



ROCHAMBEAU

THE FRENCH INTERNATIONAL SCHOOL



Rochambeau

2025 Employee Benefit Guide

January 1, 2025 - December 31, 2025 Plan Year

Introduction

At **Rochambeau** we are proud to offer you a comprehensive benefit package for you and your eligible dependents. This enrollment guide is designed to provide highlights of the benefit plans. Please refer to the Summary Plan Description (SPD) for detailed information on the plans. If you have questions regarding your benefits, please contact Human Resources.

A Letter from the Executive Director

Dear Colleagues,

I am delighted to share the 2025 Open Enrollment Benefits Guide and invite all benefits-eligible staff to participate in our annual benefits open enrollment from December 1st through December 13th. 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

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Disclaimer: The information provided by Brown & Brown, Inc. and/or its affiliates ("Company") in this Guidebook 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 the Company's discretion, or by the insurance company. This information is provided for general information purposes only and should not be considered legal, tax, accounting or other professional advice or opinion on any specific facts or circumstances. Readers are urged to consult their legal counsel, tax or other professional advisor concerning any legal, tax or related questions that may arise. Any tax information 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. The Company assumes no liability whatsoever in connection with the use of such information or documents.

Enrolling in Benefits

Eligibility for Benefits

You are eligible for benefits if you are a full-time employee or part-time employee working 20+ hours a week. Benefits are effective on the first of the month following your date of hire.

You may cover your legal spouse and any eligible dependent children.

Dependent Children: This includes your natural child, stepchild, and any child you have adopted or who has been placed for adoption up to age 26.

Disabled Dependents: If your dependent child is mentally or physically handicapped, coverage may be extended beyond the age of 26. Please check with Human Resources to obtain more information.

Examples of INELIGIBLE Dependents

You may not cover a family member other than the ones listed above (for example, parents, grandchildren, nieces, or nephews are **not** eligible). Foster children are also not eligible under this plan. **Rochambeau reserves the right to audit your dependent information. Rochambeau may request documentation of any of your dependents' status.**

Enrollment and Qualified Life Events

You may generally elect benefits as a new hire and during annual open enrollment periods. In most cases, you may not change your benefits mid-year unless you experience a qualifying event in your life; such as marriage, divorce, birth or adoption of a child, death of a spouse or dependent, loss of employment, or a change in employment status that affects your or your spouse's benefits eligibility. Please notify Human Resources within 30 days of the event if you would like to enroll or make a change to your coverage.

Managing Your Benefits

Through the ADP portal, employees can enroll in benefits, report life change (marriage, birth, etc.), view and update beneficiary information, and much more.

Questions? Please contact Human Resources.

Home Resources ▾ Myself ▾

Enrollments

New Hire ▲ Not started

🕒 20 days left to complete this event

You can make changes to your enrollment from June 1, 2023 to June 30, 2023 at 11:59 p.m. ET.

[Start enrollment](#)

Your Benefits

Review your current benefits, your previous year's benefits, or any changes due to a life event.

[View benefits](#)

Report a Life Change

Qualifying Events, like a marriage or losing coverage, allows you to request changes to benefits outside of Open Enrollment.

[Report a change](#)

Dependents and Beneficiaries

View or edit dependent and beneficiary information, or add a new dependent or beneficiary

[Manage](#)

Wisely®

Sign up for Wisely and get paid up to 2 days early at no extra cost.

- No hassles cashing your paychecks
- Tools and support to help you make the most of your money

[Learn more](#)

Employee Contributions

The Rochambeau Benefits Plan is designed under “Section 125” of the IRS Code. This allows you to take advantage of federal and state laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, any required contributions for medical, dental, and vision will be made with pre-tax dollars.

You may only change your pre-tax benefit elections once per year, during open enrollment, unless you experience a qualified “change in status.” You may waive participation in the Section 125 Plan and elect to pay all contributions with after-tax dollars. Contact Human Resources for a waiver form if you elect to pay for your benefits with after-tax dollars.

CareFirst BCBS Medical/Rx Plan Contributions

Coverage Level	BlueChoice Advantage Plan		BlueChoice Open Access HMO HSA Plan	
	Monthly	Bi-weekly (26 pays)	Monthly	Bi-weekly (26 pays)
Employee Only	\$400.81	\$184.99	\$326.68	\$150.78
Employee & Spouse	\$921.83	\$425.46	\$751.39	\$346.80
Employee & Child(ren)	\$741.50	\$342.23	\$604.36	\$278.94
Employee & Family	\$1,218.43	\$562.35	\$993.11	\$458.36

CareFirst BCBS Dental Plan Contributions

Coverage Level	BlueDental Plus Plan 5		BlueDental Basic Plan 1	
	Monthly	Bi-weekly (26 pays)	Monthly	Bi-weekly (26 pays)
Employee Only	\$25.81	\$11.91	\$14.04	\$6.48
Employee & Spouse	\$59.36	\$27.40	\$32.29	\$14.90
Employee & Child(ren)	\$47.74	\$22.03	\$25.97	\$11.99
Employee & Family	\$78.47	\$36.21	\$42.68	\$19.70

CareFirst BCBS (Davis) Vision Plan Contributions

Coverage Level	CareFirst BCBS Advantage Plan	
	Monthly	Bi-weekly (26 pays)
Employee Only	\$8.25	\$3.81
Employee & Spouse	\$18.97	\$8.76
Employee & Child(ren)	\$15.27	\$7.05
Employee & Family	\$25.07	\$11.57



Health Advocacy *Optavise*

Need help with your benefits and healthcare?

