ROCHAMBEAU

THE FRENCH INTERNATIONAL SCHOOL

2024 Employee Benefits Guide

Benefit Plan Year
01/01/2024 – 12/31/2024

What's Inside

You can find information on...

2024

Table of Contents

Dear Colleagues,

I am delighted to share the 2024 Open Enrollment Benefits Guide and invite all benefits-eligible staff to participate in our annual benefits open enrollment from December 5th through December 15th.

I encourage you to take a moment to read the information in this guide and consider what benefits best serve your needs for the coming year. Rochambeau is proud to offer insurance plans to all eligible staff that enable the best healthcare for individuals and our families.

Finally, I want to offer my deep appreciation to all for waking up every day focused on making Rochambeau an inspiring place to develop today's learners into tomorrow's leaders. You are the heart of Rochambeau, and I look forward to working with each of you.

Sincerely,

Helene Fabre
Executive Director

2024 Benefits Open Enrollment

Begins Tuesday, December 5th through Friday, December 15, 2023

Rochambeau benefits-eligible employees have the opportunity to enroll in Rochambeau benefits when hired, during the annual open enrollment period, and when a qualifying life event occurs. Once enrolled in benefits, elections remain in effect unless a qualifying life event, such as marriage, divorce, birth of a child, or adoption, occurs (changes must be made within 20 calendar days of the event). Human Resources requests benefits-eligible employees to review benefits annually and make any changes during the Open Enrollment period. Please note that Health Savings Accounts (HSA) require annual enrollment.

Open Enrollment is your annual opportunity to reflect on your and your family's needs and fine-tune your benefits package to match. Many life events can occur over the year, impacting the types of plans and the coverage you need. Consider the changes you and your family have experienced in the past year or anticipate in the coming year. Then, determine which benefit plans and programs will best meet your needs.

Some important things to know as we approach Open Enrollment for 2024:

Medical insurance is a critical protection for you and your family in the event of illness or injury. Rochambeau's plan provides extensive coverage with low co-payments and deductibles. CareFirst BlueCross BlueShield will remain our medical, prescription drug, dental, and vision coverage provider in 2024, with reduced medical plan premium rates. The Dental and Vision plan rates will remain unchanged from the 2023 rates.

We will be streamlining our medical plans from three options to two. This improvement aims to enhance the overall value of our benefits offerings while ensuring that you get the most out of your benefits package. The school will offer the following medical plans:
***BlueChoice Advantage Option 2-S**
***BlueChoice Open Access HSA Option 10**

We want to emphasize that this decision has been carefully considered, and it is driven by a commitment to providing you with the best possible benefits while optimizing costs. We have observed that employees have been paying more for specific options than their actual value. By reducing the number of plans and focusing on those that offer the best value, we aim to ensure that your contributions are aligned with the benefits you receive.

Here are some key points to keep in mind regarding these changes:
Simplicity: With fewer options, choosing the right plan for your needs will become more uncomplicated and straightforward.
Cost Savings: This adjustment may lead to cost savings for you, as we have carefully assessed the pricing to match the actual value of each plan better.

We acknowledge that transformation can bring about adjustments, however rest assured, we are here to provide support throughout this transition. If you have any immediate questions or concerns, please contact our HR team.

Add Dependents and Keep Beneficiary Information up to date. If adding a new dependent to coverage during Open Enrollment, supporting documentation (e.g., copies of birth or marriage certificates) must be received by HR by Friday, December 15, 2023. You may submit your supporting documentation via email at hr@rochambeau.org or HR secure fax at (301) 798-4802.

For 2024, individuals under a high deductible health plan (HDHP) will have an HSA contribution limit of $4,150. The HSA contribution limit for family coverage will be $8,300. Those amounts are about a 7% increase over what you can contribute this year for 2023.

The school will now offer a Health Flexible Spending Account (FSA) Limited-Purpose FSA (LPFSA).

Reliance Standard is our new Employee Assistance Plan (EAP) provider and Life and Disability Insurance provider. Reviewing your life insurance beneficiaries during open enrollment is also good practice each year. While beneficiaries can be changed at any time during the year, this may be an excellent time to review and update the information if necessary. The EAP offers 24/7 support, resources, and information.

The school will also offer wellness initiatives starting in January 2024, including periodic chair massages, mindfulness rooms at each campus, and mental health wellness programs throughout the school year. Our goal is to further enhance our wellness, engagement, and success in our lives,

The Member Advocacy Program will continue with **Optavise**, a free service for Rochambeau medical plan participants and their adult dependents covered under the school medical plan. Optavise can:

-Find top-rated in-network providers in your area
-Get cost estimates before you go
-Consider site of care choices (virtual care vs in-person, PCP, urgent care, ER)
-Track your medical claims and healthcare spending.

The school will continue providing parking and transit benefits through **TASC**. The school will contribute $25 per month for transit and $25 for parking for enrolled staff.

While the following benefit is not part of Open Enrollment, we encourage you to review our 403(b) Retirement Plan administered through **TIAA**. To assist employees in saving for retirement, Rochambeau offers a 403(b) Retirement Savings Plan that is tax-deferred and available to employees of educational institutions and certain non-profit organizations. Contributions and investment earnings grow tax-deferred until withdrawal, assumed to be retirement, at which time they are taxed as ordinary income. Rochambeau offers a generous employer contribution to employee 403(b) plan when eligible employees contribute the minimum pre-tax contribution of 5% that Rochambeau will match. Employees who are members of a union should refer to their CBA for eligibility requirements. TIAA has financial consultants who can meet with you to review your retirement planning goals and answer your questions. Please contact Lulu Molavi, HR Generalist (molavin@rochambeau.org), or (301) 768-4393 for more information.

The school is showing our commitment to your well-being by offering meaningful and flexible benefits that support your physical, emotional, and financial health. It's up to you to choose what suits you and your family.

Should You Participate in Open Enrollment?

This year is considered an **active** enrollment for your medical/Rx, dental and vision benefits. This means that all employees must enroll or waive benefits for 2024. Your enrollment information will **not** roll over to the 2024 plan year automatically.

Making Critical Decisions During Open Enrollment

Each year during Open Enrollment, eligible Rochambeau staff can make important decisions that impact benefits for the upcoming plan period.

It is important to remember that your choices cannot be reversed or changed until the next annual Open Enrollment period.

The benefits you elect now will go into effect on **January 1, 2024.**

After Open Enrollment ends, you cannot do the following:

- Switch from one health plan to another.
- Switch from one dental plan to another.
- Add yourself or additional dependents to health, dental or HSA coverage.
- Cancel or alter your own and/or your dependent's health or dental plan coverage.
- Cancel or alter your employee-paid life insurance.
- Add, cancel or alter voluntary vision insurance

Changes can be made for certain qualifying events such as marriage, childbirth or adoption, loss of existing coverage for family members or retirement.

Changes must be made within 30 days of the qualifying event.

Once again, please remember that your choices during Open Enrollment will become effective on January 1st and remain permanent until the next annual Open Enrollment period.

For this reason, it is very important to spend time carefully reviewing Open Enrollment materials in their entirety to make sure you select the plans that best meet your coverage and financial needs.

Please review this 2024 Benefits Guide carefully as you consider your plan choices. Attend a Microsoft Teams webinar to better understand the details of the two medical plan choices, get an overview of all the benefits programs, and have an opportunity to ask questions on:

WEDNESDAY, DECEMBER 6th FROM 5:45-6:30 PM
Click here to join the meeting Meeting ID: 233 738 405 138 Passcode: 3qyaME
MONDAY, DECEMBER 11TH FROM 5:45-6:30 PM
Click here to join the meeting Meeting ID: 289 858 770 29 Passcode: 2EYyfY
THURSDAY, DECEMBER 14TH 5:45-6:30 PM
Click here to join the meeting Meeting ID: 229 283 090 096 Passcode: XbaJqe

If you can't attend, you can also view a recording of the webinar on the annual enrollment website on the Human Resources portal.

Enroll Online
You can enroll online through your ADP Self-Service portal.
Steps to Enrolling Online
1 . Log on to Self-Service.
2 . Click the Annual Enrollment message.
3 . Walk through the enrollment steps.
4 . To view or change your elections, select the Benefit Plan(s) you wish to change. You may also enroll, add, or drop dependents. Verify or update the information and click Agree to record your response(s).
5. Click View to review your Elections Preview Statement or Done to return to the Benefits Enrollment Summary. Be sure to save a copy of your Elections Preview Statement and carefully review it for accuracy. After December 15, most elections cannot be changed (except within 31 days of a family status change).

Making Changes
The IRS provides strict regulations about changes to pre-tax elections during the plan year. If you experience a qualified IRS family status change, you are permitted to make a change within 31 days of the event. If the change request is not completed within 31 days of the event, you cannot change your elections until the following year's benefits annual open enrollment period.

Below is a list of some of the more commonly known qualified family status changes:
• Marriage, divorce or annulment
• Birth of a child, adoption, placement of a foster child or assumption of legal guardianship of a child
• Change in your spouse's or dependent's employment status that affects benefits eligibility, including termination or commencement of employment, or change in worksite
• You or your spouse returns from an unpaid leave of absence
• You or your dependent becomes eligible or loses eligibility for Medicare or Medicaid
• The death of your spouse or dependent
• Change in your employment that affects benefits eligibility (working at least 20 hours per week)
• Loss of eligibility for a dependent

The change you request must be consistent with the qualifying event. Some changes require documentation, which must also be provided within 31 days of the event. Should you have questions or difficulty making your change, please contact Lulu Molavi, HR Generalist at molavin@rochambeau.org or (301) 768-4393.

