



Ashley
Everything for Recovery

Employee Benefits Guide

2026-2027

Benefits Effective August 1, 2026 – July 31, 2027

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Contacts / Resources

Benefit	Partner	Website / Phone
Medical & Prescription Group #: 0LSP	CareFirst	member.carefirst.com 888-567-9155
Health Reimbursement Account (HRA)	Flores	flores247.com 800-532-3327
Flexible Spending Accounts (FSA)	Flores	flores247.com 800-532-3327
Dental Group #: 0LSP	CareFirst	member.carefirst.com 866-891-2802
Vision Group #: 1033259	EyeMed	eyemed.com 866-939-3633
Life and AD&D Life: FLX969821 AD&D: OK971260	New York Life	mynylgbs.com 888-842-4462
Disability STD: LK752806 LTD: LK966509	New York Life	mynylgbs.com 888-842-4462
Employee Assistance Program (EAP) Including ComPsych Web ID: NYLGBS	New York Life	guidanceresources.com 800-344-9752
Accident & Critical Illness Accident: AI110922 Critical Illness: CI110885	Cigna	cigna.com 800-754-3207
Financial Advisors	CAPTRUST	captrustadvice.com 800-967-9948
Human Resource / Payroll		
Stephanie O'Toole, Human Resources	sotoole@ashleytreatment.org 410-273-2286	
Julie Rund, Human Resources	jrund@ashleytreatment.org 410-273-2255	
Sharon Adams, Payroll	sadams@ashleytreatment.org	

Mobile Apps

CareFirst Mobile App	Log into My Account, view online ID cards, find a provider or urgent care, and more.
CloseKnit Health	Simple, convenient care centered around you. Available 24/7/365, always on time, hassle-free.
Flores Mobile	Submit supporting documentation for debit card transactions and reimbursement requests on-the-go.
EyeMed App	Access your benefit information on-the-go. Check eye exam, frame, contact, and lens benefits.

Eligibility / Your Coverage

Who is Eligible

- * Full-Time Employees (30+ hours/week) are eligible for all plans.
- * Your legal spouse or domestic partner - Your child(ren) up to age 26 for medical, dental, and vision (and disabled children up to any age*)
- * Dependent children up to age 26 for Voluntary Life
- * *Includes natural, step, legally adopted, placed for adoption, or under your legal guardianship.

When Does Coverage Begin?

Benefits for new hires, unless explained otherwise, will become effective on the first of the month following date of hire.

If you do not enroll during your eligibility period, you may enroll at the next open enrollment period.

Qualified Life Event

Change in Marital Status	Change in Dependents	Change in Employment
Marriage	Birth, adoption or placement for adoption of an eligible child (retroactive to the date of the event)	Change in you or your spouse's work status that affects benefits eligibility
Divorce	Death of your covered dependent	Relocation if the move impacts eligibility for the plan
Death of your spouse	Gain or loss of Medicare or Medicaid during the year	

Domestic Partners

Contact Human Resources for specific details regarding domestic partners' eligibility for continuation of coverage with Ashley, Inc. benefit plan due to termination of employment.

Contribution toward the cost of coverage for your domestic partner and their dependents is considered taxable income to you.

Domestic partner premiums will either be deducted on a post-tax basis or imputed as income based on the value of coverage. You may wish to consult with a tax adviser for more information.

Domestic partner's expenses under the FSA are generally not considered qualifying medical expenses.

Termination of Coverage

If you or a covered dependent no longer meet the eligibility requirements, have a qualifying event or if your employment ceases, your benefits will end at the end of the month in which employment ends.

You are responsible for informing Human Resources within 30 days if any of your dependents become ineligible for benefits.

Medical Overview



Ashley offers three medical plans through CareFirst with the following features:

- Deductibles and out-of-pocket maximums accumulate August 1st through July 31st.
- Includes prescription drug coverage .
- Please refer to the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC) as well as the carrier contracts for information regarding specific benefit levels, exclusions and limitations for all policies .
- Medical deductible runs on a plan year (August 1– July 31).

Information About Your Plan

Live outside of the CareFirst service area?

If you enroll in the BlueChoice Advantage PPO plan and obtain services outside the CareFirst service area (MD/DC/Northern VA), your providers must participate with BlueCard PPO for claims to process in-network. Make sure to ask if your providers participate with BlueCard PPO.

Laboratory Services

While inside the CareFirst service area, you must utilize a LabCorp for lab services. Services performed by any other provider will be considered out-of-network.