For employees enrolled in the CareFirst medical plans, your Optavise Advocate is here to save you time, money and frustration by answering your questions, maximizing your benefits, and navigating the system on your behalf.

Answers to any Question About Your Benefits

From “How does my deductible work?” to “How can I get a new ID card?” – no question is too big or too small. You bring the questions; your Advocate has the answers.

The Right Care at the Right Cost

Why pay more for high quality care? Our Personalized Cost Comparison Report will help you find lower-cost providers for common medical tests and procedures, such as colonoscopies, CT scans, MRIs, X-rays, ultrasounds, mammograms and many more.

Prescription Drug Savings

Your Advocate can look for online coupons and discounts for your prescriptions, compare prices for generic alternatives and find out if mail order options are available.

Find a Doctor

Your Advocate can help you find an in-network doctor or specialist and even make appointments on your behalf.

Preventive Care

Not sure what preventive care tests are recommended for your age and gender? Your Advocate can give you the details and explain how these important checks are covered by your benefits.

Review Bills for Errors

Mistakes with your medical bills DO happen, but you shouldn't have to pay for them! Your Advocate will carefully review your bills for errors and expedite corrections.

Appeal Denied Claims

Your Advocate will review a denied claim to determine whether it was coded incorrectly and begin the appeals process.

Optavise advocacy is completely confidential and offered at no additional cost for eligible employees and their dependents.

Call (866) 253-2273

Monday-Friday: 8 a.m. – 9 p.m. EST



Medical/Rx CareFirst BlueCross BlueShield

BlueChoice Advantage Option 2-S Plan — National In-Network Coverage through Blue Card

Plan Highlights	In-Network	Out-of-Network*
Annual Deductible (Individual / Family)	\$500 / \$1,000	\$1,000 / 2,000
Out-of-Pocket Maximum (Individual / Family)	\$4,500 / \$9,000	\$6,500 / \$13,000
Preventive Services	No Charge	Deductible, then 20%
Primary Care Office Visit	\$10 copay	Deductible, then 20%
Specialist Office Visit	\$20 copay	Deductible, then 20%
Diagnostic Lab	Non-Hospital: \$10 copay Hospital: Deductible, then \$100 copay	Deductible, then 20%
Diagnostic X-Ray	Non-Hospital: \$20 copay per visit Hospital: Deductible, then \$150 copay	Deductible, then 30%
Advanced Imaging	Non-Hospital: \$60 copay Hospital: Deductible, then \$200 copay	Deductible, then 20%
Urgent Care Center	\$50 copay	Paid as In-Network
Emergency Room (waived if admitted)	Deductible, then \$200 copay	Paid as In-Network
Outpatient Surgery	Non-Hospital: \$100 copay Hospital: Deductible, then \$200 copay	Deductible, then 20%
Inpatient Facility Services	Deductible, then \$300 per admission	Deductible, then 20%
Maternity Services	Pre/Postnatal visits: No Charge Childbirth/delivery facility services: Deductible, then \$20 copay Inpatient: Deductible, then \$300 per admission	Deductible, then 20%
Mental Health Services	Inpatient: Deductible, then \$300 per admission Outpatient/Office Visits: \$10 copay	Deductible, then 20%
Annual Prescription Drug Deductible	\$0	
Prescription Out of Pocket Maximum	Combined with Medical	
Preventive Drugs	No charge	
Generic Drugs	\$10	Applicable copayment, plus charges in excess of the allowed amount
Preferred Brand Drugs	\$25	
Non-Preferred Brand Drugs	\$45	
Specialty Drugs	50% up to \$100/\$150 max based on tier	
Mail-Order Maintenance Drugs – 90-day supply	\$20 / \$90 / \$120 / 50% up to \$200 max / 50% up to \$300 max based on tier	NA

*Balance billing applies - Out-of-network providers can charge more for their services. If you see an out-of-network provider, you may be responsible for paying the difference between their price and the maximum amount your CareFirst health plan will pay

Medical/Rx CareFirst BlueCross BlueShield

BlueChoice Open Access HSA Option 10 Plan – Local In-Network Coverage through the BlueChoice Network