Medical Benefits at a Glance

	HMO HSA Plan	Advantage Plan	
	In-Network	In-Network	Out-of-Network**
Maximum Employee HSA Contribution	$4,150/$8,300*	N/A	
Lifetime Maximum	Unlimited	Unlimited	
Annual Deductible * Individual/Family	$1,600/$3,200*	$500/$1,000*	$1,000/$2,000*
Out of Pocket Max	$4,500/$7,900* Medical and Rx Combined	$4,500/$9,000 * Medical and Rx Combined	$6,500/$13,000 * Medical and Rx Combined
Preventive Care	100% covered	100% covered	No charge after deductible
Regular Office Visits	No Charge after deductible	$10 per visit	You pay 20% after deductible
Specialist Office Visits	$5 copay after Deductible	$20 per visit	You pay 20% after deductible
Diagnostic Lab	No Charge after deductible	$10 per visit	You pay 20% after deductible
Diagnostic X-rays	No Charge after deductible	$20 per visit	You pay 20% after deductible
Inpatient Hospital Services	No Charge after deductible No Charge after deductible	Deductible then $300 per day ($1,500 per admission max)	You pay 20% after deductible
Outpatient Hospital Services	No Charge after deductible	Deductible then $200 per visit	You pay 20% after deductible
Urgent Care	No Charge after deductible	$40 per visit	
Emergency Room	No Charge after deductible	Deductible then $200 per visit	
Prescription Drugs: Retail (up to a 30-day supply)			
Generic (Tier 1)	No Charge after deductible	$10 copay	
Brand Formulary (Tier 2)	$25 copay after Deductible	$25 copay	
Brand Non-Formulary (Tier 3)	$45 copay after Deductible	$45 copay	
Prescription Drugs: Mail-Order (up to a 90-day supply)			
Generic (Tier 1)	No Charge after deductible	$20 copay	
Brand Formulary (Tier 2)	$50 copay after deductible	$200 copay	
Brand Non-Formulary (Tier 3)	$90 copay after deductible	$300 copay	
Prescription Drugs Maximum Out of Pocket (Retail and Mail-Order)			
Individual / Family	Included with Medical	Included with Medical	
Employee Monthly Payroll Deduction			
Employee	$317.48	$389.14	
Employee + Spouse	$730.23	$894.98	
Employee + Child(ren)	$587.34	$719.90	
Family	$965.13	$1,182.94	
Employee Bi weekly Payroll Deduction (26 pays)			
Employee	$146.53	$179.60	
Employee + Spouse	$337.03	$413.07	
Employee + Child(ren)	$271.08	$332.26	
Family	$445.44	$545.97	

** Balance billing may apply

Please see the Summary of Benefits and Coverage (SBC) on page 36 for more details

Dental Benefits

Rochambeau will continue to offer dental coverage through CareFirst BCBS, which has two dental plan options. **Via these plans, CareFirst members have access to one of the nation's largest dental networks with participating dentists located throughout the US.**

Under the **BlueDental Basic Plan**, plan members will have Preventive and Basic services coverage **with a $1,000 annual maximum per family member**. In addition, members have the flexibility to see any dentist of their choice, even if "out-of-network." However, members can reduce their out-of-pocket costs significantly by selecting a dentist who participates in "In-Network."

The **BlueDental Plus plan** is suitable for those seeking more comprehensive coverage. **This plan option includes Preventive, Basic, and Major Services as well as Orthodontia benefits. The annual plan maximum is $2,000 per family member.** Under the BlueDental Plus plan, members will receive the most savings by staying inside the CareFirst provider network.

Enhanced dental benefits: 2 additional no charge exams and cleanings per benefit period for members with the following conditions: Pregnancy up to 6 months post partum, diabetes and hypertension.

	BlueDental Basic Plan #1		BlueDental Plus Plan #5	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Associate Only Deductible	$25	$50	$25	$50
Family Deductible	$75	$150	$75	$150
Annual Maximum	Plan pays $1,000 Maximum per Insured		Plan pays $2,000 Maximum per Insured	
Preventative Services Oral Exams (2 per benefit period) Prophylaxis (2 per benefit period) Bitewing X-rays Full Mouth X-rays Palliative Emergency Treatment Fluoride Treatments Sealants Space Maintainers	No Charge	20% of allowed benefit[1]	No Charge	No Charge[1]
Basic Services Direct Placement Fillings Periodontal Scaling Simple Extractions	Deductible, then 20%	40% of allowed benefit after deductible	Deductible, then 20%	20% of allowed benefit[1]
Major Services Full/Partial Dentures Fixed Bridges, Crowns, Inlays, Onlays Denture Adjustments Recementing of Crowns/Inlay/Bridges Repair of Prosthetic Appliances Dental Implants	N/A	N/A	Deductible, then 50%	Deductible then 50% of allowed benefit[1]
Orthodontia	N/A	N/A	50%	50% of allowed benefit[1]
Orthodontic Lifetime Maximum	N/A	N/A	$1,000 per insured	
Employee Monthly Payroll Deductions				
Employee	$13.50		$24.82	
Employee + Spouse	$31.05		$57.07	
Employee + Child(ren)	$24.98		$45.90	
Family	$41.04		$75.44	
Employee Bi-Weekly Payroll Deduction (26 pays)				
Employee	$6.23		$11.45	
Employee + Spouse	$14.33		$26.34	
Employee + Child(ren)	$11.53		$21.18	
Family	$18.94		$34.82	

*Balance billing may apply

Vision Benefits

The **BlueVision Plus** plan through CareFirst will continue to be offered in 2024. Members receive professional vision services, including routine eye exams, eyeglasses and contact lenses offered by CareFirst BlueCross BlueShield through the Davis Vision, Inc. national network.

To find a provider, visit www.carefirst.com and utilize the *Find a Provider* feature or contact Davis Vision directly at 800-783-5602.

Note: Enhanced vision benefits -1 *additional* exam per benefit period – no charge for members with the following conditions: **Pregnancy up to (6) months postpartum, diabetes, and hypertension.**

	BlueVision Plus	
	In-Network	Out-of-Network
Eye Exam (once every 12 months)	No Copay	Plan pays $45, you pay the balance
Frames (once every 24 months)	• No Copay for Davis Vision Collection Frames • $130 allowance for non-collection frames. You pay balance minus 20% discount	Plan pays $60, you pay the balance
Lenses (once every 24 months)	$20 copay	Single: Plan pays $52 Bifocal: Plan pays $82 Trifocal: Plan pays $101 You pay the balance
Elective Contact Lenses (conventional or disposable)[1]	**In lieu of glasses:** • No Copay for Davis Vision Lens Collection $130 allowance for non-collection frames. You pay balance minus 15% discount	Plan pays $112, you pay the balance
Medically Necessary Contact Lenses[1]	No copay with prior approval	Plan pays $285, you pay the balance
Employee Monthly Payroll Deduction		
Employee	$8.25	
Employee + Spouse	$18.97	
Employee + Child(ren)	$15.27	
Family	$25.07	
Employee Bi weekly Payroll Deduction (26 pays)		
Employee	$3.81	
Employee + Spouse	$8.76	
Employee + Child(ren)	$7.05	
Family	$11.57	

Health Savings Account (HSA)

2024 IRS Contribution Maximum

- Single (Employee Only Tier) = **$4,150**
- Family (Employee + Spouse, Employee + Child(ren), Family Tiers) = **$8,300**
- Employees aged 55 and older who are eligible to participate in an HSA can contribute an additional $1,000 in "catch-up" contributions.

WHAT IS AN HSA?

Think of a Health Savings Account or HSA as a savings plan for health care that you'll need today, tomorrow, and into the future. It works like a regular bank account, but you don't pay federal income tax on the money you deposit.

When you use your HSA money to pay for qualified medical expenses, you won't pay income taxes on that money either. You can even build your savings into a nest egg for retirement. Note- if you are on ANY FORM OF MEDICARE, you are not eligible to contribute to an HSA. However, you can maintain an HSA account and use the existing funds for your healthcare expenses.

There's no "use it or lose it" rule either. The money is there when you need it and it's yours to keep.

WHY HAVE AN HSA?

An HSA simply helps you plan, save and pay for health care costs. The money belongs to you- you keep it, even if you change jobs, change health plans, or retire.

It has triple tax benefits.

- Money deposited in the account is not subject to Federal Income Tax
- Savings grow tax-free
- Withdrawals made for qualified expenses are also income tax free

It's not just for doctor's visits: You can use your HSA to pay for medical needs such as eyeglasses, hearing aids and qualified prescriptions.

You can invest it. Once your balance reaches the designated investment threshold which is typically around $2,000, you can begin investing in mutual funds. If you earn money on your investments, you don't pay income tax on that money either.

You can save for the future. By saving in an HSA, you can be better prepared for expenses due to illness or accident. When you turn Age 65 or become entitled to Medicare benefits, you may withdraw money from your HSA for expenses that are not qualified medical expenses which would normally be subject to standard income taxes. **Save as much as you can now, and you could have a nice nest egg when you retire.**

What are the Advantages of a Health Savings Account?

Ownership – Portability – Tax Savings – Long-Term Savings

- ✓ Completely employee-owned - you own and manage the account
- ✓ HSA contributions are payroll deducted on a pre-tax basis
- ✓ There are no "use it or lose it rules." HSA funds roll over from year to year.
- ✓ The interest earned from the money in the HSA is tax-free

HSA Funding

- ✓ Employee HSAs are funded through Optum Bank.
- ✓ Employees may contribute pre-tax dollars throughout the year up to the annual IRS calendar year maximum, based on the level of coverage elected.

Contributions will be deposited on a per-pay basis.

2024 Calendar Year
$4,150 Individual coverage
$8,300 Individual + Spouse, Individual + Child/Children, Family coverage

55 and older: catch-up contribution of an additional $1,000 during the calendar year.

BlueCard & BlueCross BlueShield Global Core

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll have the care you need when you're away from home, from coast to coast. Blue Cross Blue Shield Global® Core (BCBS Global® Core) also provides you with access to care outside of the U.S.

Your membership gives you a world of choices. More than 93% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're inside the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area ***(Maryland, Washington, D.C., and Northern Virginia*)**, you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay upfront for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com** or call BlueCard Access at 800-810-BLUE (2583).
3. Call the Customer Service number on the back of your member ID card to verify benefits or find out if pre-certification or prior authorization is required.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or pay upfront for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of the benefits.