Medical Provider Finder

To search for in-network medical providers: Log on to member.carefirst.com

Choose Your Network:

BlueChoice HMO Open Access

Plan Options 1 and 2 are within this network

BlueChoice Advantage 2.0

Plan Option 3 is within network



Medical Plan Options

This summary highlights your medical plan options. For full details, coverage limits, and pre-authorization requirements, please review your Summary of Benefits.

Both choices are Health Maintenance Organization (HMO) plans, which require you to receive care from a specific network of providers. HMO plans typically feature lower out-of-pocket costs and predictable pricing, but they do not cover out-of-network care.

Both HMO options have HRA employer contributions. However, Option 2 features a lower deductible and out-of-pocket maximum, reducing financial risk for individuals with higher medical needs.

	Option 1 BlueChoice HMO Open Access	Option 2 BlueChoice HMO Open Access
Plan Provisions	In-Network (Individual / Family)	In-Network (Individual / Family)
Deductible	\$7,000 / \$14,000	\$5,000 / \$10,000
Employer HRA Contribution	\$5,500 / \$11,000	\$5,000 / \$10,000
Coinsurance	None	None
Out-of-Pocket Maximums	\$8,000 / \$16,000	\$8,000 / \$16,000
Coinsurance / Copays		
Preventive Care	No Charge	No Charge
Primary Care / Specialist Care	Deductible, then No Charge/ Deductible, then \$20 copay	Deductible, then No Charge/ Deductible, then \$5 Copay
Virtual Primary Care with CloseKnit	Deductible, then no charge	Deductible, then no charge
X-ray	Ded., then No Charge	Deductible, then No Charge
Lab	Ded., then No Charge	Deductible, then No Charge
Urgent Care	Ded., then No Charge	Deductible, then No Charge
Emergency Room Care	Ded., then No Charge	Deductible, then No Charge
Outpatient Surgery	Ded., then No Charge	Deductible, then No Charge
Inpatient Hospitalization	Ded., then No Charge	Deductible, then No Charge
Prescription Drugs		
(Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty)		
Retail Pharmacy	Ded., then \$15 / \$35 / \$60 / 50% to \$100 / 50% to \$150	Ded., then \$15 / \$35 / \$60 / 50% to \$100 / 50% to \$150
Mail-Order (90-day Supply)	Ded., then \$30 / \$70 / \$120 / 50% to \$200 / 50% to \$300	Ded., then \$30 / \$70 / \$120 / 50% to \$200 / 50% to \$300.

Medical Plan Options

This summary highlights your medical plan options. For full details, coverage limits, and pre-authorization requirements, please review your Summary of Benefits.

PPO plans offer greater flexibility than HMO plans by covering both in-network and out-of-network providers. While choosing in-network care significantly lowers your costs, this plan is ideal if you value a broader choice of doctors.

Option 3		
CareFirst Advantage (PPO) OUT OF STATE COVERAGE		
Plan Provisions	In-Network (Individual / Family)	Out-of-Network (Individual / Family)
Deductible	\$5,000 / \$10,000	\$10,000 / \$20,000
Employer HRA Contribution	\$5,000/\$10,000	
Coinsurance	100%	80%
Out-of-Pocket Maximums	\$8,000 / \$16,000	\$15,000 / \$30,000
Coinsurance / Copays		
Preventive Care	No Charge	Deductible, then 20%
Primary Care	Ded.	Deductible, then 20%
Specialist Care	Ded., then \$5 Copay	Deductible, then 20%
Virtual Primary Care with CloseKnit	Deductible, then no charge	N/A
X-ray	Deductible, then no charge	Deductible, then 20%
Lab	Deductible, then no charge	Deductible, then 20%
Urgent Care	Deductible, then no charge	In-Network Deductible, then 20%
Emergency Room Care	Deductible, then no charge	Paid As In-Network
Outpatient Surgery	Deductible, then no charge	Deductible, then 20%
Inpatient Hospitalization	Deductible, then no charge	Deductible, then 20%
Prescription Drugs		
(Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty)		
Retail Pharmacy (30-day Supply)	Ded., then \$15 / \$35 / \$60 / 50% to \$100 / 50% to \$150	Paid As In-Network
Mail-Order (90-day Supply)	Ded., then \$30 / \$70 / \$120 / 50% to \$200 / 50% to \$300	Paid As In-Network

Specialty drugs must be filled through the exclusive specialty pharmacy network

Medical Rates and Health Reimbursement

Benefit contributions are automatically deducted from your paycheck every two weeks on a pre-tax basis. This lowers your taxable income, reducing the amount of taxes you pay.