Plan Highlights	In-Network	Out-of-Network
Annual Deductible (<i>Individual / Family</i>)	\$1,650 / \$3,300	
Out-of-Pocket Maximum (<i>Individual / Family</i>)	\$4,500 / \$7,900	
Preventive Services	No Charge	
Primary Care Office Visit	Deductible, then No Charge	Not Applicable
Specialist Office Visit	Deductible, then \$5	
Diagnostic Lab	Deductible, then No Charge	
Diagnostic X-Ray	Deductible, then No Charge	
Advanced Imaging	Deductible, then No Charge	
Urgent Care Center	Deductible, then No Charge	Paid as In-Network
Emergency Room (<i>waived if admitted</i>)	Deductible, then No Charge	Paid as In-Network
Outpatient Surgery	Deductible, then No Charge	
Inpatient Facility Services	Deductible, then No Charge	
Maternity Services	Deductible, then No Charge	
Mental Health Services	Deductible, then No Charge	
Annual Prescription Drug Deductible	Integrated with medical	
Prescription Out of Pocket Maximum	Integrated with medical	
Preventive Drugs	No charge	Not Applicable
Generic Drugs	Deductible then No Charge	
Preferred Brand Drugs	Deductible then \$45	
Non-Preferred Brand Drugs	Deductible then \$60	
Specialty Drugs	Deductible then 50% up to \$100/\$150 based on the tier	
Mail-Order Maintenance Drugs – 90-day supply	\$20 / \$90 / \$120 / 50% up to \$200 max / 50% up to \$300 max based on tier	

Medical/Rx *CareFirst BlueCross BlueShield*

Rochambeau offers two medical plan options through CareFirst; the **BlueChoice Advantage Plan** and the **BlueChoice Open Access HMO HSA Plan**. While receiving care in the Maryland, DC, and Northern Virginia service area, both plans utilize the **BlueChoice** Network. Members enrolled in the Advantage plan have non-emergent coverage nationally through Blue Card. HMO HSA members only have in-network emergency and urgent care coverage outside of the BlueChoice service area.

The plans provide the flexibility to seek a specialist without a referral and include:

- Telehealth and virtual care options – primary, urgent, nurse advice line
- Core BlueVision coverage for annual vision exam
- Behavioral Health Digital Resource
- Disease management programs
- CareFirst WellBeing wellness program
- Blue Rewards incentive Program
- Blue365 – health and wellness deals and discounts

Interactive Member Portal

MyAccount makes it easy for CareFirst members to understand and manage your health plan and benefits 24/7. Register today at www.carefirst.com/myaccount.

By setting up an account, you'll have password-protected access to:

- Find and select in-network doctors, specialists, dentists and behavioral health providers—including hospitals, urgent care centers, labs and imaging facilities
- View copays and identify other expenses for which you may be responsible
- View, order or print your member ID card
- Check the status of claims, remaining deductibles and out-of-pocket totals
- Opt-in to get communications electronically—click on your name at the top of the page and select Communication Preferences

Blue365 Discount Program

Blue365 offers premier health and wellness discounts and is free to join. Access health and wellness related deals on fitness products, gym memberships, healthy eating and more.

To take advantage of Blue365, register now at www.carefirst.com/wellnessdiscounts. Just have your CareFirst member ID card handy. If you have medical coverage, use your member ID number to register. If you do not have CareFirst medical coverage, but instead only have dental or vision benefits, enter 233 instead of a member ID number.

Questions about your prescription benefits?

To view your drug list and find out more about your prescription benefits, you can:

- Log in to MyAccount and view the Drug & Pharmacy Resources section;
- Check your enrollment materials; or
- Call the Pharmacy telephone number on the back of your member ID card.

Prescription Mail Order

Save time and money on maintenance prescriptions

- Fill prescriptions online, by phone or by mail
- Schedule automatic refills
- Select delivery location
- Consult a pharmacist by phone 24/7
- Receive email notification of order status

Accessing Mail Order On MyAccount

- Visit carefirst.com/myaccount and log in.
- Under the Coverage tab, select Drug and Pharmacy Resources.
- Select Request a New Mail Order Prescription and enter the prescription information to be verified by your doctor.



Medical/Rx CareFirst BlueCross BlueShield

Know Before You Go - Know where to go before you need care to save more on healthcare costs

Your Care Options	Cost	Needs or Symptoms	Available 24/7	Rx	Virtual Care	In-Person Care
CloseKnit Virtual Care (see below) CloseKnit offers 24/7/365 virtual-first primary care, urgent care, mental health and other specialty services *in-person care available when applicable	\$	<ul style="list-style-type: none"> Preventive visits Urgent care Mental health therapy Psychiatry for ages 2+ 	✓	✓	✓	✓
24-Hour Nurse Advice Line Call 800-535-9700 for general questions about health issues or where to go for care	\$0	<ul style="list-style-type: none"> Cough, cold and flu Rashes 	✓	X	✓	X
PCP Visit Discuss diagnosis treatment of illness, chronic conditions, routine check-ups	\$	<ul style="list-style-type: none"> Routine physical Diabetic care 	X	✓	Verify with your provider	✓
Convenience Care (e.g., Retail clinics such as CVS MinuteClinic) Health screenings, vaccinations, minor illness or injury	\$\$	<ul style="list-style-type: none"> Cough and cold Pink eye 	X	✓	X	✓
Urgent Care (e.g., ExpressCare or Patient First) Non-life-threatening illness or injury requiring immediate care	\$\$\$	<ul style="list-style-type: none"> Sprains Cut requiring stitches 	X	✓	X	✓
Emergency Room Life-threatening illness or injury	\$\$\$\$	<ul style="list-style-type: none"> Chest pain Difficulty breathing 	✓	✓	X	✓