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S.. The Blue Cross Blue Shield Global® Core program (BCBS Global® Core) provides medical assistance services and access to doctors, hospitals and other healthcare professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- In most cases, when being seen at hospitals in the BCBS Global Core Network, you shouldn't have to pay upfront for inpatient care. You're responsible for the usual out-of-pocket expenses; the hospital should submit your claim.
- At hospitals outside of the BCBS Global Core Network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Afterward, complete an international claim form and send it to the BCBS Global Core Service Center. The claim form is available online at **bcbs.globalcore.com**.
- To find a BlueCard provider outside of the U.S., visit **bcbs.com** and select *Find a Doctor or Hospital.*

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24 hours a day, seven days a week, for information on doctors, hospitals, and other health care professionals or to receive medical assistance services. In conjunction with a medical professional, a medical assistant coordinator will make an appointment with a doctor or arrange hospitalization if necessary.

Join Blue365® and start saving today!

With the Blue365 wellness discount program, great deals are yours for every aspect of your life—like 20% off at Reebok.com, discounted nutrition products or a gym membership for only $29 a month.

To take advantage of Blue365, register now at **carefirst.com/wellnessdiscounts**. It's an online destination featuring healthy deals and discounts exclusively for our members.

Just have your CareFirst member ID card handy. If you have medical coverage, use your member ID number to register for Blue365. If you do not have CareFirst medical coverage, but instead only have wellness, vision, dental or disability benefits, enter *233* instead of a member ID number.

In a couple of minutes, you will be registered and ready to shop. Every week, we will send a special deal straight to your email inbox.

Check out these top brands with discounts just for you:

Beltone
jenny craig
chewy
PHILIPS sonicare
eyemed
fitbit
QualSight LASIK
fitness your way
Reebok
GARMIN
TruHearing
Hotels.com
Walt Disney World

CST22S1-1P (5/22)

Blue365
Because health is a big deal™

Blue Rewards

Earning your rewards has never been easier! With our Blue Rewards program, you can decide which healthy activities interest you and be rewarded for completing them.

How it works

Blue Rewards offers you incentives for taking steps to get and stay healthy. Both you and your spouse/domestic partner can earn rewards for completing one, or all, of the following activities:

Earn $50

Consent to receive wellness emails and take the RealAge® assessment

RealAge is a simple assessment that will help you determine the physical age of your body compared to your calendar age.

Must complete within 180 days of your effective date.

Earn $25

Retake the RealAge assessment

If you earned the reward for taking the assessment initially, you 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 $100

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

You can visit your PCP or a CVS MinuteClinic® to complete your screening.

Must complete within 180 days of your effective date.

Earn up to $200

Participate in health coaching

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

Sessions must be held 2–60 days apart and must be completed before end of your benefit period.

Members with a high-deductible plan must reach their deductible before they can use their Blue Rewards debit card.

Learn more about the activities

Choosing a PCP

Even if you are young and healthy, or don't visit the doctor often, choosing a PCP is key to maintaining good health. PCPs play a huge role in keeping you healthy for the long run by:

- Helping you keep on top of preventive care like annual exams
- Coordinating the care you receive from other providers
- Providing quick and easy access to the care you need
- Getting to know you, your medical history, your habits and any concerns

RealAge

RealAge is a confidential, online health assessment that helps determine the physical age of your body compared to your calendar age. RealAge identifies the habits impacting your body's age so you can improve your well-being.

Health screening

Health screenings help you understand your current health status, so you can take steps to improve it. You can complete a health screening with your PCP or at a CVS MinuteClinic.

Your CareFirst Blue Rewards Visa® Debit Card

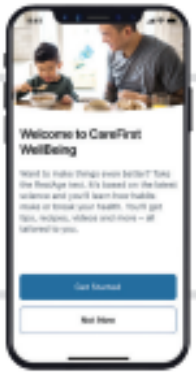
After you complete one or more of the activities, you'll receive your debit card in about 10–14 days. The card can be used toward your annual deductible or other out-of-pocket costs like copays or coinsurance related to eligible expenses (medical, prescription drug, dental and vision) under your CareFirst BlueCross BlueShield (CareFirst) health plan. Make sure to always save your receipts as proof of your expense.

Keep the card as long as you are a CareFirst member as any future incentives you earn will be automatically added to the same card.

You have until the end of your benefit period to use your reward, plus an additional 90 days to reimburse yourself for any eligible expense that occurred within that benefit period.

Note: only one card is issued to the policyholder, but it can be used by everyone covered under your policy (including dependent children).

To get started earning your rewards, visit **carefirst.com/wellbeing** to download the CareFirst WellBeing app and register for your account. If you have been using Sharecare through CareFirst, you can download the app and log in with your current user name and password.



Note: If you don't have a CareFirst *My Account*, follow the screen prompts to register, using your CareFirst member ID or alternate ID.

CloseKnit.

Care Designed Around You

Virtual-First Primary Care 24/7/365

closeknithealth.com

CloseKnit

What is CloseKnit?

We're a different kind of primary care practice.

We're a virtual-first primary care practice. 'Virtual-first' means we treat most illnesses virtually. Instead of going to a doctor's office, your 'visit' is done through an easy-to-use app — anytime, anywhere, 24/7/365. If you need in-person care, we'll arrange that for you.

Primary care services include:

- Well care, preventive and urgent care
- Behavioral and mental health support
- Education and enrollment support
- Appointment scheduling, insurance navigation and assistance with billing questions

Am I Eligible?

There are only two requirements for eligibility:

- [ ] 18+ years old
- [ ] Enrolled in a CareFirst BlueCross BlueShield health plan
  (Excluding Medicare and Medicaid programs)

Benefits of CloseKnit

- A Care Team that knows your history & your goals
- Chat with your Care Team 24/7/365
- Concierge support to navigate bills & benefits
- A dedicated team to help with coordination for in-person and specialty care
- Fully integrated with your CareFirst BlueCross BlueShield Benefits

Complies with all personal and security standards

How to Get Started

1 Download the app

Use your phone or tablet to download the CloseKnit app.

2 Register for an account

Enter your email address and verify the code sent.

Enter your name and member ID as they appear on your CareFirst BlueCross BlueShield insurance card.

Create and confirm a password of your choosing.

3 Share your health priorities

Create a profile with basic information so our Care Team can best support your needs.

You're all set!

You can start accessing care immediately.

CloseKnit

Rochambeau offers Life, Short and Long Term Disability benefits through Reliance Standard. Short Term and Long Term Disability Benefits provide income in the event you become disabled due to an injury or illness that is not work-related.

Basic Life and AD&D:	Basic Life insurance coverage provides important, supplemental financial protection for you and your family in the event of your death. AD&D (Accidental Death and Dismemberment) insurance provides important financial protection in the event of your death, loss of hands, feet and/or vision when an employee experiences loss within 365 days of the related accident **Benefit:** **Eligible Employees**: The benefit is a flat $10,000

Supplemental Life and AD&D:	For eligible employees who wish to purchase additional life and Accidental Death and Dismemberment (AD&D) coverage, Rochambeau provides the following options for you and your family. **Benefit:** **Employee:** You may apply for additional life insurance in multiples of $10,000 ($10,000 to $150,000 not to exceed 5x your annual base salary). The guaranteed issue amount is $100,000 **Spouse:** You may apply for Dependent life insurance in multiples of $5,000 from $5,000 to $150,000. The guaranteed issue amount is $20,000. **Child:** •birth but less than six months - $500 •six months through age 17 (up to age if full-time student) - $10,000

*Please refer to the ADP enrollment portal for Supplemental Life rates.

Short Term Disability:		For eligible employees, Short Term Disability coverage protects your income in the event of an illness or injury. The STD waiting period for both sickness and accident is 3 days **Benefit:** After the waiting period, the plan pays a benefit of 60% of your pre-disability earnings for up to 12 weeks. The maximum weekly benefit is $1,500. **If for some reason, your condition persists beyond the initial 12 week period, and you can not return to work, you will need to transition to LTD to continue receiving benefits.*

Long Term Disability:		For eligible employees, Long Term Disability (LTD) coverage provides a benefit that may be payable if you are unable to work due to an injury or illness. This benefit provides income replacement to sustain the financial needs of you and your family after your STD coverage has been exhausted. **Benefit:** All full-time employees are eligible for Long Term Disability. Coverage begins on the 91st day of accident or illness. You will receive 60% of your base pay, not to exceed $7,500 per month.

Life comes with challenges.

Your Assistance Program is here to help.

Reach out to your Assistance Program for short-term counseling, financial coaching, caregiving referrals and a wide range of well-being benefits to reduce stress, improve mental health and make life easier.

The following services are free to use, confidential, and available to you and your family members:

Mental Health Sessions
Up to 3 sessions* to help manage stress, anxiety and depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues, with options for in-person, telephonic, or video counseling sessions.

Life Coaching
To help reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation
To help build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, and saving for retirement or tuition.

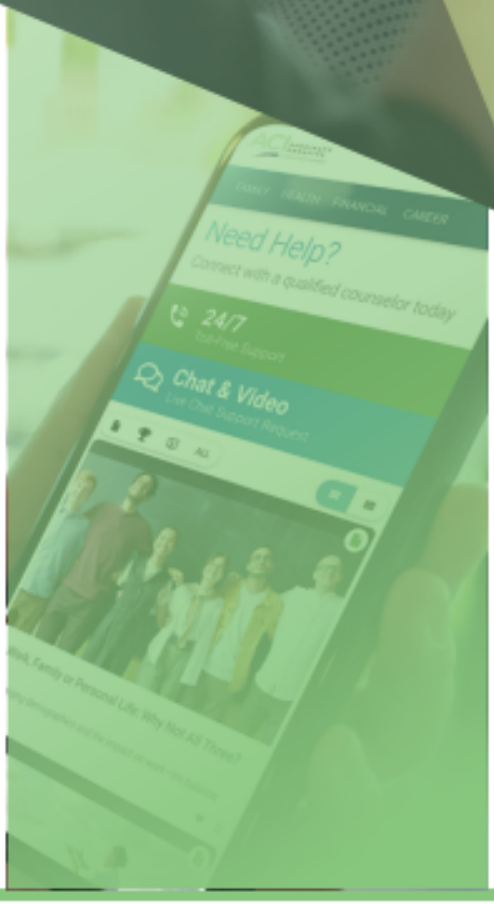
Legal Consultation
To help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Life Management
To provide information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant
To help manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining and personal services.

