McLean School
Transformative.

BENEFITS GUIDE

PLAN YEAR

January 1, 2025 to December 31, 2025

McLean School offers a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you. We've put together this benefits guide to help you with this process.

Elections you make during open enrollment will become effective January 1, 2025, and last through December 31, 2025. Elections made throughout the year when allowable based on a qualifying event will become effective the first of the following month.

Should you have any questions on any of the benefits outlined in this guide, do not hesitate to reach out to Jeffrey Berman or Sarir Dehnadi in the School's Business Office. Our benefits consultants at HUB International Mid-Atlantic will also be onsite on November 20th and 21st, and are available throughout the year by phone or email.

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WHO IS ELIGIBLE?

To participate in our employee benefits program employees must work a minimum of 20 hours a week or a 50% course load for faculty; The spouse, domestic partner and dependent children, up to the end of the calendar year in which they turn 26, of eligible faculty and staff can also receive these benefits.

HOW TO ENROLL

Open enrollment, with the exception of Unum Accident and Critical Illness, will be handled in Ease:

- All employee should login to Ease (https://mcleanschool.ease.com), our online enrollment portal, **to verify your current elections, name and address and then make any desired changes.**
- If you need to re-set your password, there is a "forgot password" feature on the home page. Your username is your email address.
- For questions on the use of Ease, please contact Carolyn Holmes in the Business Office or one of our HUB International Mid-Atlantic representatives who will be available November 20th from 7:00am to 4:00pm and November 21st from 7:00am to 1:00pm.

WHEN TO ENROLL

Open enrollment begins on Monday, November 18th and runs through noon on Tuesday, November 26th. The benefits you choose during open enrollment will become effective January 1, 2025.

WHAT IF I DON'T WANT TO MAKE ANY CHANGES?

If you don't want to make any changes to your elections, no action is required! However, if you elected to contribute funds to any type of flexible spending account (FSA), including the medical FSA for CareFirst plan participants, the IRS requires you to make a new election **every** year and this must be done in Ease (see above).

WHEN WILL I RECEIVE MY NEW INSURANCE CARDS?

You will receive your new insurance cards by mail sometime around January 1st.

Tip: ID cards for both you and any covered dependents will be available at www.carefirst.com by January 1st.

Smart debit cards for the Health Retirement Account (HRA) and medical and dependent care flexible spending account will be mailed to new participants by Clarity. Those already participating in the School's HRA or FSA programs will continue to use the same debit cards until they expire.

CHANGES AFTER OPEN ENROLLMENT

Elections for medical, dental and vision insurances and the medical and dependent care flexible spending accounts are locked in until the next open enrollment period unless you have a qualifying life event. Examples of these include a marriage, divorce, legal separation, birth or adoption of a child, change in a dependent child's status, etc.

If you experience a qualifying event, you must notify the School's Business Office within **30 days** of the event in order to change any elections.

UPCOMING MEETINGS

Matthew Roberts from HUB International Mid-Atlantic will be available on November 20th and 21st to answer specific questions you may have. Please sign up for a time slot to meet with him so he can communicate all the facets of our benefits program.

If you have questions throughout the plan year, you can contact Kelly Jarvis or Mat Gorchesky via email or phone. Contact information for both is found later on in this guide.

MEDICAL INSURANCE

Medical insurance is the most important benefit McLean offers and we're pleased to announce that **we will be continuing our partnership with CareFirst for 2025!** This plan enables you to choose from a national network of providers, specialists, and hospitals, as well as allowing you to use non-participating providers, albeit with higher out-of-pocket costs. As outlined in the chart below, McLean's CareFirst medical benefit remains largely unchanged.

Some important tips to help you maximize these benefits:

- While not required, you should select a Primary Care Physician (PCP) for you and your family members. Establishing a relationship with one is the best way for you to receive consistent, quality care.
- This is an open access plan which means that you are not required to get a referral in order to see a specialist. It is recommended, however, that you work with your PCP to determine if you need to see a specialist and to assist you in finding one.
- To ensure you receive the maximum laboratory benefit from your plan, you must use a LabCorp facility locally.
- The School will cover 75% of your deductible through a Health Reimbursement Account (HRA).
- Refer to your CareFirst benefit summary and summary of benefits and coverage for additional coverage information.