CloseKnit – CareFirst’s leading virtual-care practice, gives you 24/7 access to primary care, urgent care, therapy and more through your computer or the CloseKnit mobile app.

- Advanced primary care - Dedicated Care Team to provide preventive care and support for chronic conditions. For adults ages 18+.
- Urgent care - Same-day care to treat minor injuries and common illnesses fast. Average wait time is 30 minutes or less. For adults and children ages 2+.
- Convenient appointments, including weekends
- Chronic care and disease management
- Help achieving your long-term health goals
- Mental health counseling
- New parent support



Medical/Rx *CareFirst BlueCross BlueShield*

Blue Rewards – Choose healthy activities that fit with your goals and earn rewards for completing them. As part of your wellness program, Blue Rewards adds an incentive to your efforts to improve or maintain your health and well-being. Both you and your spouse can each earn rewards for completing one, all or any combination of the following healthy activities. Dependents, regardless of age, are not eligible for Blue Rewards.

Once you've completed one or more of the activities, you'll receive a CareFirst Blue Rewards Visa® medical expense debit card with your rewards on it. This card can be used toward your annual deductible and out-of-pocket costs. The incentive card can now be used to purchase certain over-the-counter health products. Keep the card for as long as you're a member as future incentives will be added to your balance as you earn them.

If you have an enrolled in the BlueChoice Open Access HMO HSA Plan you must reach your plan deductible before being able to use your Blue Rewards medical expense debit card. If you have CareFirst vision or dental benefits, you can certify to only use the card for eligible vision/dental expenses before meeting your deductible.

Start earning your rewards today. Download the CareFirst WellBeing app or visit www.carefirst.com/wellbeing to log in or register for your account.

CVS MinuteClinic is an independent company that provides medical services to CareFirst members. CVS MinuteClinic does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the medical services it provides.



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 \$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 \$25
Retake the RealAge assessment

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 up to \$200
Participate in health coaching


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

All personal coaching sessions are confidential and conducted over the phone.


CareFirst WellBeing is your personalized digital connection that offers motivating digital resources accessible anytime, plus specialized programs for extra support—at no cost to you. Begin exploring your personalized digital connection to a healthier life by visiting carefirst.com/wellbeing




RealAge®
 Learn the physical age of your body, compared to your calendar age with the online health assessment.




Personalized health timeline
 Receive recommendations and health information tailored to your goals and interests.




Meditation, relaxation and more
 Break free from stress with mindfulness tools, unwind at the end of the day or ease into a restful night of sleep with meditation, streaming music and videos.



Trackers
 Connect your wearable devices or enter your own data to monitor sleep, steps, nutrition and more.



Challenges
 Get extra motivation for achieving your health goals.



Health profile
 Access your important health data all in one place.

This well-being program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.

Health Savings Accounts (HSA)

CareFirst BlueFund (Further)

Health Savings Account (HSA)

employees who participate in the **HMO HSA plan** may be eligible to set aside money in an HSA. The money you contribute to an HSA is exempt from taxes; you save FICA and Federal taxes when contributing through payroll, and you spend the money tax-free when you spend it on qualified expenses.

Qualified expenses include unreimbursed medical, dental and vision expenses incurred by you and your eligible dependents - even if you don't cover your dependents. An HSA is like a Flexible Spending Account (FSA); however, the HSA is a personal bank account, not a plan, so there's no "use-it or lose-it" rule. The money in your HSA remains in your HSA until you're ready to spend it; there's no time limit. If you change jobs or retire, you take the HSA with you. HSA funds can also be spent on Medicare, Cobra and Long-Term Care insurance premiums.

Who is eligible to open and fund an HSA?