Medical Advocacy
To help navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.

Member Portal and App
Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.



EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

EAP services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Matrix is a branding name. Reliance Standard Life Insurance Company (Home Office Schaumburg, IL) is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. First Reliance Standard Life Insurance Company (Home Office New York, NY) is licensed in New York and Delaware. Standard Security Life Insurance Company of New York (Home Office New York, NY) is licensed in all states. Absence services are provided by Matrix Absence Management, Inc. Product features and availability may vary by state.

*3 Sessions per Six Months for California Employees

Contact ACI Specialty Benefits
855-775-4357
rsli@acieap.com
http://rsli.acieap.com
Company Code: RSLI859

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ACI SPECIALTY BENEFITS
An AllOne Health Company

RS-2506 (09/22)

Bereavement Support Services

Comfort and Guidance for Challenging Times

Bereavement Support Services provide confidential and professional support services to all family members and beneficiaries to cope with the loss of a loved one—at no extra cost.

In addition to coverage from Reliance Standard Life Insurance, all family members and beneficiaries are eligible to receive telephonic grief counseling sessions and legal and financial consultation through ACI Specialty Benefits.

Grief Counseling:

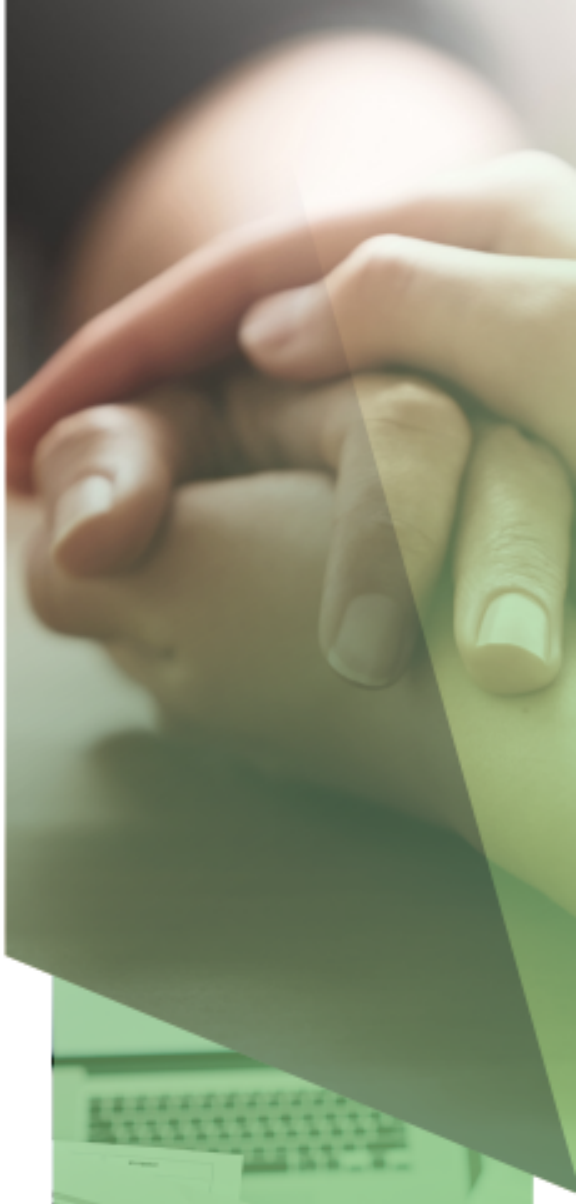
- Up to 3 Telephonic Grief Counseling Sessions for Assessment and Referral
- All Sessions Are Confidential, Conducted by Licensed Mental Health Clinicians

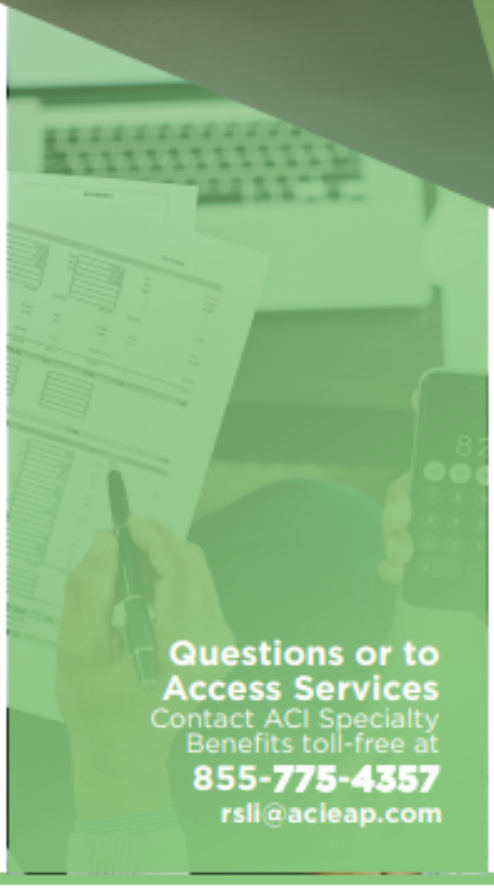
Legal and Financial Consultation:

- Consultation for a Wide Range of Legal and Financial Matters Including Estate Planning, Deeds, Wills and Trusts
- Telephonic Legal Consultation for Unlimited Number of Issues per Year. Includes One 60-minute In-office or Telephonic Consultation with Local Attorney and 25% Discount for Continued Services.
- Telephonic Financial Consultation for Unlimited Number of Issues per Year
- Do It Yourself Document Preparation through the Online Legal Resource Center, as well as Document Assistance Services at a Reduced Fee

Program Access:

- All Covered Employees, Family Members and Beneficiaries Eligible, Regardless of Location or Relationship
- Dedicated Toll-Free Line, Always Live Answer





Questions or to Access Services
Contact ACI Specialty Benefits toll-free at
855-775-4357
rsli@acieap.com

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An AllOne Health Company

RS-1948 (10/22)

your digital life is unique. so is your identity theft benefit.

Get the only comprehensive monitoring of its kind to help you protect yourself from digital fraud

Identity theft and fraud impacted 1 in 6 people last year.[1] When fraud occurs, unraveling it can be overwhelming and costly. That's why your employer is providing you with InfoArmor Identity Protection. Should you experience fraud, InfoArmor's comprehensive recovery services will go the extra mile to help you resolve your case and restore your identity, saving you time, money, and stress. Plus you can rely on up to $25K in identity fraud expense reimbursement to cover related out-of-pocket costs.†

Nobody thinks identity theft will happen to them until it does. That's when you need a trusted expert by your side to help pick up the pieces. InfoArmor's unique combination of proprietary technology and remediation expertise provides peace of mind every step of the way — so you can live confidently online.

Powerful monitoring and security tools, plus full-service remediation and reimbursement

Dark web monitoring

In-depth monitoring goes beyond just looking out for a participant's Social Security number. Bots and human intelligence scour closed hacker forums for compromised credentials and other personal information. Then we alert you if your information is compromised.

Lost wallet assistance

Losing your wallet isn't fun. This security feature allows you to easily access and replace wallet contents. InfoArmor's encrypted vault stores:

- User IDs & passwords
- ATM/credit cards
- Checking accounts
- Driver's licenses
- Health insurance cards

$25K fraud-related loss reimbursement

Should fraud occur, we have your back. You'll receive full-service remediation and up to $25K in identity fraud expense reimbursement for out-of-pocket costs.†

InfoArmor IDENTITY PROTECTION

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What members are saying:

99%
are satisfied with their customer care experience[2]

98%
are satisfied with how their problem was resolved on their first call[2]

99%
are satisfied with their recovery in cases of identity theft[2]

full-service case management and resolution

Highly trained and certified specialists are available 24/7 to restore compromised identities, even if the fraud or identity theft occurred prior to enrollment. Here's how it works:

Research

A dedicated Restoration Specialist works closely with you. Details and documents pertaining to the case are collected in a fraud packet. The Restoration Specialist gives guidance and assistance on the initial steps required.

Resolve

The Restoration Specialist works on your behalf to resolve the fraud with third parties. If needed, your specialist will submit all required evidence to your legal representation or other investigators and help mediate any claims.

Restore

Post-resolution, your specialist works to ensure there is no lasting damage. Whether the fraud has a financial, medical, or credit impact — we won't stop until things are made right. And with up to $25K in identity fraud expense reimbursement,[1] you won't have to worry about related out-of-pocket costs.

Enroll in your benefit today by calling 855-246-7347 or visit www.reliancestandard.com/infoarmor

Has your identity been compromised?
Call toll free at 855-246-7347. Help is available 24/7.

1: 2021 Identity Fraud Study, Javelin Strategy & Research
2: 2020, Allstate Identity Protection internal analysis

†Identity theft insurance covering expense and stolen funds reimbursement is underwritten by Assurant. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

RS-2414 (10/22)

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InfoArmor®
IDENTITY PROTECTION

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ON CALL INTERNATIONAL
It could happen to you!

Travel Assistance

Emergency help while you are traveling

Sure, we all expect our trips to go off without a hitch and most times they do. However, if you experience an emergency when traveling — no matter how big or how small — you have around-the-clock access to On Call International's 24-hour, toll-free travel assistance services. Whether you need help with an illness or injury, lost passport, missing luggage or even a prescription refill, you can rest assured you (and your covered dependents) have access to a personal travel emergency companion anytime you're more than 100 miles away from home.