	BlueChoice Advantage	
Services	**In-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family)	$2,000/$4,000	$4,000/$8,000
Coinsurance	100%	80%
Calendar Year Out-of-Pocket (OOP) Maximum (Individual/Family)	$4,000/$8,000	$8,000/$16,000
Preventive Care	No charge	No charge after deductible
Primary Care Physician (PCP)	No charge after deductible	20% after deductible
Specialist	No charge after deductible	20% after deductible
Hospitalization	No charge after deductible	20% after deductible
Outpatient Surgery	No charge after deductible	20% after deductible
Urgent Care	No charge after deductible	20% after in-network deductible
Prescription Drugs - Generic - Preferred - Non-preferred - Preferred Specialty - Non-preferred Specialty	After deductible, $15 $35 $60 50% to $100 50% to $150	No coverage

HEALTH REIMBURSEMENT ACCOUNT

The School is investing in your physical wellness and financial security by offering a health reimbursement arrangement (HRA) for those participating in the CareFirst medical insurance program. This employer-funded benefit sets aside tax-free dollars that you can use to pay for healthcare costs that are not paid for by your insurance plan.

HRAs typically cover out-of-pocket expenses, such as:

- Copayments (physician offices and Rx) and deductibles
- Hospital expenses
- Labs, x-rays, and out-patient procedures
- Dental, orthodontics, vision care, glasses, and contacts
- Over-the-counter medication with a prescription

In 2025, the School's contribution to your HRA remains $1,500 (individual) or $3,000 (family). Employees wishing to supplement the School's HRA contribution can do so through a medical flexible spending account as described later in this guide.

MEDICAL INSURANCE

The Kaiser medical option is only available to employees currently enrolled in the plan. **There will be no changes to these benefits for 2025!**

	Signature DHMO		
Services*	**In-Network**		**Out-of-Network**
Plan Year Deductible (Individual/Family)	$0/$0		No coverage
Coinsurance	100%		NA
Plan Year Out-of-pocket (OOP) Maximum (Individual/Family)	$1,300/$2,600		NA
Preventive Care	$0		NA
Primary Care Physician (PCP)	$20		NA
Specialist	$30		NA
Hospitalization	$300		NA
Outpatient Surgery	$75		NA
Emergency Care	$100		NA
Prescription Drugs - Generic - Preferred - Non-preferred	Kaiser $7 $15 $30	Retail $20 $35 $50	NA

MEDICAL CONTRIBUTIONS

In 2025, McLean School will again cover 75% of your medical premiums. The below employee **per pay period deductions** for 2025 will be withheld on a pre-tax basis, which means you do not pay federal, state, Social Security or Medicare taxes on this portion of your pay.

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
CareFirst HRA – 12 Pay	$106.09	$243.99	$196.25	$322.50
CareFirst HRA – 10 Pay	$127.30	$292.79	$235.50	$387.00
Kaiser HMO – 12 Pay	$111.69	$263.94	$218.04	$344.27
Kaiser HMO – 10 Pay	$134.03	$316.73	$261.64	$413.12

DENTAL INSURANCE

CareFirst BlueCross BlueShield

For 2025, McLean School will continue to offer a dental plan through CareFirst. This plan offers an annual benefit of $2,000 per covered member (preventive services do not count towards this maximum) and a $2,000 lifetime orthodontia benefit.

	BlueDental Plus Plan 5	
Services	**In-Network**	**Out-of-Network**
Calendar-Year Deductible (Individual/Family)	$25/$75	$50/$150
Preventive & Diagnostic Services - Exams, cleanings and x-rays	Plan covers 100% You pay 0% Not subject to deductible	Plan covers 100% You pay 0% Not subject to deductible
Basic Services - Fillings, root canals and gum work	Plan covers 80% You pay 20% Subject to deductible	Plan covers 80% You pay 20% Subject to deductible
Major Services - Crowns, dentures and implants	Plan covers 50% You pay 50% Subject to deductible	Plan covers 50% You pay 50% Subject to deductible
Orthodontia Services - For adults and dependent children to age 26	Plan covers 50% You pay 50%	Plan covers 50% You pay 50%
Calendar-Year Maximum Per Covered Member	$2,000	$2,000
Lifetime Ortho Maximum	$2,000	$2,000

Under the above BlueDental Plus 5 plan, reimbursement for out-of-network dental services is based on the "Usual and Customary" (UCR) cost for the procedure - this is what 90% of dentists in a given zip code charge for the procedure.