Employees should confirm eligibility with a tax advisor before contributing to an HSA and must be:

- covered by the CareFirst BlueChoice HMO HSA plan and
- not covered under another medical plan that is not a qualified HDHP - including Medicare, Medicaid, TRICARE and/or a Health Care Flexible Spending Account (FSA)

How much can I contribute to an HSA? The IRS sets a contribution limit every calendar year. The contribution limits are:

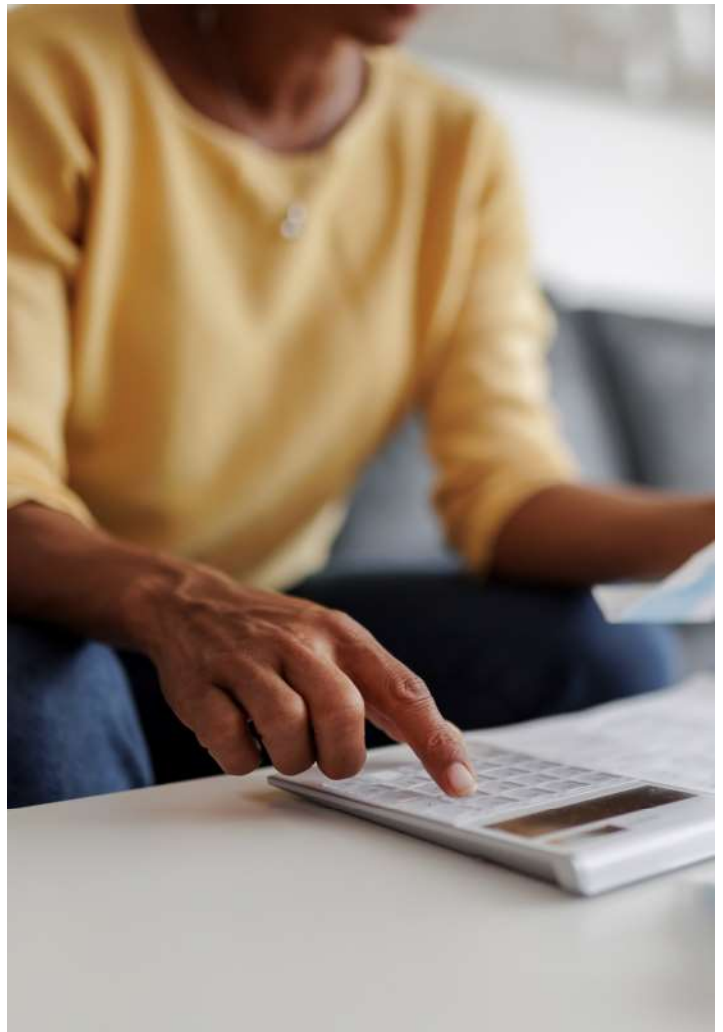
- 2025 limits will be: \$4,300 for Individual Coverage; \$8,550 for Family Coverage
- If you're age 55 or older, you can contribute up to \$1,000 more than the limits listed here

What if I establish an HSA mid-year? Your HSA contributions are generally determined on a monthly basis. If you establish an HSA mid-year, you're allowed to make the full year's contribution, provided you are eligible on December 1 of that year and you remain eligible to make HSA contributions throughout the next calendar year.

When can I start using the funds in my HSA? You can use the funds in your HSA once they are available. If you incur expenses under the qualified HDHP prior to having enough funds in your HSA, you can reimburse yourself months or years later, once you do have the funds available - so long as you were enrolled in the qualified HDHP at the time of service and the HSA was established at the time of service.

Can I use my HSA to pay for non-qualified expenses? Money withdrawn from an HSA for non-qualified expenses is taxable and subject to a 20% penalty. Although the 20% penalty goes away at age 65, the non-qualified expenses are always subject to income tax.

Can I use the money in my HSA to pay for my dependents' health care expenses? You can use the money in your HSA to pay for the health care expenses belonging to your eligible spouse and/or dependent children - even if they are not covered as your dependents. Refer to Internal Revenue Code Section 502 to determine if your spouse and/or child is an eligible dependent.



Once enrolled manage your account through CareFirst MyAccount - register today at www.carefirst.com/myaccount.

Flexible Spending Accounts (FSA) TASC

Flexible Spending Accounts (FSA)

FSA plans allow you to have pre-tax money deducted from your paycheck to pay for certain expenses. Since contributions are made through payroll deductions before tax, you decrease your taxable income and thereby increase your take-home pay.

Methods to Request a Reimbursement:

- Online via tasconline.com (log in to your account)
- TASC mobile app (log in to your account)
- Easily attach substantiation/receipt with camera tool

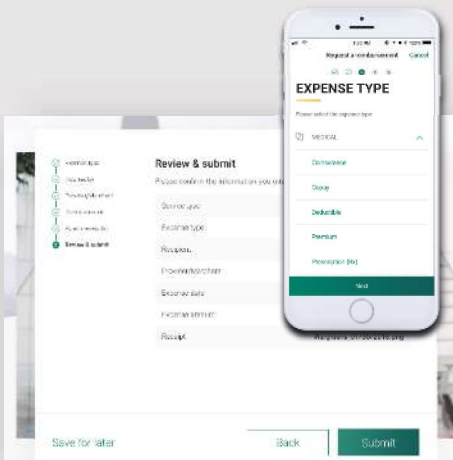
Direct Deposit options

- Into MyCash Account on TASC Card (processed within 12 hours!)
- Into personal bank account

TASC Customer Care

(800) 422-4661

www.tasconline.com/ubaaccess



Elect annual contribution for the Plan Year (up to \$3,300 for 2025) to be deducted from your paycheck—before taxes—in equal amounts throughout Plan Year.