How your Travel Assistance services work

Using your travel emergency services is a cinch! Just contact On Call International directly at (603) 328-1966 anytime you need assistance while traveling. On Call's Global Response Center is open 24 hours a day, 365 days a year and can provide the following services through your group coverage with Reliance Matrix. The following is an outline of the On Call emergency travel assistance service program. For a complete description of all services and the program terms and limitations, please request a Description of Covered Services from your employer.

24-Hour Travel Assistance

On Call International provided through Reliance Matrix

In the U.S., toll free
(800) 456-3893

Worldwide, collect
(603) 328-1966

Travel Assistance Services administered by

ON CALL INTERNATIONAL

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For emergency medical, legal and travel assistance information and referral service 24 hours a day, 365 days a year, call the numbers below. To place a collect call, dial the INTERNATIONAL COUNTRY CODE:

_____

followed by On Call's collect call number

fold

TO REACH ON CALL VIA INTERNATIONAL CALLING:

Go to **http://www.att.com/esupport/traveler.jsp?group=tips** for complete dialing instructions. It is recommended that you do this prior to departing the US, find the access code from the country you will be visiting, and note it on the front of the cut-out card so you will have the information readily available in case of an emergency. (AT&T provides English-speaking operators and the ability to place collect calls to On Call, whereas local providers may encounter difficulty placing collect calls to the US).

Travel assistance services are provided by On Call International (On Call) under the terms and conditions of a service agreement with Reliance Matrix. On Call International is not affiliated with Reliance Matrix or with AT&T.

Covered services

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

Pre-trip assistance	• Inoculation requirements information • Passport/visa requirements • Currency exchange rates	• Consulate/embassy referral • Health hazard advisory • Weather information
Emergency medical transportation*	• Emergency evacuation • Medically necessary repatriation • Visit by family member or friend • Return of traveling companion	• Return of dependent children • Return of vehicle • Return of mortal remain
Emergency personal assistance services	• Urgent message relay • Interpretation/translation services • Emergency travel arrangements	• Recovery of lost or stolen luggage/ personal possessions • Legal assistance and/or bail bond
Medical assistance services	• Medical referrals for local physicians/dentists • Medical case monitoring	• Prescription assistance and eye glasses replacement • Convalescence arrangements

*The services listed above are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum.

On Call International is not affiliated with Reliance Matrix. Reliance Matrix is not responsible for the content of the On Call travel assistance services, and is not responsible for, and cannot be held liable for, any services provided or not provided by On Call.

On Call is not responsible for the unavailability or results of any medical, legal or transportation services. You are responsible for obtaining all services not directly provided by On Call and for the expenses associated with them.

For more information, visit reliancematrix.com.

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ON CALL INTERNATIONAL
It could happen to you!

RS-2110 (09/22)

Optavise

DECISONS, DECISIONS, DECISIONS

Your Advocate is here to help during open enrollment.

"Does one option better meet my needs than another?"

Of course! There are multiple options and multiple benefits so that you can create a package of benefits that meet your needs. We can explain the differences between your options so that you can make the best decision for yourself and your family.

"Is my family covered?"

Let's find out! College-age dependents, adopted children, spouses, partners, relatives living in your home? Knowing exactly who you can cover is sometimes confusing. We can help.

"Is my doctor in the network?"

We can help you find out! And, if your doctor isn't, we can help make sure you find the best doctors and facilities that are in your network.

Your Advocate can answer your Open Enrollment questions, and any benefits or health care question throughout the year!

FREE & CONFIDENTIAL

Your Advocacy Support

Your Advocate can save you time, money & frustration by:

- Answering your questions
- Maximizing your benefits
- Navigating the system

(866) 253-2273

advocate@optavise.com

Mon - Fri: 7 a.m. - 8 p.m. (CST)
Saturday: 8 a.m. - 1 p.m. (CST)

TASC

Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions, vaccinations, and OTC
- Eye exams; prescription glasses/lenses

TIPS

- Determine your elections based on your estimated out-of-pocket expenses for the year
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Each $1 you contribute to your FSA reduces your taxable income by $1.

With less tax taken, your take-home pay increases!

Consider this example: *(for illustration only)*

Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA ($600 spent using post-tax dollars)	With FSA ($600 spent using pretax dollars)
$1,932	$2,098

That's a net increase in take-home pay of **$166 every month!**

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at **www.tasconline.com/tasc-calculators**.

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

How to participate.

**It's easy to start saving with an FSA.
Just follow 3 simple steps:**

1. DECIDE how much you want to contribute.

Check with your employer for plan specifics and review at the IRS limits at **www.tasconline.com/benefits-limits**.

The more you contribute, the lower your taxable income will be.

However, it's important to be conservative when choosing your annual contribution based on your anticipated qualified expenses since:

- The money you contribute to your benefit account can only be used for eligible FSA expenses.
- Any unused FSA funds at the close of the plan year are not refundable to you. *(A grace period or carryover option may be in place for your plan. Check with your employer for plan guidelines and allowances.)*

PLANNING TIPS

START by making a conservative estimate of how much you expect to spend on eligible out-of-pocket expenses for the year.

COMPARE your estimate to the IRS limits. If your estimate is higher than these annual contribution limits, consider making the maximum contribution allowed.

2. ENROLL by completing the enrollment process.

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year.

Your total annual contribution to a **Healthcare FSA** will be available to you immediately at the start of the plan year. Alternatively, your **Dependent Care FSA** funds are only available as payroll contributions are made.

SPECIAL FEATURES

MyCash Account: Included on your TASC Card for faster reimbursement deposits and non-benefit purchases.

TASC Mobile App: Track and manage all benefits and access numerous helpful tools, anywhere and anytime! *Search for "TASC" (green icon).*

3. ACCESS your funds easily using the TASC Card.

This convenient card automatically approves and deducts most eligible purchases from your benefit account with no paperwork required. Plus, for purchases made without the card, you can request reimbursement online, by mobile app, or using a paper form.

Reimbursements happen fast—within 12 hours—when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash balance on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!

Download on the App Store

GET IT ON Google Play

Questions? Ask your employer or contact your Plan Administrator:
Total Administration Services Corporation • www.tasconline.com • 1-800-422-4661

TASC

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Use pretax dollars to pay for vision and dental expenses.

A Limited-Purpose Flexible Spending Account (LPFSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for qualifying expenses.

The benefit works like a full Healthcare FSA but is limited to vision and dental expenses:

VISION EXPENSES

- Eye exams
- Prescription glasses/ contact lens
- Contact lens solution
- Prescription drugs/medications
- Laser eye surgery; LASIK
- Co-payments and deductibles

DENTAL EXPENSES

- Orthodontia (braces, Invisalign)
- Cleanings
- Crowns
- Fillings
- Dentures
- Co-payments and deductibles

TIPS

- You can participate in the LPFSA and an HSA for maximum savings!
- An LPFSA is subject to the same IRS plan limits as a full Healthcare FSA
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

How an LPFSA Works with an HSA.

When you (or your spouse) enroll in an HSA plan, you may no longer participate in a full coverage Healthcare FSA. Instead, you are eligible to enroll in an LPFSA through your employer-sponsored plan.

The LPFSA allows you to contribute to an HSA while also contributing to an FSA for vision and dental expenses. This additional pretax deduction helps you maximize your tax savings beyond the HSA Plan alone. And when you don't want to tap into your HSA funds for new eyeglasses, let's say, you can rely on the LPFSA to pay for that eligible vision expense.

Leaning on your LPFSA helps your HSA funds grow.

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at **www.tasconline.com/tasc-calculators**.

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

How to participate.

**It's easy to start saving with an LPFSA.
Just follow 3 simple steps:**

1. DECIDE how much you want to contribute.

Check with your employer for plan specifics and review at the IRS limits at **www.tasconline.com/benefits-limits**.

The more you contribute, the lower your taxable income will be. In spite of this, it's important to be conservative when choosing your annual contribution based on your anticipated qualified expenses since:

- The money you contribute to your benefit account can only be used for eligible vision and dental expenses incurred in the plan year.
- Any unused FSA funds at the close of the plan year are not refundable to you. A grace period or carryover may be in place for your plan. Check with your employer for plan specifics.

PLANNING TIPS

START by making a conservative estimate of how much you expect to spend on eligible out-of-pocket expenses for the year.

COMPARE your estimate to the IRS limits. If your estimate is higher than these annual contribution limits, consider making the maximum contribution allowed.

2. ENROLL by completing the enrollment process.

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year.

Your total annual contribution to a **Limited Purpose FSA** will be available to you immediately at the start of the plan year, ready to use.

SPECIAL FEATURES

MyCash Account: Included on your TASC Card for faster reimbursement deposits and non-benefit purchases.

TASC Mobile App: Track and manage all benefits and access numerous helpful tools, anywhere and anytime! *Search for "TASC" (green icon).*

3. ACCESS your funds easily using the TASC Card.

This convenient card automatically approves and deducts most eligible purchases from your benefit account with no paperwork required. Plus, for purchases made without the card, you can request reimbursement online, by mobile app, or using a paper form.

Reimbursements happen fast—within 12 hours—when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash balance on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!

Download on the App Store

GET IT ON Google Play

Questions? Ask your employer or contact your Plan Administrator:
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FX-4285-082922

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Use pretax dollars for work-related transit and parking expenses.

The Transportation Equity Act makes it possible for employees to contribute pretax dollars to a Transit and/or Parking Account to pay for qualified work-related transportation expenses.

Depending on your tax bracket, you can save up to 40% on your commuting and parking costs by using pretax dollars—a significant tax benefit that reduces your taxable income.

ELIGIBLE EXPENSES

TRANSIT ACCOUNT	PARKING ACCOUNT
Public Transportation (bus, train, ferry, subway)	Park and ride
Ride Sharing Services (UberPool, Lyft Plus, vanpool)	Parking ramps
	Parking meters

Eligible purchases may only be made by the participating employee. Funds cannot be used for regular Uber/Lyft rides.