Bi-Weekly Medical Costs	
(Option 1) BlueChoice HMO Open Access HRA	Full-Time
Employee Only	\$25.85
Employee + Spouse / DP	\$180.00
Employee + Child(ren)	\$133.85
Employee + Family	\$226.15
(Option 2) BlueChoice HMO	Full-Time
Employee Only	\$107.10
Employee + Spouse / DP	\$412.40
Employee + Child(ren)	\$340.67
Employee + Family	\$502.03
(Option 3) BlueChoice Advantage HMO Open Access HRA	OUT OF STATE COVERAGE Full-Time
Employee Only	\$144.54
Employee + Spouse / DP	\$484.96
Employee + Child(ren)	\$400.61
Employee + Family	\$590.33

Ashley, Inc.'s HRA Contribution			
	Option 1 BlueChoice HMO Open Access HRA	Option 2 BlueChoice HMO Open Access HRA	Option 3 BlueChoice Advantage HRA
Individual	\$5,500	\$5,000	\$5,000
Family	\$11,000	\$10,000	\$10,000

**Eligible expenses must be incurred by July 31, 2027 (end of the plan year).
Unused funds do NOT roll over from year to year.**

Our medical plans include a Health Reimbursement Account (HRA), which is a tax-advantaged account funded by your employer to help cover your medical plan costs that are subject to the deductible. **Your HRA is designated for eligible medical expenses only and does not cover dental, vision, or other non-medical services.**

Register your online account through Flores at flores247.com

Please refer to your plan documents regarding filing claims and debit cards.

Dental Rates & Overview



Please refer to the plan summary for additional details and limitations

BlueDental Plus PPO		
Benefit Maximum Per Person	In-Network	Out-of-Network
Policy Year Annual Max	\$5,000	
Orthodontia Lifetime Max	\$1,500	
Deductible (applies only to Basic & Major Services)		
Individual	\$25	\$50
Family	\$150	\$150
Benefit	You Pay	
Preventive Services	No Charge	
Basic Services	20% of Allowed Benefit ¹	
Major Services	50% of Allowed Benefit ¹	
Orthodontia	50% of Allowed Benefit ¹	
¹ Allowed Benefit (AB) is the amount established for payment of covered In-Network services. The Allowed Benefit will generally be lower than the amount charged. You are responsible for copayments, coinsurance, and all charges that exceed the Allowed Benefit for services received Out-of-Network. This is called balance billing.		

Bi-Weekly Dental Costs Full-Time	
Employee Only	\$8.11
Employee + Spouse / DP	\$18.63
Employee + Child(ren)	\$18.63
Employee + Family	\$30.65

Dental insurance is offered through CareFirst. Your choice of dentists can determine the cost savings you receive. You will pay less for in-network services. CareFirst will pay claims based on allowed charges for out-of-network providers. You are responsible for paying the balance of the bill.

Vision Rates & Overview

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions.

The EyeMed vision plan provides coverage for exams, glasses and contact lenses, as shown below.

In-network coverage is provided when you use EyeMed providers. Refer to plan summary for limitations.

Based on Policy Year	In-Network	Out-of-Network
Eye Exam Once every plan year PLUS Provider / Standard Provider	\$0 Copay / \$10 Copay	\$40
Lenses Once every plan year Single / Lined Bifocal/ Lined Trifocal	\$25 Copay	\$30 / \$50 / \$70
Frames Once every plan year PLUS Provider / Standard Provider	\$0 copay, 20% off balance over \$170 allowance / \$0 Copay 20% off \$120 allowance.	\$84
Contacts Instead of glasses, Once every plan year Elective / Medically Necessary	\$120 allowance ¹ / Covered in full	\$84 / \$210
¹ If you elect conventional contact lenses you will receive a 15% discount on the balance over \$120.		

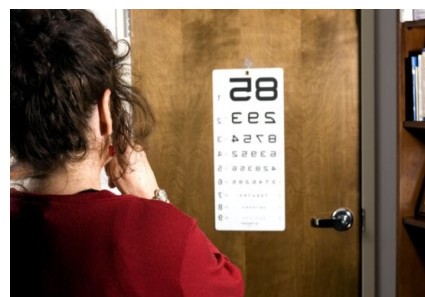
Bi-Weekly Vision Costs	Vision Plan
Full-Time	
Employee Only	\$3.00
Employee + 1	\$5.71
Employee + 2 or More	\$8.38

Vision Provider Finder

To search for in-network vision providers:

Log on to: eyemed.com

Network: Insight



Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars through regular payroll deductions to cover eligible medical, dental, and vision expenses. Operating on an annual basis, an FSA functions similarly to a savings account dedicated strictly to health-related costs like treatments, eyeglasses, and contacts.