Contributed dollars are used to pay for eligible expenses (via debit card or reimbursement).

FSA is a FREE benefit to you, paid for by your employer.

- Elect pre-tax dollars for eligible healthcare expenses:
- Medical
- Dental/Ortho
- Vision
- Prescriptions

Employees contributing to a Health Savings Account may enroll in the FSA but reimbursable expenses are limited to dental and vision until the medical deductible is satisfied.

Annual contribution is fronted to you on the first day of the Plan Year.

You can enroll even if your spouse participates in a plan with their employer; each of you can enroll in an FSA plan.

Maximum dependent age: 26

TIPS:

- Be conservative. Set aside only dollars you will actually use, knowing you can carryover the \$640 to the entire next plan year.
- If you're not sure how much you're going to spend, the \$640 carryover takes part of the risk out of making an election.
- Access your account to check balances frequently.
- Run Out Period of 90 days is available at the end of the plan year, to submit receipts from the prior plan year's expenses. Do NOT use the debit card for runout expenses, must submit manually.

TASC Card

Provides immediate access to FSA funds to pay for eligible expenses, acting like a debit card – there is no need to pay out-of-pocket and request a reimbursement. The card is mailed to your home upon enrollment (looks like junk mail). The card is accepted for eligible expenses only. Replaces the need for requesting a reimbursement - keep your receipts in the event verification is required.

You may request one additional card for dependent/spouse at no cost. Cards are good for four years and automatically reissued.



Dental CareFirst BlueCross BlueShield

The **BlueDental Plus Plan 5** has an extensive list of covered services, including preventive cleanings and x-rays at no charge when you use an in-network provider. You and your family members may go to any licensed dentist but will enjoy additional savings if you see an CareFirst PPO dentist.

	In-network	Out-of-network*
Deductible (individual/family)	\$25/\$75	\$50/\$150
Annual maximum	\$2,000 per insured	
Preventive and diagnostic	No charge	No charge
Basic services	20%	20%
Major services—surgical	20%	20%
Major services—restorative	50%	50%
Orthodontic services	50%	50%
Lifetime maximum on orthodontic services	\$1,000 per insured	

*Balance billing applies - Out-of-network providers can charge more for their services. If you see an out-of-network provider, you may be responsible for paying the difference between their price and the maximum amount your CareFirst health plan will pay

The **BlueDental Basic Plan 1** is a low-cost plan for routine dental care only, and does not provide coverage for major surgical and restorative services. You and your family members may go to any licensed dentist but will enjoy additional savings if you see an CareFirst PPO dentist.

	In-network	Out-of-network*
Deductible (individual/family)	\$25/\$75	\$50/\$150
Annual maximum	\$1,000 per insured	
Preventive and diagnostic	No charge	20%
Basic services	Deductible then 20%	Deductible then 40%
Major services—surgical	NA	NA
Major services—restorative	NA	NA
Orthodontic services	NA	NA
Lifetime maximum on orthodontic services	NA	

*Balance billing applies - Out-of-network providers can charge more for their services. If you see an out-of-network provider, you may be responsible for paying the difference between their price and the maximum amount your CareFirst health plan will pay

Accessing Your Benefit Information

With your secure online member account, you can check plan benefits and claim status, sign up for electronic benefit statements, access discount ID cards, and much more.

Visit www.carefirst.com to get started.



Vision CareFirst BlueCross BlueShield (Davis)

The **BlueVision Plus Option C** through CareFirst utilizes the Davis Vision network and includes major eyewear retailers—Visionworks, Target Optical, Walmart, Costco and more! The network also includes convenient online retail options like—Warby Parker, 1-800 Contacts, Glasses.com and Befitting are also included.

	In-Network	Out-of-Network Reimbursement
Eye exam	\$0	Up to \$45
Frames	\$0 for Davis Vision Frame Collection or \$130 allowance plus 15% off balance	Up to \$60
Spectacle lenses Basic lens options: single, bifocal and trifocal	\$20	Up to \$101
Contact lenses	\$0 for Davis Vision Contact Collection or \$130 allowance plus 15% off balance	Up to \$127
Laser vision correction	Up to 25% off allowed amount or 5% off any advertised special	NA

Members can use their benefits at a network providers location or online

Befitting.com—Uses advanced AI (artificial intelligence) technology to find the perfect pair of eyeglasses with personalized, curated recommendations. They offer several brands at varying price points. Members receive 20% off frame coverage after their benefits are exhausted.

Glasses.com—One of the most trusted online stores for popular eyewear brands, including prescription glasses and sunglasses. They offer a wide selection at varying price points, and free shipping and returns.

Warby Parker—Warby Parker was founded with a mission to inspire and impact the world with vision, purpose and style. They offer designer-quality prescription glasses (starting at \$95), contacts, vision care exams and vision tests.