TIPS

- Each $1 you contribute to a pretax account reduces your taxable income by $1
- You can change your commuter benefit elections on a monthly basis
- Store receipts in the Receipt Repository on the TASC Mobile App for easy access!

How it works.

You can choose to participate in the Transit Account or the Parking Account, or both. When you enroll in the plan(s), you elect an annual contribution for each account for the plan year, based on your anticipated expenses and IRS limits. That election is deducted from your payroll (before taxes) in equal installments throughout the year. **Plan funds may only be used by the participating employee (not available for expenses incurred by family members).**

eco friendly

In addition to tax advantages, commuter benefits also promote environmental responsibility. Employees who leave their cars at home and use public transportation greatly reduce their carbon emissions. When we reduce vehicle mileage, we improve air quality and help prevent serious illness.

You will receive a TASC Card in the mail to use for eligible purchases. Simply swipe the card to pay for an eligible work-related expense, such as a subway pass or parking ramp fee, and the funds are directly withdrawn from your available account balance.

IMPORTANT NOTE: The TASC Card is the only way to access your Transit Account funds because the law does not permit cash reimbursement if you pay out of pocket. Cash reimbursement is only available for eligible out of pocket purchases under the Parking Account.

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

How to participate.

It's easy to start saving with TASC Commuter Benefits. Just follow 3 simple steps:

1. DECIDE how much you want to contribute.

Enroll in a Transit and/or Parking Account at the beginning of a plan year and elect a **monthly** contribution amount which will be deducted in equal installments per paycheck throughout the plan year.

Also consider:

- The money you contribute to the account(s) can only be used by the participating employee for qualified work-related expenses and cannot be shared between accounts.
- If you need to adjust your elections, submit an Election Change Form to your employer and your payroll deductions will change on the first of the following month.

PLANNING TIPS

Your contributions to each account are subject to IRS limits. View limits on our website:

www.tasconline.com/benefits-limits

Check with your employer to see if your plan allows **rollover** of unused commuter account funds into the next plan year. If not, plan wisely and track balances throughout the year via our mobile app or secure web portal.

2. ENROLL by completing the enrollment process.

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year. Commuter benefit funds are only available as money is contributed *(money in, money out).*

When you enroll online you'll be given access to a secure, easy-to-use web portal where you can access and manage your account any time. We also offer a free mobile app for easy account access on the go.

SPECIAL FEATURES

MyCash Account: Included on your TASC Card for faster reimbursement deposits and non-benefit purchases.

TASC Mobile App: Track and manage all benefits and access numerous helpful tools, anywhere and anytime! *Search for "TASC" (green icon).*

3. ACCESS your funds easily using the TASC Card.

This convenient card automatically approves and deducts most eligible purchases from your benefit account(s) with no paperwork required.

For parking purchases made without the card *(Parking Account only—Transit Account does not allow reimbursements)* you can request reimbursement online, via mobile app, or using a paper form. Reimbursement deposits happen fast—within 12 hours—when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash monies on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!

Download on the App Store

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Questions? Ask your employer or contact your Plan Administrator:
Total Administration Services Corporation • www.tasconline.com • 1-800-422-4661

TP-5042-082922

TASC

Terms You Should Know

COBRA: Is continuation of Coverage under the Consolidated Omnibus Budget Act. COBRA allows employees and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods under certain circumstances such as voluntary or involuntary job loss, reduction of hours worked, transition between jobs, death, divorce or other life events. Qualified individuals may be required to pay the premium for the coverage plus an additional 2% administration fee.

Coinsurance: This is the percentage of a covered health care expense that you pay, usually after you've met your deductible. For example, if the plan pays 80% of an expense, the other 20% is your coinsurance.

Concierge medicine: An umbrella term commonly used to describe a relationship between a patient and physician in which the patient pays a monthly or annual fixed fee. Patients pay fees for conveniences like same-day appointments and 24/7 physician availability. If a member chooses to receive care through a concierge provider, access fees are the member's responsibility and are not processed through insurance. Fees for medical care may be processed through the insurance plan.

Consumer Directed Health Plan (CDHP): A health insurance plan that has a high minimum deductible that you must meet before the plan pays for non-preventive benefits.

Deductible: The amount of covered health care expenses you pay out of your own pocket before the plan begins to pay its portion of your expenses.

Eligible Expenses: The services and supplies eligible for reimbursement under your medical plan.

Facility fee: A charge that you may have to pay when you see a doctor at a clinic that is not owned by that doctor. Facility fees are charged in addition to any other charges for the visit. Facility fees are often charged at clinics that are owned by hospitals to cover the costs of maintaining that facility when they don't employ their own physicians. ** To avoid being charged a Facility Fee, call the provider prior to your appointments and ask if you will be billed any fees for the facility the provider will be utilizing.*

FSA: Flexible Spending Accounts allow employees to set aside money on a pre-tax basis to pay for Medical and Dental expenses for things such as Deductibles, co-pays, Prescription and over the counter medications, Medical supplies etc. You can find a list of qualified expenses at www.https://www.tasconline.com

Health Savings Account (HSA): A special account, tied to a CDHP, where you contribute money on a "pre- tax" basis to use for health care expenses, including the deductible. Participating in an HSA may save you money on taxes.

In-Network Provider: Doctors, hospitals, labs and other health care facilities that belong to a PPO or HMO plan network. In most circumstances, you will pay less for your care when you use in-network providers.

LPFSA: Limited Purpose FSA is a Flexible Spending Account that allows enrollees to set aside money on a pre-tax basis to pay for eligible Dental and Vision expenses. LPFSA is not administered by your Health plan and does not pay for Healthcare or Dependent Care expenses.

Out-of-Network or Non-PPO Provider: Health and Dental care providers who aren't members of a PPO network. In most circumstances, you'll pay more for your care if you use an out-of-network provider than you would if you got the same services from an in-network provider.

Out-of-Pocket Maximum: A benefit that protects you from having to pay extremely high medical costs in one calendar year. After you reach your out-of-pocket maximum, your medical plan pays 100% of your covered medical expenses for the rest of that calendar year *(copays and service-specific deductibles may still be required).*

PPO (Preferred Provider Organization): A medical or dental care network plan that gives you the option to get care from an in-network provider or an out-of-network provider.

R&C (Reasonable & Customary) Charges or Fees: This term refers to the current range of fees charged for a particular service by providers in a geographic area. If you use out-of-network providers and your doctor or dentist charges more than the R&C charges in your area, you will have to pay the difference. Also, amounts you pay above the R&C charges don't count toward your out-of-pocket limit.

BlueChoice Open Access HSA/HRA INT Option 10

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible , provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit http://content.carefirst.com/sbc/contracts/BHHMC02URXCMC480.pdf.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $1,600 individual/ $3,200 family	Generally, you must pay all the costs from provider up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Prescription Drug deductible is combined with Medical.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug combined: In-Network: $4,500 individual/ $7,900 family	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call **1-855-258-6518** for a list of provider network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider & Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Not Covered	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over; HSA qualified plans are subject to the required deductible. (closeknithealth.com) If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: Deductible, then $5 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail Health Clinic	Deductible, then No Charge	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	Some services may have limitations or exclusions based on your contract

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	LabTest: Non-Hospital: Deductible, then No Charge Hospital: Deductible, then No Charge XRay: Non-Hospital: Deductible, then No Charge Hospital: Deductible, then No Charge	LabTest: Non-Hospital: Not Covered Hospital: Not Covered XRay: Non-Hospital: Not Covered Hospital: Not Covered	Within the CareFirst service area, In-Network Lab Test benefits apply only to tests performed at LabCorp. If a service is rendered at a Hospital Facility, prior authorization is required, and the additional Facility charge may apply. Please see your contract.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: Deductible, then No Charge Hospital: Deductible, then No Charge	Non-Hospital: Not Covered Hospital: Not Covered	If a service is rendered at a Hospital Facility, prior authorization is required, and the additional Facility charge may apply. Please see your contract.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com/rx	Generic drugs	Deductible, then No Charge	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	Deductible, then $25 copay	Paid As In-Network	
	Non-preferred brand drugs	Deductible, then $45 copay	Paid As In-Network	
	Preferred Specialty drugs	Deductible, then 50% of Allowed Benefit up to a maximum payment of $100	Not Covered	
	Non-preferred Specialty drugs	Deductible, then 50% of Allowed Benefit up to a maximum payment of $150	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Not Covered	For services provided at a Hospital Facility, prior authorization is required
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then No Charge	Non-Hospital & Hospital: Not Covered	For services provided at a Hospital Facility, prior authorization is required
If you need immediate medical attention	Emergency room care	Deductible, then No Charge	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	Deductible, then No Charge	Paid As In-Network	Prior authorization is required for air ambulance services, except when Medically Necessary in an emergency
	Urgent care	Deductible, then No Charge	Paid As In-Network	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then No Charge	Not Covered	Prior authorization is required
	Physician/surgeon fee	Deductible, then No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: Deductible, then No Charge	Office Visit: Not Covered	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over; HSA qualified plans are subject to the required deductible. (closeknithealth.com) For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then No Charge	Not Covered	Prior authorization is required; Additional professional charges may apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge	Not Covered	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then No Charge	Not Covered	None
	Childbirth/delivery facility services	Deductible, then No Charge	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Deductible, then No Charge	Not Covered	Prior authorization is required
	Rehabilitation services	Provider: Deductible, then $5 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Not Covered	If a service is rendered at a Hospital Facility, prior authorization is required, and the additional Facility charge may apply; Limited to 30 visits/therapy type/condition/benefit period
	Habilitation services	Provider: Deductible, then $5 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Not Covered	Prior authorization is required; If a service is rendered at a Hospital Facility, the additional Facility charge may apply; Limited to Members until the end of the month in which the member turns 19
	Skilled nursing care	Deductible, then No Charge	Not Covered	Prior authorization is required; Limited to 60 days/benefit period
	Durable medical equipment	Deductible, then 25% of Allowed Benefit	Not Covered	Prior authorization is required for specified services. Please see your contract.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Inpatient Care: Deductible, then No Charge Outpatient Care: Deductible, then No Charge	Inpatient Care: Not Covered Outpatient Care: Not Covered	Prior authorization is required; Limited to a maximum 180 day Hospice Eligibility Period; Inpatient Care: Limited to 30 days/Member
If your child needs dental or eye care	Children's eye exam	$10 copay per visit	Not Covered	Limited to 1 visit/benefit period
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion, except in limited circumstances
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See **www.carefirst.com**
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6518.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,600
Specialist Copayment	$5
Hospital (facility) Copayment	$0
Other Copayment	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,610**

