides quality legal protection and personal service for $20 or less per month.

The ULB Plan is easy to use. When you sign up for the ULB Plan, you'll select a lawyer from our list of panel attorneys. As soon as your application is processed, you will receive our detailed Summary of Services and a membership card with your attorney's name and phone number. Any time you have a need for legal services or a legal question, simply contact your attorney. Your direct call to your attorney ensures complete confidentiality. There are no claim forms or separate billings to be concerned with – your regular monthly fee pays your attorney's fees for all ULB covered services.

United Legal Benefits Protects You and Your Family

For a low monthly fee, United Legal Benefits offers legal counsel and representation to you, your spouse and your legal dependents.

UNITED LEGAL BENEFITS

Health Advocate

HealthAdvocate

Help is Only a Phone Call Away

Your Own Personal Health Advocate

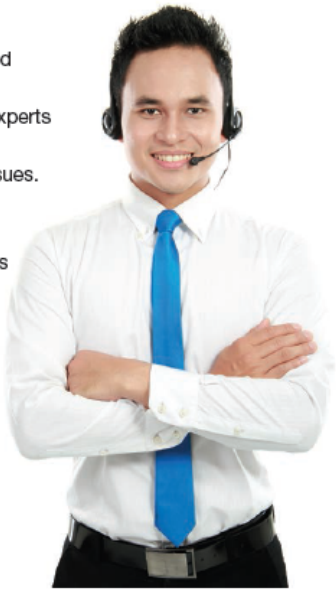
We've all been there—spent endless time researching medical treatments, hunting down the right specialist, or interpreting medical bills. Now, you can turn over these issues to a Personal Health Advocate who knows the ins and outs of the system.

Save time, money and worry

Personal Health Advocates, typically registered nurses, supported by medical directors and benefits and claims specialists, are industry experts who can help you get to the bottom of a wide variety of healthcare and insurance-related issues.

Help for the whole family

You, your spouse, dependent children, parents and parents-in-law can all use the service.



Email: answers@healthadvocate.com
Web: www.healthadvocate.com/member

Just Call!

24/7 Support 866.695.8622

How we can help

- ☑ **Find the right doctors**, hospitals and other providers
- ☑ **Schedule appointments**, transfer medical records
- ☑ **Explain conditions** and research latest treatments
- ☑ **Resolve billing and insurance claims issues**
- ☑ **Secure second opinions**
- ☑ **Clarify benefits** and get approvals for covered services
- ☑ **Find options for non-covered services**
- ☑ **Estimate costs** for medical procedures and negotiate payments
- ☑ **Locate eldercare services**

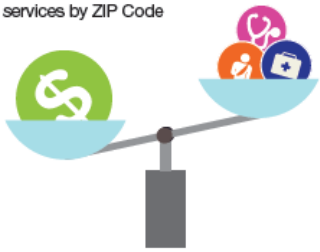
Plus. . . Help Shopping for Healthcare

Save money on your healthcare expenses by comparing prices for medical procedures right in your area. Our Health Cost Estimator+ and pricing support will:

- Get pricing estimates for doctors, hospitals and other facilities nationwide
- Compare costs for hundreds of medical services by ZIP Code
- View provider quality and safety scores
- Read patient reviews

Three easy ways to get help:

Online | Mobile | Call



Staff Meeting Schedule

2017 All-Staff Meeting Schedule

Date	Time	Location	Hosts
Monday, 1/30/17	10:00 am - 11:30 am	5th Floor Blair Room	Exec. Office/Adminstration
Monday, 3/27/17	10:00 am - 11:30 am	Montgomery Park	Finance & Exec. Office/Adminstration
Monday, 5/22/17	10:00 am - 11:30 am	Montgomery Park	Development & Impact Strategies
Thursday, 6/22/17	8:00 am - 10:30 am	TBD	N/A
July/August, Summer Event	Afternoon	TBD	Exec. Management Council
Monday, 9/25/17	10:00 am - 11:30 am	Montgomery Park	Impact Strategies & Exec. Office/Admin.