1-800-Contacts—Online contact lens retailer for popular eyewear brands, including prescription glasses and sunglasses. They provide quick delivery with multiple distribution centers across the country. For even more convenience, their mobile app has a prescription upload option.

Extra perks for every plan

- LASIK discount
- Hearing aid discount
- Repair and breakage warranty on frames

Effective and affordable eye care

- Fixed fee pricing on all cosmetic lens options
- \$50 extra allowance at Visionworks

Fully covered frames within Exclusive Frame Collection

- Davis Vision Exclusive Frame Collection
- Over 200 name-brand frames
- Plan covers in full



Life/AD&D Reliance Standard

To help protect your family from the financial burden of death or sudden injury, Rochambeau provides **Life and Accidental Death & Dismemberment (AD&D)** with Reliance Standard to all benefit eligible employees. The employer paid life benefit is \$10,000 in the event of a death. In the event of an accidental death or dismemberment then the plan will pay an additional \$10,000.

Benefit Reduction

Benefits reduce to 65% at age 65, 40% at age 70, and to 20% at age 75.

Voluntary Life and AD&D

For employees who wish to purchase additional life and AD&D coverage, Rochambeau provides eligible employees the following life and AD&D insurance options for you and your family. Rates are based on age and available in the ADP Self Service portal.

Employee & Spouse:

You may purchase coverage at a minimum of \$10,000, increments of \$10,000, to a maximum of \$150,000 - guarantee issue for initial eligibility is \$100,000 for employee and \$20,000 for spouse.

Dependent Child(ren):

You may purchase coverage for your dependent child(ren) according to the following ages:

- 14 days to 6 months: \$500
- Age 6 months to 26 years of age: \$10,000

Choose one benefit amount for all eligible children in the family. All child amounts are guaranteed issue, so no EOI form is required.

Guarantee Issue and Evidence of Insurability (EOI)

When you are first eligible under this plan, you can elect coverage up to the guarantee issue amount without completing a medical questionnaire. Coverage amounts in excess of the guarantee issue amount will require that you complete a medical questionnaire and that Reliance Standard approve you. This process is called providing evidence of insurability. You are also required to complete the evidence of insurability process for any amount of coverage if you decide to enroll in this plan at any time following your initial enrollment opportunity. If evidence of insurability is required, the coverage you elect under this plan will not become effective until it is approved by Reliance Standard.

You are responsible for the entire premium cost for the Voluntary Life/AD&D Insurance Plan.



Disability Reliance Standard

Rochambeau provides disability insurance for all benefit eligible employees (except admin and maintenance association employees) through Reliance Standard.

Short Term Disability (STD) benefits provide income to you if you become disabled due to an injury or illness and cannot work for a short period.

The benefit covers 60% of pre-disability earnings to a maximum of \$1,500 per week after the 3rd day of disability due to injury or sickness. The benefit has a maximum benefit period of 13 weeks.

Long-Term Disability (LTD) coverage provides a benefit that may be payable in the event that you are unable to work due to an injury or illness. This benefit provides income replacement to help sustain the financial needs of you and your family.

The benefit covers 60% of pre-disability earnings to a maximum of \$7,500 per month after 90 days of a qualifying disability. The benefit runs until the normal Social Security retirement age or until the end of the qualifying disability.



Employee Assistance Program



From the stress of everyday life to relationship issues or even work-related concerns, ACI's Employee Assistance Program (EAP) provides professional and confidential services to help employees and family members address a variety of personal, family, life, and work-related issues.

Some benefits include, but are not limited to:

Mental Health Sessions - Up to 5 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.

Financial Consultation - To help build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identity 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.

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, **855-775-4357**, <http://rsli.acieap.com>, company code **RSLI859**.

Additional Benefits



Identity Theft Protection

To protect you and your family from the devastating loss of time, money and security, Reliance Standard provides employees eligible for the disability plan with a full-service ID Recovery Program that will perform the recovery process for you should you or a member of your family fall victim to identity theft.

In addition to the recovery program, you also have access to real-time card monitoring through WalletArmor®. WalletArmor® is an interactive, easy-to-use vault for protecting your wallet's contents, passwords, and important personal documents.

If you suspect that your personal information has been compromised, please call InfoArmor at **1-855-246-7347**. If you want to protect the contents of your wallet and important personal documents, enroll in WalletArmor® at www.reliancestandard.com/walletarmor.

Travel Assistance

Through your employer paid life/AD&D coverage with Reliance Standard, you automatically receive travel assistance services provided by On Call International (On Call). On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination, and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. On Call also offers pre-trip assistance, including passport/visa requirements, foreign currency, and weather information.

At any time before or during a trip, you may contact On Call for emergency assistance services. For emergency medical, legal and travel assistance information and referral service 24 hours a day, 365 days a year, you can reach On Call at the following numbers: **1-800-456-3893** (in the U.S., toll-free) or **1-603-328-1966** (worldwide, collect).