Please note that expenses for a domestic partner generally do not qualify for FSA coverage.








You can register and manage your account through Flores at flores247.com. For information on filing claims and using your debit card, refer to your FSA plan documents. To browse eligible purchases, visit fsastore.com.

Healthcare FSA Contribution Limit	Dependent Care FSA Contribution Limit
\$3,400 per year	\$7,500 per year (\$3,750 if married and filing separately)

Healthcare FSA Qualified Expenses	Dependent Care FSA Qualified Expenses
Healthcare FSA funds are available in full on day one.	Children under age 13
You have the option to roll over up to \$610 of unused FSA dollars to the following plan year.	Older dependents, including children, spouses, and parents who are physically or mentally unable to care for themselves and that live with you more than 1/2 of the year.
These roll over funds will not count against your future FSA election /contribution limit.	Dependent Care FSA funds are contributed to your account as they are taken from your paycheck.
Any unused balances more than \$680 will be forfeited on 10/29/2027.	Eligible expenses include daycare, before-school and after-school care, babysitters, and elder daycare.
	Kindergarten or higher education does not qualify.

CareFirst Virtual Visits

Included with a CareFirst plan

-  No copays for PCP, urgent care and behavioral health visits through CloseKnit* and select in-person providers (may be subject to deductible**)
-  24/7/365 access to care at home or across the U.S. through CloseKnit
-  Same-day or scheduled virtual appointment:
-  Convenience of managing healthcare needs through desktop or CloseKnit mobile app
-  Comprehensive care from a dedicated team
-  Full-time, dedicated, highly credentialed providers
-  Coordination for in-person, specialty care if needed

More information: carefirst.com/virtualconnect



Scan the QR code or visit closeknit.com to get started.



CareFirst Mail Order & Rx Cost Saver

Mail order is a convenient way to fill your prescriptions. It's especially helpful for getting refills for drugs you take frequently--often daily. These are referred to as maintenance medications and are used to treat chronic, long-term conditions, such as high blood pressure, diabetes or asthma. A prescription for a maintenance medication can often be filled multiple times before your doctor is required to write a new one.

How does Rx Cost Saver work?

Rx Cost Saver offers access to lower pricing, when available, on non-specialty generic drugs that also have discounted pricing available through the GoodRx^{®**} prescription program.

Rx Cost Saver works automatically. All you have to do is present your CareFirst member ID to the pharmacist—that's it. We do the rest. No other action is required.

Here's an example.

- You or your doctor submits a prescription to the pharmacy.
- The pharmacist submits the claim, and we compare prices behind the scenes.
- Let's say your covered benefit price for the prescription is a \$20 copay and the discount pricing from GoodRx[®] is a \$16 copay. You'll pay the lower price, \$16.
- We will also apply your payment to your deductible (if applicable) and out-of-pocket maximum. It's that easy.



It's easy to register for mail order

Choose one of the following three ways:



Online

Go to carefirst.com/myaccount and log in. Under the *Coverage* tab, select *Drug and Pharmacy Resources*, and select *Request a New Mail Order Prescription*. Once you've entered your prescription information, we will contact your doctor to request up to a 90-day supply of your medication.



By phone

Call the toll-free phone number on the back of your member ID card. Our Customer Care representatives can walk you through the process.



By mail

If you already have your prescription, you can send it to us with a completed *Mail Service Pharmacy Order Form*. Log in to *My Account* and select the *Coverage* tab, then choose *Drug and Pharmacy Resources*. Scroll to the bottom of the page and click on *My Drug Forms*. Mailing instructions are included on the form.



Scan the QR code to watch a video on how to fill your prescriptions at your local pharmacy or by mail order.

How a Health Plan Works

A Note About Health Care Reform

If you choose to purchase individual coverage through the Marketplace, you should know that because Ashley, Inc.'s medical insurance meets specific ACA requirements, you may not be eligible to receive a federal subsidy.

Additional information is available at healthcare.gov.

Balance Billing

Balance billing occurs when a provider invoices you for the difference between their charge and the carrier's discounted price (the "Allowed Benefit"). For instance, if the provider's charge is \$100 and the Allowed Benefit is \$70, they may bill you for the remaining \$30. However, in-network providers are not permitted to balance bill for the difference between their charge and the Allowed Benefit.