Managing Joe's type 2 Diabetes (a year of a routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,600
Specialist Copayment	$5
Hospital (facility) Copayment	$0
Other Coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$275
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,025**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	$1,600
Specialist Copayment	$5
Hospital (facility) Copayment	$0
Other Copayment	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$30
Coinsurance	$73
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,703**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CareFirst
Family of health care plans

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	civilrightscoordinator@carefirst.com
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0*. When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ (Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɛ́ nì ɓídɛ́-wùdù mú ɓɛ́ m̀ ké se wídɛ́ dò pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɛ́ fǔùn-nɔ̀ɓà nìà dɛ́ waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɛ́ nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàdàìn hwè. Ɔ jǔ ké nyɔ dò dyi m̀ gɔ̃ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dò mu ɓó nììn ɓɛ́ ɔ ké nì wudɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ دیں: اس نوٹس میں آپ کے انشورنس کوریج سے متعلق اہم معلومات شامل ہے۔ اس میں کچھ اہم تاریخیں بھی ہو سکتی ہیں اور ممکن ہے کہ آپکو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات اور اس سے متعلق مدد اپنی زبان میں بلا خرچہ حاصل کرنے کا حق ہے۔ ممبران کو اپنی شناختی کارڈ کی پشت پر موجود نمبر پر کال کرنی چاہیے۔ دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کر سکتے ہیں۔ جب کوئی ایجنٹ جواب دے تو اپنی زبان بتائیں اور آپ کو ترجمان سے جوڑ دیا جائے گا۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ‌های مهمی باشد و الزاماتی خاص مقرر شده باشد که شما باید از آن‌ها مطلع باشید. شما از این حق برخوردار هستید که اطلاعات و راهنمایی‌ها به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به زبان خود، با شماره 855-258-6518 تماس بگیرید و منتظر بمانید تا یک مترجم به شما وصل شود. اعضا باید شماره درج شده در پشت کارت شناسایی خود را تماس بگیرند. سایر افراد می‌توانند با شماره 855-258-6518 تماس بگیرند و تا زمانی که از آن‌ها خواسته شود عدد 0 را فشار ندهند منتظر بمانند تا به یک مترجم متصل شوند. پس از پاسخگویی اپراتورها، زبان مورد نظر خود را بگویید تا به مترجم متصل شوید.

العربية (Arabic) تنويه: هذه إعلان عن معلومات تغطية التأمين الخاص بك، وقد يحتوي على تواريخ مهمة، وقد تكون هناك مواعيد نهائية محددة يتعين عليك اتخاذ إجراء خلالها. لديك الحق في الحصول على هذه المعلومات والمساعدة المتعلقة بها مجانًا وبلغتك الخاصة. يجب على الأعضاء الاتصال بالرقم الموجود على ظهر بطاقة هويتهم. يمكن للآخرين الاتصال بالرقم 855-258-6518 وانتظار الرد حتى يُطلب منهم الضغط على الرقم 0. بمجرد الرد، أخبر الوكيل بلغتك المفضلة، وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyį́į́lígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'į́į́h. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédę́ę́' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį áádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

BlueChoice Advantage Option 2-S

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible , provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit http://content.carefirst.com/sbc/contracts/BAVMBF0KRXXMBFL7.pdf.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $500 individual/ $1,000 family; Out-of-Network: $1,000 individual/ $2,000 family.	Generally, you must pay all the costs from provider up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Prescription drugs, Outpatient surgery, Urgent care, Mental Health office visit, Home health, Rehabilitation services, Hospice.	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug combined: In-Network: $4,500 individual/ $9,000 family; Out-of-Network: $6,500 individual/ $13,000 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call **1-855-258-6518** for a list of provider network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: $10 copay per visit Hospital Facility: $200 copay per visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over; HSA qualified plans are subject to the required deductible. (closeknithealth.com) If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: $20 copay per visit Hospital Facility: $200 copay per visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail Health Clinic	$10 copay per visit	Deductible, then 20% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	Deductible, then No Charge	Some services may have limitations or exclusions based on your contract

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	LabTest: Non-Hospital: $10 copay per visit Hospital: Deductible, then $100 copay per visit XRay: Non-Hospital: $20 copay per visit Hospital: Deductible, then $150 copay per visit	LabTest: Non-Hospital: Deductible, then 20% of Allowed Benefit Hospital: Deductible, then 20% of Allowed Benefit XRay: Non-Hospital: Deductible, then 20% of Allowed Benefit Hospital: Deductible, then 20% of Allowed Benefit	Within the CareFirst service area, In-Network Lab Test benefits apply only to tests performed at LabCorp.; If a service is rendered at a Hospital Facility, the additional Facility charge may apply. Please see your contract.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: $60 copay per visit Hospital: Deductible, then $200 copay per visit	Non-Hospital: Deductible, then 20% of Allowed Benefit Hospital: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply. Please see your contract.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com/rx	Generic drugs	$10 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 90-day supply of maintenance drugs is 2 copays; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	$25 copay	Paid As In-Network	
	Non-preferred brand drugs	$45 copay	Paid As In-Network	
	Preferred Specialty drugs	50% of Allowed Benefit up to a maximum payment of $100	Not Covered	
	Non-preferred Specialty drugs	50% of Allowed Benefit up to a maximum payment of $150	Not Covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: $100 copay per visit Hospital: Deductible, then $200 copay per visit	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	Physician/surgeon fees	Non-Hospital: $20 copay per visit Hospital: Deductible, then $20 copay per visit	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then $200 copay per visit	Paid As In-Network	Copay waived if admitted; Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	Deductible, then $50 copay per visit	Paid As In-Network	Prior authorization is required for air ambulance services, except when Medically Necessary in an emergency
	Urgent care	$40 copay per visit	Paid As In-Network	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $300 copay per day	Deductible, then 20% of Allowed Benefit	Prior authorization is required; Member maximum payment: Participating Provider: $1,500 per admission
	Physician/surgeon fee	Deductible, then $20 copay per visit	Deductible, then 20% of Allowed Benefit	None
If you have mental health, behavioral	Outpatient services	Office Visit: $10 copay per visit	Office Visit: Deductible, then 20% of Allowed Benefit	Virtual Connect through CloseKnit available at $0 cost share to members 18 and over; HSA qualified plans are subject to the required deductible. (closeknithealth.com) For treatment at an Outpatient Hospital Facility, additional charges may apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services	Inpatient services	Deductible, then $300 copay per day	Deductible, then 20% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply; Member maximum payment: Participating Provider: $1,500 per admission
If you are pregnant	Office visits	No Charge	Deductible, then 20% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then $20 copay per visit	Deductible, then 20% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then $300 copay per day	Deductible, then 20% of Allowed Benefit	Member maximum payment: Participating Provider: $1,500 per admission
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible, then 20% of Allowed Benefit	Prior authorization is required
	Rehabilitation services	Provider: $20 copay per visit Hospital Facility: $200 copay per visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply; Limited to 30 visits/therapy type/condition/benefit period
	Habilitation services	Provider: $20 copay per visit Hospital Facility: $200 copay per visit	Provider & Hospital Facility: Deductible, then 20% of Allowed Benefit	Prior authorization is required; If a service is rendered at a Hospital Facility, the additional Facility charge may apply; Limited to Members until the end of the month in which the Member turns 19
	Skilled nursing care	Deductible, then $200 copay per admission	Deductible, then 20% of Allowed Benefit	Prior authorization is required; Limited to 60 days/benefit period
	Durable medical equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Inpatient Care: No Charge Outpatient Care: No Charge	Inpatient Care: Deductible, then 20% of Allowed Benefit Outpatient Care: Deductible, then 20% of Allowed Benefit	Prior authorization is required; Limited to a maximum 180 day Hospice Eligibility Period; Inpatient Care: Limited to 30 days/Member
If your child needs dental or eye care	Children's eye exam	$10 copay per visit	Member pays expenses in excess of $33 Allowed Benefit	Limited to 1 visit/benefit period
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion, except in limited circumstances
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.carefirst.com
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6518.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist Copayment	$20
Hospital (facility) Copayment	$300
Other Copayment	$10

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,180**

Managing Joe's type 2 Diabetes (a year of a routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist Copayment	$20
Hospital (facility) Copayment	$300
Other Coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$485
Coinsurance	$155
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,140**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist Copayment	$20
Hospital (facility) Copayment	$200
Other Copayment	$20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$420
Coinsurance	$73
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$993**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CareFirst
Family of health care plans

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	civilrightscoordinator@carefirst.com
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0*. When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ (Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɛ́ nì ɓídɛ́-wùdù mú ɓɛ́ m̀ ké se wídɛ́ dò pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɛ́ fǔùn-nɔ̀ɓà nìà dɛ́ waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɛ́ nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàdàìn hwè. Ɔ jǔ ké nyɔ dò dyi m̀ gɔ̃ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dò mu ɓó nììn ɓɛ́ ɔ ké nì wudɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ دیں: اس نوٹس میں آپ کے انشورنس کوریج سے متعلق اہم معلومات شامل ہے۔ اس میں کچھ اہم تاریخیں بھی ہو سکتی ہیں اور ممکن ہے کہ آپکو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات اور اس سے متعلق مدد اپنی زبان میں بلا خرچہ حاصل کرنے کا حق ہے۔ ممبران کو اپنی شناختی کارڈ کی پشت پر موجود نمبر پر کال کرنی چاہیے۔ دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کر سکتے ہیں۔ جب کوئی ایجنٹ جواب دے تو اپنی زبان بتائیں اور آپ کو ترجمان سے جوڑ دیا جائے گا۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ‌های مهمی باشد و الزاماتی خاص مقرر شده باشد که شما باید از آن‌ها مطلع باشید. شما از این حق برخوردار هستید که اطلاعات و راهنمایی‌ها به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به زبان خود، با شماره 855-258-6518 تماس بگیرید و منتظر بمانید تا یک مترجم به شما وصل شود. اعضا باید شماره درج شده در پشت کارت شناسایی خود را تماس بگیرند. سایر افراد می‌توانند با شماره 855-258-6518 تماس بگیرند و تا زمانی که از آن‌ها خواسته شود عدد 0 را فشار ندهند منتظر بمانند تا به یک مترجم متصل شوند. پس از پاسخگویی اپراتورها، زبان مورد نظر خود را بگویید تا به مترجم متصل شوید.