2017 Pay Date

Employee Pay Period	UWCM Pay Date
Dec 26 - Jan 8, 2017	Jan. 12, 2017
Jan 9 - Jan 22, 2017	Jan. 26, 2017
Jan 23 - Feb 5	Feb. 9, 2017
Feb 6 - Feb 19	Fed. 23, 2017
Feb 20 - Mar 5	Mar. 9, 2017
Mar 6 - Mar 19	Mar. 23, 2017
Mar 20 - Apr 2	Apr. 6, 2017
Apr 3 - Apr 16	Apr. 20, 2017
Apr 17 - Apr 30	May. 4, 2017
May 1 - May 14	May. 18, 2017
May 15 - May 28	Jun. 1, 2017
May 29 - Jun 11	Jun. 15, 2017
Jun 12 - Jun 25	Jun. 29, 2017
Jun 26 - Jul 9	Jul. 13, 2017
Jul 10 - Jul 23	Jul. 27, 2017
July 24 - Aug 6	Aug. 10, 2017
Aug 7 - Aug 20	Aug. 24, 2017
Aug 21 - Sept 3	Sept. 7, 2017
Sept 4 - Sept 17	Sept. 21, 2017
Sept 18 - Oct 1	Oct. 5, 2017
Oct 2 - Oct 15	Oct. 19, 2017
Oct 16 - Oct 29	Nov. 2, 2017
Oct 30 - Nov 12	Nov. 16, 2017
Nov 13 - Nov 26	Nov. 30, 2017
Nov 27 - Dec 10	Dec. 14, 2017
Dec 11 - Dec 24	Dec. 28, 2017
Dec 25 - Jan 7, 2018	Jan. 11, 2018
Jan 8 - Jan 21, 2018	Jan. 25, 2018

2017 Paid Holidays and Work Week

UWCM recognizes that holidays are special times for all. UWCM officially observes ten holidays:

UWCM has a 37.5 hour work week.

8:30 am- 5:00 pm, Monday through Friday.

Holiday	Dates
New Years Day	Monday - 1/2/17
Martin Luther King Jr.'s Birthday	Monday - 1/16/17
Presidents Day	Monday - 2/20/17
Memorial Day	Monday - 5/29/17
Independence Day	Tuesday - 7/4/17
Labor Day	Monday - 9/4/17
Thanksgiving Day	Thursday - 11/23/17
Friday after Thanksgiving	Friday - 11/24/17
Christmas Day	Monday - 12/25/17
FLOATING HOLIDAY:	
New Years Day	Monday - 1/1/18

2017 Holiday Highlights
1-4 Day Weekend Holiday
7-3 Weekend Holiday

Carrier Contacts

Your carriers are just a phone call away! Please contact them via the phone number below or visit their website to view your claims, request an ID card, locate a provider and much more!

Medical/Vision	**CareFirst BlueCross BlueShield**	www.carefirst.com	888-630-2583
Dental	**Dominion**	www.dominionnational.com	1-888-518-5338
Life and Disability	**Unum**	AskUnum@unum.com	800-ASK-UNUM
Flexible Spending	**TASC**	www.tasconline.com/mytasc	800-422-4661
Health Advocate	**Health Advocate**	HealthAdvocate.com/members	866-695-8622
Employee Assistance	**Unum**	AskUnum@unum.com	English: 800-854-1446
Program			Spanish: 877-858-2147
Emergency Travel Assist	**Unum**	www.unum.com	w/in the U.S.: 1 (800) 872-1414 Outside U.S.: (609) 986-1234
403(B) Retirement Plan	**TRowe Price Assoc**	WWW.RPS.Troweprice.com	800-492-7670

Additional UWCM Programs

- **Auto and Home Insurance:** This program allows you to purchase high quality auto, home and renters insurance at low group rates.
- **Bereavement Leave:** With prior approval, up to 3 days in event of death of an immediate family member.
- **Computer Purchase Program:** Interest free financing for computer and computer-related equipment for staff following 2 years of employment.
- **Credit Union/Financial Banking Memberships:** Open to all employees.
- **Employee Referral Program:** Referring employees receive $500 cash award after new employee completes 90 days of employment plus an additional $500 after completion of one year of service.
- **Flexible Paid Leave:** Combination of vacation and sick leave based on years of UW service—2 yrs or less, 21 days; 2-5 yrs, 28 days; 5-9 yrs, 35 days; 9+ yrs, 42 days.
- **Individual Development Plan:** Individual job-related development and training reviewed and implemented annually.
- **SMARTMOVE:** Receive professional real estate assistance and cash rebates of up to $10,000 or more whenever you buy or sell a home as well as a closing cost credit of up to $2,500.
- **Social Security:** Employer match.
- **Summer Work Schedule:** June-August work schedule adjusted to allow 6 Friday through Sunday weekends without using FlexLeave.
- **Talent Development & Training:** Translate new learning into action that achieves results, facilitate continuous learning, growth and succession of talent. This action learning includes training, tools and opportunities for cross-functional teamwork, rotation and exchanges.
- **Transportation Fringe Benefit:** Subsidized parking pass or MTA pass.
- **Tuition Reimbursement:** For career related accredited courses: $1,000 per semester, $2,000 maximum per calendar year.
- **Unemployment Compensation:** Must meet state's eligibility.
- **Volunteering:** United Way Volunteer Involvement Program—with supervisory approval, staff will be allowed paid release time up to 8 hours per quarter.