Copays

A copay is a fixed amount you pay for a health care service and does not count toward your deductible but does count toward your annual out-of-pocket maximum.

Coinsurance

Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

Deductible Amount

The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.

Out of Pocket Maximums

The most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the plan year.

Inclusive Health Benefits

Healthcare Equality Index

Dedicated to providing inclusive and compassionate healthcare, Ashley, Inc. is honored to take part in the Human Rights Campaign Foundation's Healthcare Equality Index (HEI). This vital initiative serves as a guiding light, ensuring that every lesbian, gay, bisexual, transgender, and queer individual who enters our doors receives care that respects and embraces their unique identity.

We are proud that Ashley Inc.'s commitment extends beyond compassionate, equitable patient care and to our own employees as well. We have thoroughly evaluated our medical policies in alignment with the World Professional Association for Transgender Health (WPATH)'s latest Standards of Care (WPATH 8). Our CareFirst medical policies are designed to be affirming and supportive. You can find a brief overview of essential benefits on pages 9-11. Benefits highlighted below are for services such as fertility treatments, hormone therapies, and surgical gender reassignment support. For comprehensive insights into the specific benefits of your medical plan or a copy of your CareFirst medical policy, please contact our dedicated Human Resources team. At Ashley, we stand united in our commitment to nurturing a culture of respect, equality, and exceptional care for all.

What our Plans Cover

Cryopreservation (egg or sperm freezing) for non-medical reasons: Cryopreservation is not covered.

Infertility treatments including Assisted Reproductive Technologies: Ashley's medical plans include infertility coverage, including AI and IVF. The member must meet criteria, and your provider must provide clinical information; however, it is not based on the diagnosis alone. CareFirst requires pre-authorization.

Pharmaceutical coverage for hormone replacement therapies and puberty blockers for youth: Ashley's medical policies cover HRT and puberty blockers. CareFirst requires pre-authorization

Coverage for reconstructive surgical procedures relating to gender reassignment: The medical policies cover reconstructive procedures for top and bottom interventions for members aged 18 years or older. Prior authorization is required. Facial feminization surgery (FFS) must be deemed medically necessary by CareFirst. There are no "one time only" approvals, as bottom surgeries and FFS are usually multiple interventions.

There are no separate deductibles for affirming care, and dependents are equally covered.

The CareFirst network contains a wide range of skilled doctors; if a member chooses to go out-of-network, they will be made aware of the costs.

HEALTHIER, HAPPIER EMPLOYEES WITH BLUE REWARDS

To help encourage your employees to take an active role in their health, CareFirst BlueCross BlueShield (CareFirst) offers the Blue Rewards incentive program as part of your medical benefits. Blue Rewards can help improve your population's health, reduce absenteeism and decrease your healthcare spending over time. With Blue Rewards, everyone benefits!

Connecting incentives to action

Blue Rewards connects your employees to CareFirst WellBeingSM resources, support and programs. Available anytime, anywhere, the program's highly personalized digital experience can help them live a healthier life. Once your employees take the RealAge[®] health assessment—one of the incentivized activities—they start to receive tailored recommendations and resources.

With Blue Rewards, your employees earn incentives for each activity they complete and can use their rewards to pay for eligible health products!

How it works

Blue Rewards helps your population become more aware of their health status and take steps toward improving it. Employees and their spouse or domestic partner can choose which activities they want to complete. Rewards will be earned for accomplishing one, all or any of the following activities:



Earn \$50

Consent to receive wellness emails and take the RealAge[®] test

RealAge is a simple questionnaire that will help determine the physical age of the body compared to its calendar age.

Must complete within 180 days of your employees' effective date.



Earn \$100

Select a primary care provider (PCP) and complete a health screening

Employees can visit their PCP or a CVS MinuteClinic[®] to complete a screening.

Must complete within 180 days of your employees' effective date.



Earn \$25

Retake the RealAge[®] test

If the reward is earned for taking the test initially, your employees can earn an additional reward for retaking it after 90 days.

RealAge answers must be updated or confirmed no earlier than 90 days after the original assessment, and before the end of the benefit period.



Earn up to \$200

Participate in health coaching

- Session 1 = \$30
- Session 2 = \$70
- Session 3 = \$100

CareFirst Behavioral Health Digital Resource

It's perfectly normal to face difficult times or some form of mental health challenge during your life. We all do. When it happens, it's important to remember you're not alone. And it's never too late to seek help.