DENTAL CONTRIBUTIONS

McLean School will cover 75% of the premiums for the CareFirst dental plan. The employee **per pay period cost** for our dental plan is as follows:

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental – 12 pay	$5.38	$10.77	$12.92	$20.46
Dental – 10 pay	$6.46	$12.92	$15.51	$24.55

VISION INSURANCE

We will also be continuing to offer vision coverage through CareFirst for 2025! Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

	BlueVision Plus H	
Services	**In-Network**	**Out-of-Network**
Exams – every 12 months	$10	$45 allowance
Lenses – every 12 months - Single - Bifocal - Trifocal	$20	$52 allowance $82 allowance $101 allowance
Frames – every 12 months	$150 allowance	$60 allowance
Contact Lenses – in lieu of glasses	$150 allowance	$112-$127 allowance

VISION CONTRIBUTIONS

McLean School once again will cover 75% of the vision premiums! The employee **per pay period cost** for our vision plan is as follows

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Vision - 12 pay	$0.79	$1.57	$1.65	$2.31
Vision - 10 pay	$0.94	$1.89	$1.98	$2.77

FLEXIBLE SPENDING ACCOUNTS

These tax-advantaged accounts offer you an opportunity to set aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket expenses (such as deductibles, coinsurance and copays) for you and your family. There are two types of flexible spending accounts (FSAs):

- Health FSA – Funds deposited in this account can be used to pay for out-of-pocket dental, vision **and** medical expenses.
- Dependent care FSA – This account allows you to contribute pre-tax dollars to cover qualified dependent care.

You cannot stockpile money in your FSA. **If you do not use it, you lose it.** You should only contribute the amount of money you expect to pay out of pocket for medical, dental, vision, or dependent care expenses between January 1, 2025 and December 31, 2025. As an added enhancement, you can use remaining funds for up to 75 days after the end of the plan year. The maximum that you can contribute to your health FSAs is $3,300 and for your dependent care FSA, $5,000. **Once you set your FSA contribution for the year it cannot be changed unless you have a "qualifying event."**

Additional information on FSAs can be found later in this guide or online at www.claritybenefitsolutions.com. Enrollment in this benefit must be done annually and in EASE**.**

FSA participants will be issued by Clarity a smart debit card that can be used to directly pay for qualified health and dependent care expenses. Those already enrolled in this program will continue to use their existing debit card.

LONG-TERM DISABILITY INSURANCE

McLean School provides benefit eligible employees with Long-Term Disability (LTD) insurance. This protects your income in the event you become disabled due to an injury or sickness.

Participation in this insurance is mandatory and the cost of the benefit is deducted from employee paychecks on an after-tax basis so that the benefit will be tax-free in the event of a disability. Premiums are based on earned wages. While the rate will remain unchanged for 2025, your payroll deduction could be different based on any adjustments to your salary. The School is remaining with Unum as the provider of this benefit for 2025.

	Benefit Overview
Benefit Begin Date	After 90 days of disability
Benefit Duration	Up to Age 65 or your Social Security Normal Retirement Age (SSNRA)
Percentage of Income Replaced	60%
Maximum Monthly Benefit Amount	$10,000

LIFE & AD&D INSURANCE

BASIC LIFE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

McLean School provides benefit eligible employees (working a minimum of 20 hours per week or 15 bins for faculty) with basic life and accidental death and dismemberment (AD&D) insurance up to $50,000. This benefit is provided to you at no cost.

VOLUNTARY LIFE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Employees can supplement their McLean provided basic life insurance benefit by purchasing additional coverage to protect themselves and their family members. This will be funded by salary deductions on an after-tax basis. While the rates are not changing for 2025, your costs may increase if you graduate to an older age band.

	Benefit Overview	
Member	**Electable Benefit**	**Guaranteed Issue Level^**
Employee	$10,000 increments up to the lesser of 5x annual earnings or $500,000	$130,000
Spouse*	$5,000 increments up to the lesser of 100% of the employee life amount or $500,000	$25,000
Child(ren)*	$2,000 increments up to $10,000	$10,000

*You must elect supplemental coverage for yourself in order to elect coverage for your spouse and/or child(ren).