العربية (Arabic) تنويه: هذه إعلان عن معلومات تغطية التأمين الخاص بك، وقد يحتوي على تواريخ مهمة، وقد تكون هناك مواعيد نهائية محددة يتعين عليك اتخاذ إجراء خلالها. لديك الحق في الحصول على هذه المعلومات والمساعدة المتعلقة بها مجانًا وبلغتك الخاصة. يجب على الأعضاء الاتصال بالرقم الموجود على ظهر بطاقة هويتهم. يمكن للآخرين الاتصال بالرقم 855-258-6518 وانتظار الرد حتى يُطلب منهم الضغط على الرقم 0. بمجرد الرد، أخبر الوكيل بلغتك المفضلة، وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyį́į́lígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'į́į́h. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédę́ę́' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį áádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

Contact Information

Benefit	Carrier	Phone
Medical Plans	CareFirst	888-567-9155
Dental Plans	CareFirst	866-891-2802
Vision Plan	CareFirst/Davis Vision	800-783-5602
Health Advocacy	Opatvise	866-253-2273
Health Savings Accounts (HSA)	Optum Bank	866-234-8913
Travel Assistance	Reliance Standard	800-456-3893 (U.S.)/ 603-328-1966 (Worldwide)
EAP & Bereavement Support	Reliance Standard /ACI	855-775-4357
Identity Theft	Reliance Standard /InfoArmor	855-246-7347
Life & Disability Plans	Reliance Standard	800-351-7500
LPFSA, FSA & Parking / Transit Benefit	TASC	800-422-4661

This guide summarizes the key features of Rochambeau, The French International School's benefit plans. Refer to the plan documents for exact terms and conditions of coverage. If any conflict arises between this guide and the official plan documents, the terms of the actual plan documents or other applicable documents will govern in all cases. Rochambeau, The French International School and its affiliated entities reserve the right to change, modify or terminate the benefit plans at any time. This guide isn't a contract for purposes of employment or payment of benefits.

COMPLIANCE

The following are federally required notices related to your **Rochambeau Benefits Program**.

Women's Health and Cancer Rights Act
Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:
· Reconstruction of the breast on which the mastectomy has been performed;
· Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
· Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

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

Maternity and Newborn Length of Stay
Under federal law, group health plans and health coverage issuers offering group coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:
· Less than 48 hours following a normal vaginal delivery; or
· Less than 96 hours following a cesarean section.

They may also not require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of those periods. The law generally does not prohibit an attending provider of the mother or newborn (in consultation with the mother) from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Special Enrollment Rights Under HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides the following special enrollment rights. If you do not enroll for medical coverage for yourself and your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or you dependents in this plan, as long as you request enrollment within 31 days after your other coverage ends. You will need to provide proof that your other coverage has ended. In addition, if you have a new dependent as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as long as you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Notice of Health Information Privacy Practices (HIPAA)
The privacy of your medical information is important to us. As a participant in a medical plan sponsored by **Rochambeau** 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

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 coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because 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 employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:
· The employee dies;
· The employee's hours of employment are reduced;
· The employee's employment ends for any reason other than his or her gross misconduct;
· The employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
· The employee 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 event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

For the 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 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. 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.

COMPLIANCE

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, the employee'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 employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the employee'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 18-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 18 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 employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

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 Employee 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.)

Monthly COBRA Rates	
Advantage Plan	
EE Only	$ 844.51
EE + Spouse	$ 1,942.30
EE+ Child(ren)	$ 1,562.33
FAM	$ 2,567.24
HMO HSA Plan	
EE Only	$ 709.45
EE + Spouse	$ 1,631.80
EE+ Child(ren)	$ 1,312.49
FAM	$ 2,156.72
Plus Dental	
EE Only	$ 50.14
EE + Spouse	$ 115.32
EE+ Child(ren)	$ 92.75
FAM	$ 152.44
Basic Dental	
EE Only	$ 27.27
EE + Spouse	$ 62.73
EE+ Child(ren)	$ 50.46
FAM	$ 82.92
Vision	
EE Only	$ 8.33
EE + Spouse	$ 19.17
EE+ Child(ren)	$ 15.42
FAM	$ 25.33

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).

Notice of Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under **Rochambeau** medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan during open enrollment. For more information contact Benefits, HR at 301-924-2811.

Preventive Services and the Affordable Care Act

Under the Affordable Care Act, you and your family may be eligible for some important preventive services which can help you avoid illness and improve your health—at no additional cost to you.

What this means for you: If your plan is subject to these new requirements, you would not have to pay a co-payment, co-insurance, or any deductible to receive preventive health services, such as recommended screenings, vaccinations, and counseling. For example, depending on your age, you may have free access to such preventive services as:

· Blood pressure, diabetes, and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;

· Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use;
· Routine vaccinations against diseases such as measles, polio, or meningitis;
· Flu and pneumonia shots;
· Counseling screening, and vaccines to ensure healthy pregnancies;
· Regular well-baby and well-child visits, from birth to age 21

Some Important Details:
· If your health plan uses a network of providers, be aware that health plans are only required to provide these preventive services through an in-network provider. Your health plan may allow you to receive these services from an out-of-network provider but may charge you a fee.
· Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.
· To know which covered preventive services are right for you—based on your age, gender, and health status—ask your health care provider.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

Alabama - Medicaid

Website: http://myalhipp.com
Phone: 1-855-692-5447

Alaska - 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

Arkansas - Medicaid

Website: http://myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

Georgia - Medicaid

HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: (678) 564-1162, Press 2

California - Medicaid

Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

Colorado
Health First Colorado & Child Health Plan Plus (Colorado's Medicaid Program)

Health First Colorado Website: https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI):https://www.colorado.gov/pacific/hcpf/health insurance-buy-program HIBI
Customer Service: 1-855-692-6442

Florida - Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268

Maine - Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711

Iowa Medicaid & Chip (Hawki)	Massachusetts Medicaid & Chip
Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
Indiana - Medicaid	**Minnesota - 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: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
Kansas - Medicaid	**Missouri – Medicaid**
Website: https://www.kancare.ks.gov Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants /pages/hipp.htm Phone: 573-751-2005
Kentucky - Medicaid	**Montana - Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP Phone: 1-800-694-3084
Louisiana - Medicaid	**Nebraska - Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada - Medicaid	**South Carolina - Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
New Jersey – Medicaid & Chip	**Texas - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com Phone: 1-800-440-0493
New York – Medicaid	**Utah – Medicaid & Chip**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

North Carolina – Medicaid	Vermont – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
North Dakoda – Medicaid	**Virginia – Medicaid & Chip**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
Oklahoma – Medicaid & Chip	**Washington – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
Oregon - Medicaid	**West Virginia – Medicaid & Chip**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Pennsylvania - Medicaid	**Wisconsin – Medicaid & Chip**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p10095.htm Phone: 1-800-362-3002
Rhode Island – Medicaid & Chip	**Wyoming – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line	Website: https://health.wyo.gov/healthcarefin/medicaid/programsand-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Know Your Benefits

Brought to you by: Brown & Brown

Understand Your Rights Against Surprise Medical Bills

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

What Are Surprise Medical Bills?

Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost-sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill.

People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

What Are the New Protections if I Have Health Insurance?

If you get health coverage through your employer, a Health Insurance Marketplace or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (such as out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (such as anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

What if I Don't Have Health Insurance or Choose to Pay for Care on My Own Without Using My Health Insurance (Also Known as "Self-Paying")?

If you don't have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

What if I'm Charged More Than My Good Faith Estimate?

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

What if I Don't Have Insurance From an Employer, a Marketplace or an Individual Plan? Do These New Protections Apply to Me?

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

What if My State Has a Surprise Billing Law?

The No Surprises Act supplements state surprise billing laws; it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply.

For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers, and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the federal process.

As another example, if your state has an All-Payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-Payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

Where Can I Learn More?

Still have questions? Visit CMS.gov/nosurprises or reach out to human resources.

Source: Centers for Medicare and Medicaid Services

Disclaimer

The information provided in this Benefits Guide is advisory. Separate plan documents explain each benefit in more detail, and the various benefits are controlled by the language of the plan documents. Benefits may be modified, added, or terminated at any time, at Rochambeau, The French International School's discretion, or by the insurance company. This information is provided for general information purposes only and should not be considered legal or tax advice or legal or tax opinion on any specific facts or circumstances. Readers and participants are urged to consult their legal counsel and tax advisor concerning any legal or tax questions that may arise. Any tax advice contained in this communication (including any attachments) is not intended to be used, and cannot be used, for purposes of (i) avoiding penalties imposed under the U. S. Internal Revenue Code or (ii) promoting, marketing or recommending to another person any tax-related matter.

ROCHAMBEAU

THE FRENCH INTERNATIONAL SCHOOL

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FOSTER ADAPTABILITY

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Notes

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