Get confidential mental health support at no cost to you

CareFirst BlueCross BlueShield (CareFirst)—together with 7 Cups of Tea¹ (7 Cups), the world's largest behavioral health support system—is pleased to offer a digital resource to help you live your best life.

With the CareFirst Behavioral Health Digital Resource, you can get the emotional care you need, when you need it, 24/7. You can also connect to a caring, accepting community and learn new skills to help you grow stronger.

Be heard, meet great people and feel like you again

If you're a CareFirst member with medical benefits, you can participate and get the mental health support you need in a way that best suits you.

- **Talk with someone who understands**—Access over 430,000 trained, volunteer listeners who, unlike family or friends, don't try to solve problems—they just listen. Through chat-based messaging, you can talk one-on-one about any issues, big or small, whatever's in your heart. *Support is available in more than 140 languages.*
- **Connect with a licensed therapist**²—A CareFirst behavioral health care manager can help you make an appointment.
- **Join a support forum**—Be part of a large, accepting community working together to provide a supportive and understanding forum through online discussion boards, specific group chats and moderated chat rooms.
- **Learn new coping skills**—Take small, simple steps to transform your life. Over 35 growth paths teach valuable skills on various topics, including overcoming depression, financial freedom, getting through breakups, grieving, work stress and more.

The help you need is waiting.

To set up your free account, visit carefirst.com/myaccount and enter your CareFirst *My Account* username and password. Once logged in to My Account, scroll down to the *Featured Resources* and select the *Behavioral Health Digital Resource* tile. Or, download the 7 Cups app from the Apple and Android stores. After you've registered, simply log in and start your journey to better mental health.



Life and AD&D Insurance

Basic Life/AD&D

A Basic Life insurance policy is provided through New York Life, at one times your annual earnings to a maximum benefit of \$200,000. Eligible employees are automatically enrolled in this benefit.

This coverage includes an Accidental Death and Dismemberment (AD&D) provision, at the same coverage amount, in the event of accidental death and other conditions. Please refer to the benefit summary for details.

According to federal law, only the first \$50,000 of employer-paid life insurance is not taxable.

Premium paid by Ashley, Inc. for coverage levels over \$50,000 will be taxable to you and will be included on your year-end W-2 statement.

What is Life Insurance?

- A lump sum payment distributed to beneficiaries upon death of the insured or insureds
- Reassurance that your loved ones would be financially secure if you passed away unexpectedly
- Ability to assist with funeral costs – the average funeral cost is \$10,000



Reminder!

Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected. Update your beneficiaries now and keep them current each year.



Disability Benefits

Disability Insurance replaces a percentage of your income during extended periods of illness or injury that prevent you from performing your regular work. New York Life administers the Disability insurance benefit plans for eligible full-time employees.

Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months.

Short-Term Disability

When do the benefits start?

8th day of accident or illness

(Benefit duration is reduced by the initial disability waiting period before benefits begin).

How much would the benefit pay?

60% of your weekly pre-disability earnings up to **\$2,000 per week**.

How long will the benefit pay?

Up to **13 weeks**, as long as you qualify as disabled.

Important Disclaimer

*STD benefits integrate with state mandated disability plans.

Maternity claims fall under this policy. *

Long-Term Disability

When do the benefits start?

After 90 days of qualified disability

How much would the benefit pay?

60% of basic monthly earnings up to **\$7,500 per month**.

How long will the benefit pay?

If you become disabled prior to age 62, benefits will continue until age 65 or to the date the 42nd payment is made, if later. If you are still working and become disabled after the age of 62 years, the duration of benefit payments are subject to the schedule found in the policy.

Voluntary Life Insurance

You can purchase Voluntary Life insurance through New York Life for yourself and dependents.

Please refer to the benefit summary for details.

Voluntary Life and AD&D	
Employee	\$10,000 increments to a maximum of \$500,000 Guaranteed issue*: \$200,000
Spouse / Domestic Partner	\$5,000 increments to a maximum of \$250,000, not to exceed the employee's election amount Guaranteed issue*: \$25,000
Child (up to age 26)	\$1,000 increments to a maximum of \$10,000
<p>*Guaranteed issue is the amount of coverage you or your dependents can elect up to without medical questions. Guaranteed issue is only available to newly benefit eligible employees. Evidence of Insurability (EOI) may be completed and submitted to New York Life for amounts above the guaranteed issue listed.</p>	