^ Requesting a benefit over the guaranteed issue level or requesting coverage outside of your initial eligibility period requires submission of an Evidence of Insurability form and is subject to underwriting review for approval.

	Monthly Cost for Each $1,000 of Life Insurance											
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Employee	$0.046	$0.058	$0.084	$0.130	$0.197	$0.302	$0.442	$0.619	$0.776	$1.116	$2.111	$6.525
Spouse*	$0.090	$0.092	$0.118	$0.163	$0.245	$0.386	$0.574	$0.857	$1.203	$1.700	$3.217	$9.943
Child(ren)*	$0.345											

	Monthly Cost for Each $1,000 of AD&D Coverage		
Insured	Employee	Spouse	Child(ren)
Amount	$0.020	$0.020	$0.020

ADDITIONAL BENEFIT OFFERINGS

CRITICAL ILLNESS

When you or a family member suffers a critical illness such as a stroke or heart attack, this insurance can help with expenses that medical insurance doesn't cover, such as deductibles, coinsurance and copays. Critical Illness insurance can be purchased for you and your dependents.

	Benefit Overview	
Member	**Electable Benefit**	**Guaranteed Issue Level^**
Employee	$5,000 increments up to $50,000	$20,000
Spouse*	$5,000 increments up to $30,000	$10,000
Child(ren)*	Automatically covered at 50% of your election	N/A

* You must elect coverage for yourself in order to elect coverage for your spouse.

^ Requesting a benefit over the guaranteed issue level or requesting coverage outside of your initial eligibility period requires answering some medical questions.

Please refer to the Unum Critical Illness flyer later in this booklet for more information about this benefit. Additionally, premiums will vary based on a number of factors including age, tobacco usage and elected coverage. Our representatives at HUB International Mid-Atlantic will be able to provide you with these costs during your one-on-one enrollment meeting.

ACCIDENT

If you are injured in an accident, you may incur unanticipated expenses, such as deductibles and copays. Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. Coverage is provided for a wide range of incidents, from common injuries to more serious events. You also have the option to add on a sickness hospital confinement benefit to provide a more robust level of benefits. Please refer to the Unum Accident flyer later in this booklet for additional information about this benefit. The **monthly** rates for this insurance remained unchanged and are as follow.

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
W/o Sickness Hospital Confinement	$14.88	$24.58	$26.76	$36.46
With Sickness Hospital Confinement	$19.10	$33.02	$35.56	$49.48

EMPLOYEE ASSISTANCE PROGRAM

An EAP can be an invaluable resource to employees dealing with life's challenges. Completely confidential services for emotional and stress-related issues, family and relationships, work transitions, or drug/alcohol dependencies can be obtained by calling 1-800-854-1446 or visiting www.unum.com/lifebalance.

LEGAL RESOURCES

McLean School offers eligible employees the opportunity to protect themselves and their family with legal services and expertise. This plan provides access to a national network of full-service law firms with over 13,000 attorneys. Commonly used legal services include a general consultation, will preparation, traffic court representation, tenant disputes with a landlord, and review of a financial contract or lease. Please see the Legal Resources brochure later in this booklet for more information, including monthly cost, on this benefit. Login to Ease (https://mcleanschool.ease.com) to elect this benefit.

RESOURCE DIRECTORY

	Resource Directory		
Benefit	**Provider**	**Contact Information**	**Group ID #**
Medical	CareFirst	Visit: www.carefirst.com Call: 855-444-3122	2U5L
Medical	Kaiser	Visit: www.kaiserpermanente.org Call: 800-464-4000	25075
Dental	CareFirst	Visit: www.carefirst.com Call: 855-444-3122	2U5L
Vision	CareFirst	Visit: www.carefirst.com Call: 855-444-3122	2U5L
Life & AD&D	Unum	Visit: www.unum.com Call: 1-866-679-3054	618515
Long-Term Disability	Unum	Visit: www.unum.com Call: 1-866-679-3054	618515
Employee Assistance Program	Unum	Visit: www.unum.com/lifebalance Call: 1-800-854-1446	R07161510
Critical Illness & Accident	Unum	Visit: www.unum.com Call: 1-866-679-3054	R0761510
Legal	Legal Resources	Visit: www.legalresources.com Call: 1-800-728-5768	N/A
FSA	Clarity Benefit Solutions	Visit: www.claritybenefitsolutions.com Call: 888-423-6359	N/A
HRA	Clarity Benefit Solutions	Visit: www.claritybenefitsolutions.com Call: 888-423-6359	N/A