Compliance Notices

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the 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 insurers 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/96 hours.

Notice of Health Information Privacy Practices

The privacy of your medical information is important to us. As a participant in a medical plan sponsored by UWCM, you may receive a HIPAA Privacy Notice. The HIPAA Notice describes how medical information about you may be used and disclosed and how you can get access to this information.
For more information about our privacy practices or for additional copies of the HIPAA Privacy Notice, please contact us using the information provided.

Contact:	Human Resources
Address:	3168 Collins Ferry Road Morgantown, WV 26505
Phone:	(443) 539-9044
Email:	HR@UWCM.com

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 1.800.433.5768.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional 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.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a qualifying event, as listed below. 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 covered 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 associate, you will become a qualified beneficiary if you lose your coverage under the plan because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.

If you are the spouse or dependent child of an associate, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- The associate dies;
- The associate's hours of employment are reduced;
- The associate's employment ends for any reason other than his or her gross misconduct;
- The associate becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The associate becomes divorced or legally separated; or
- If you are a dependent child, you stop being eligible for coverage under the plan as a "dependent child".

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying even has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the employer, or the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the associate and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. You must provide this notice to the benefits staff.

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the associate, the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 19-month period of continuation coverage.

If your family experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children can get up to 19 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to your spouse and any dependent children receiving continuation coverage if the associate or former associate 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.

If you have questions about your plan or your COBRA continuation coverage rights, refer to the contact listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Associate Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

In order to protect your family's rights, you should keep the plan administrator informed of 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.

For more information about Medicare prescription drug plans, visit www.medicare.gov. Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) affects both employment practices and health plan administration.

- **Employment Practices.** Employers employing 15 or more employees cannot refuse to hire, cannot discharge, or otherwise discriminate against any employee or applicant due to the individual's genetic information, in any terms, conditions, or privileges of employment, including compensation.

- **Health Plan Administration.** Health plans of all types, whether individual or group, insured or self-funded, and whether sponsored by private, public or non-profit employers, are prohibited from using an individual's or his/her family member's genetic information for eligibility and rating purposes, except if based on a manifest condition. Plans are also prohibited from altering a premium or contribution amount based upon an individual's genetic nature.

A health risk assessment (HRA) cannot be used for or in connection with enrollment; nor can it be used for underwriting purposes, including premium discounts, benefit access, or other financial rewards. If the intent is to collect genetic information and family medical history, the HRA must be administered *after* the effective date of coverage, and cannot result in any kind of financial or benefit reward or detriment. If a financial reward is to be tied to the HRA, the HRA must be cleansed of all genetic information, including family medical history. It is important to note that genetic information is deemed to be protected health information (PHI), and subject to all of the privacy protections afforded PHI (see HIPAA Privacy Rules).

IMPORTANT NOTICE 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 UWCM 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.

1. UWCM has determined that the prescription drug coverage offered by CareFirst BlueCross BlueShield 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 CareFirst BlueCross BlueShield coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with UWCM 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the HR Department 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 UWCM changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	2017-18
Name of Entity/Sender:	UWCM Systems, Inc.
Contact--Position/Office:	Human Resources
Address:	1800 Washington Blvd., Suite 340 Baltimore, MD 21230
Phone Number:	(410) 895-1418
Email:	Rob.dubeau@uwcm.org

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 July 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**KANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	**KENTUCKY – 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: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	**MISSOURI – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK – Medicaid	**VERMONT– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
OREGON – Medicaid	**WISCONSIN – 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.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid	**WYOMING – Medicaid**
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
RHODE ISLAND – Medicaid	
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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.

Notes:


United
Way
United Way
of Central Maryland