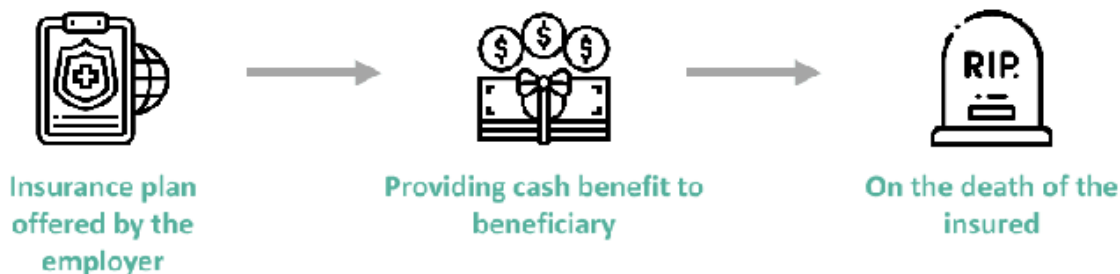


Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected.



Voluntary Life Insurance



Employee Assistance Program (EAP)

Whatever life
throws at you,
throw it our way

Employee Assistance &
Wellness Support



Our suite of value-add resources includes:

› **Employee
Assistance
Program¹**

Are you feeling overwhelmed by the demands of balancing work and family life? Maybe you have questions about a legal or financial concern. You and your family members now have access to various counseling services including legal, financial, and work-life balance assistance. All counseling calls are answered by a Master's or PhD-level counselor who will collect some general information and will discuss your needs. The Employee Assistance Program provides a maximum of three sessions, per issue, per year.

› **Guidance
Resources⁰¹**

When you need information quickly to help handle life's challenges, you can visit guidanceresources.com for resources and tools on topics such as health and wellness, legal regulations, family and relationships, work and education, money and investments, moving services and resources, and home and auto. You will also have access to articles, podcasts, videos, slideshows, on-demand trainings, and "Ask the Expert" which provides personal responses to your questions.

› **Well-being
Coaching¹**

Sometimes you may need help with personal challenges and physical issues that can be overwhelming. To help you achieve your goals, you will have access to a certified coach who will work with you, one-on-one, to address health and well-being issues such as burnout, weight loss, time management, and coping with stress. You have access to five sessions per year. All sessions are conducted telephonically.

› **FamilySource⁰¹**

Managing the everyday concerns of home, work, and family can be difficult. To help resolve those concerns, you have access to family care service specialists that provide customized research, educational materials, and pre-screened referrals for childcare, adoption, elder care, education, and pet care.

Contact Information

24/7 — Employee Assistance and Wellness Support



Phone: (800) 344-9752



Website: guidanceresources.com

First time visitor? Click "Register" and enter "NYLGBS" as the Organization Web ID.

Supplemental Benefits



Ashley, Inc. offers additional voluntary benefit plans through Cigna. These plans are not medical insurance and do not replace your medical coverage, but rather pay cash directly to you in addition to any benefits you receive from your health plan.

Accident Insurance
Pays a cash benefit when you or your covered family members suffer injuries sustained in an accident.
Accidental Death Benefit
Hospital Admission, Emergency Care and Ambulance
Fractures, tears, concussion
Burns
Critical Illness
Helps protect you from financial loss by providing a lump-sum benefit upon diagnosis of a covered condition, such as Heart Attack, Stroke, Cancer, and Major Organ Failure, etc.

What Can I Do with the Money I Receive?

- Cover cost of copays, deductibles, and coinsurance
- Reimburse yourself for transportation and lodging costs
- Help with childcare and other domestic expenses - Assist with home health care cost
- Make up for lost wages
- Pay everyday expenses, such as rent, utilities, and groceries

Additional Company Benefits

Please see Human Resources for details.

Designated Holidays (7 per year)

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Other Paid Leave

Ashley provides up to 3 days of Jury Duty and up to 5 days of Bereavement Leave. We also provide up to 2 weeks annually for Military leave.

401(k) Plan (VOYA)

Full-time employees (30 hrs./wk. or more) can enroll in the plan on the first of the month after a full month of continuous service. All other employees are eligible once they complete 1,000 working hours in a given fiscal year (7/1 through 6/30). Eligible employees are subject to automatic enrollment with a 6% contribution from their pay unless they opt-out. For all participants, Ashley will match dollar for dollar up to the first 6% of the employee contribution. Employees are 100% vested in the company matching immediately. Automatic deferral increases at 1% each year up to 10%. Employees must opt out of this option if they do not wish to participate. Employees may contribute up to 50% of their pay, subject to the annual dollar limit of \$24,500. If age 50 or more by year end, you may make a "catch-up" contribution. For 2026 the "catch-up" contribution is \$8,000. If age 60 through 63 by December 31, the catch-up limit is \$11,250.