Contacts



Vendor	Line of Coverage	Phone#	Website
Optavise	Health Advocacy	866-253-227	https://www.optavise.com/
CareFirst BlueCross BlueShield	Medical /Rx Dental Vision	833-229-9493	www.carefirst.com
BlueFund (Further)	Health Savings Account (HSA)	866-758-6119	www.carefirst.com
TASC	Flexible Spending Account (FSA)	800-422-4661	www.tasconline.com/ubaaccess
Reliance Standard	Life/AD&D and Disability	855-775-2524	www.reliancematrix.com
ACI Specialty Benefits (Reliance Standard)	Employee Assistance Program (EAP)	855-775-4357	http://rsl.acieap.com Company Code: RSLI859
InfoArmor (Reliance Standard)	Identity Theft Assistance	855-246-7347	www.reliancestandard.com/walletarmor
On Call International	Travel Assistance	800-456-3893 (U.S.) 603-328-1966 (worldwide, collect)	https://www.oncallinternational.com/

Legal Notices

HIPAA Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides you certain rights to privacy concerning your health information. The regulations designate certain types of information as Protected Health Information (PHI).

Healthcare providers (medical professionals) and health plans, including Rochambeau the French International School health plan representatives, are restricted in their use of PHI to purposes of treatment, payment, and healthcare operations and as required by national public health activities. Written authorization is required to use or disclose your PHI pertaining to your medical, dental, prescription drug, employee assistance program and healthcare spending accounts outside of these purposes.

You may receive a form requesting your authorization to use your PHI for another purpose. Should you grant this authorization, your PHI is still protected from use and disclosure by any party other than the one(s) to whom you grant written authorization, and from use and disclosure by authorized parties for any purpose other than the one you specifically authorized.

Protected Health Information

PHI includes information that could be used to identify you as an individual in electronic, printed or spoken forms that relates to (1) past, present or future health, physical or mental condition, (2) provision of healthcare, or (3) past, present or future payment for the provision of healthcare.

HIPAA gives you the right to:

- Receive notice of the health plan's uses and disclosures of your PHI, your privacy rights and the health plan's legal duties regarding your PHI;
- Obtain access to your own PHI; Amend your PHI;
- Request restriction of the uses and disclosures of your PHI;
- Receive an accounting of non-exempt uses and disclosures of your PHI over the past six years upon request; and
- Receive communications by an alternative means or at an alternate location upon request.

For more information regarding the HIPAA privacy rules, refer to your Summary Plan Description.

HIPAA Privacy Notice Update

HIPAA requires Rochambeau the French International School to notify you that a Privacy Notice is available from the Benefits Department. To request a copy of Rochambeau the French International School Privacy Notice or for additional information, please contact the Human Resources Department - 301.530.8260

Newborns and Mothers Health Protection Act Rights

Under federal law, group health plans offering group health 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceeded 48 hours (or 96 hours).

For information on pre-certification, please refer to your Summary Plan Description.

Women's Health and Cancer Rights Act

Rochambeau the French International School medical plans cover mastectomy-related services. In the case of a participant or beneficiary who receives benefits in connection with a mastectomy, coverage will be provided in a manner determined by the attending physician and the patient for:

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

These services are subject to the same copay deductible provisions that apply to other benefits under Rochambeau the French International School medical plan (as described in this guide).

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 31 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Effective April 1, 2009— The Rochambeau the French International School group health plan will allow an employee or dependent who is eligible, but not enrolled, for coverage to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE**— If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP**— If the employee or dependent becomes eligible for premium assistance under Medicaid or a State child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date your or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Human Resources Department at 703.232.1491 Ext. 4

Summary Plan Description (SPD) Access

This guide does not provide all the details about the benefits programs. More information is available in each program's Summary Plan Description (SPD). In addition to receiving your SPDs after enrolling, they are available at any time from the Human Resources Department at 301.530.8260.

Summary of Benefits and Coverage (SBC)

Effective for plan renewals after January 1, 2012, the Patient Protection and Affordable Care Act requires employers that offer health coverage to provide a uniform Summary of Benefits and Coverage (SBC) to people who apply for and enroll in the health plan. This document contains the following:

- Four-page overview of plan benefits, cost sharing and limitations
- Required set of examples of how the plan works
- Phone number and internet address for obtaining copies of plan documents
- A Standard glossary of medical and insurance terms must also be available

The SBC will be updated each plan renewal to reflect applicable plan changes.

Legal Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.asp Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspreassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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.

Legal Notices

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate]

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

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

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

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

Your health plan generally must:

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

If you have a question about filing a complaint, you can call the Maryland Insurance Administration at 1-800-492-6116.

Maryland Insurance Administration
200 Saint Paul St Suite 2700
Baltimore, MD 21202
<https://insurance.maryland.gov>



ROCHAMBEAU

THE FRENCH INTERNATIONAL SCHOOL

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410.794.3800
www.bbrown.com

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This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.