Tuition Reimbursement Program

Employees are eligible for reimbursement of tuition and fees up to \$5,250 per calendar year after completing one year of service.

CAPTRUST Financial Advisors

Employees have free access to financial advisors through CAPTRUST. Whether you are looking for advice with budgeting, managing debt, retirement, college savings, or more, you can receive personalized guidance from trusted advisors.

Life Mart

Movie tickets, theme parks, events, online shopping, and more.

Spiritual & Emotional Wellbeing:

Daily non-denominational services and Employee Assistance Program (EAP).

Wellness Perks

On-site gym, tranquil 1-mile walking loop, and discounts on Massage & Acupuncture services.

IMPORTANT NOTICES

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). WHCRA requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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;
- Prosthesis; and treatment of physical complications of the mastectomy, including lymphedema.

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for other benefits under the plan.

Special Enrollment Rights

If you are declining enrollment for yourself, or your dependents (including your spouse) in the medical plan because of other medical coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' coverage). However, you must request enrollment within 30 days after your previous coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available from the insurance carriers for medical, dental, and vision insurance. A copy of the Privacy Practices for the Health Care Flexible Spending Accounts is available from Human Resources.

Newborns' and Mothers' Health Protection Act

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

Important Notice About Your Prescription Drug Coverage and Medicare

If you and your covered dependents are not currently covered by Medicare and will not become covered by Medicare within the next 12 months, this Notice is for informational purposes only. **Please read this notice carefully and share it with any of your Medicare-eligible dependents.** This notice has information about your current prescription drug coverage with Ashley Treatment Center 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. Ashley Treatment Center has determined that the prescription drug coverage offered by Ashley Treatment Center 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 15 through December 7. 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 coverage with Ashley Treatment Center will not be affected. You can keep this coverage if you join a Medicare drug plan and this plan will coordinate with your Medicare drug coverage. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your medical and prescription drug coverage through Ashley Treatment Center, be aware that you and your dependents will not be able to get this coverage back until the next 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 Ashley Treatment Center 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.

Medicare notice reminder:

Keep this 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).

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed on this notice 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 Ashley Treatment Center 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).

Date: April 23rd 2026

Sender: Ashley Treatment Center

Contact: Human Resources

Address: 800 Tydings Ln, Havre De Grace, MD 21078

Email Address: Hr@ashleytreatment.org

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, we are asking that you not provide genetic information when responding to any request for medical information.

"Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility.

VIRGINIA – Medicaid & CHIP

Website: <https://www.coverva.org/hipp/>

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-855-242-8282

ADD IN AFTER SPEAKING TO GROUP

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

<https://www.dol.gov/agencies/ebsa>

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

<https://www.cms.hhs.gov/>

1-877-267-2323

Menu Option 4, Ext. 61565

PATIENT PROTECTION CHOICE OF PROVIDERS

In cases where the TCPS, Inc. Group Health Plan allows or required a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, TCPS, Inc. Group Health may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your Employer Representative.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the TCPS, Inc. Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology,

PATIENT PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**”. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network.

You can choose a provider or facility in your plan’s network.

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

When balance billing isn’t allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, you may contact:

The US Department of Health and Human Services at:

Phone: 800-985-3059

Website: <https://www.cms.gov/nosurprises/consumers>

General Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

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

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

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

You must provide this notice to:

Contact: Human Resources

Mailing Address: 800 Tydings Ln, Havre De Grace, MD 21078

Email Address: Hr@ashleytreatment.org

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health

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

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

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

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

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

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

For more information visit

<https://www.medicare.gov/medicare-and-you>.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Contact: Human Resources

Mailing Address: 800 Tydings Ln, Havre De Grace, MD 21078

Email Address: Hr@ashleytreatment.org

Notices Disclaimer

Please Note: The notices contained in this open enrollment packet may not be all-inclusive. Allegeant strives to provide your employees current legal notices as they pertain to the employer health plans. It is ultimately the responsibility of the employer to ensure accuracy and furnish to their employees in accordance with the various laws. These notices should not be construed as legal advice. A best practice is for the employer to seek the advice and approval of legal counsel prior to adopting these notices in practice. Allegeant will not be liable for unintended deficiencies pertaining to the content or distribution of these notices. Responsibility rests with the employer.