	HUB International Mid-Atlantic
Senior Relationship Manager	Kelly Jarvis Call: 301-708-3955 or Email: kelly.jarvis@hubinternational.com
Client Advocate	Mat Gorchesky Call: 240-403-2562 or Email: mat.gorchesky@hubinternational.com

QUESTIONS & ANSWERS

WHAT DO I NEED TO DO?

- Please sign up for a time slot to meet with representatives from HUB International Mid-Atlantic on November 20th or 21st.
- If you are enrolling for medical, dental, vision, or Legal insurance for the first time, make your elections in Ease (mcleanschool.ease.com).
- If you want to change any of your current medical, dental, vision, or Legal elections, do so in Ease (mcleanschool.ease.com).
- If you want to participate in the FSA, you must make an active election in Ease (mcleanschool.ease.com).
- If you want to sign up for the voluntary Unum insurances, you will do so directly with Matthew Roberts from HUB International Mid-Atlantic.

WHEN DOES OPEN ENROLLMENT START AND END?

- Open enrollment starts Monday, November 18th.
- Open enrollment ends at noon on Tuesday, November 26th.

IF I HAVE QUESTIONS, WHO CAN I CONTACT?

- Kelly Jarvis, HUB International Mid-Atlantic, (301) 708-3955, kelly.jarvis@hubinternational.com
- Jeffrey Berman and Sarir Dehnadi, McLean School

OPEN ENROLLMENT GLOSSARY OF TERMS

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common open enrollment terms to help you navigate your benefits options.

Balance billing – The difference between what an insurance carrier allows for a certain procedure and the amount a non-participating or out-of-network provider chargers. If you see providers that don't participate with Cigna, this may come into play.

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment – A flat fee that you pay toward the cost of covered medical services.

Covered expenses – Health care expenses that are covered under your health plan.

Deductible – A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent – Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible spending account (FSA) – An account that allows you to save tax-free dollars for qualified dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year.

Health reimbursement account (HRA) – HRAs are employer-funded arrangements that reimburse employees for certain medical expenses. Typically, an employer can only offer an HRA to employees with a group health plan, often a high deductible health plan (HDHP). Your employer determines the amount of money available in the HRA, which is typically an amount less than your annual health plan deductible.

In-network – Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.
Inpatient – A person who is treated as a registered patient in a hospital or other health care facility.

Medicare – An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

Member – You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-network – Health care you receive by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket expense – Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket maximum (OOPM) – The highest out-of-pocket amount paid for covered services during a benefit period.

Primary care physician (PCP) – A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual & customary reimbursement (UCR) – Specific to your dental plan, reimburses out-of-network dental claims at what 9 out of 10 dentists in a specific zip code charges for that procedure.

CareFirst
Family of health care plans

BlueChoice Advantage

Offers you the freedom to choose

BlueChoice Advantage offers in- and out-of-network coverage to help control your out-of-pocket costs and there's no referral to see a specialist. We also offer online tools and resources at **carefirst.com** that give you the flexibility to manage your health and wellness goals wherever you are.

Take advantage of your benefits

- $0 cost for comprehensive preventive healthcare visits.
- Choose any provider you want—no referrals required.
- A network of almost 47,000 CareFirst BlueChoice providers (PCPs, nurse practitioners, specialists, hospitals, pharmacies and diagnostic centers) in Maryland, Washington, D.C. and Northern Virginia.
- After-hours care, including a free 24-hour nurse advice line, video visits for physical and mental health, convenience care clinics and urgent care centers.
- If you need care outside the CareFirst BlueCross BlueShield (CareFirst) service area of Maryland, Washington, D.C. and Northern Virginia, you have access to the largest network across the country, with 96% of hospitals and 95% of physicians in-network.

Benefits at a glance

Preventive care and sick office visits

You are covered for all preventive care as well as sick office visits.

Large provider network

You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your healthcare.

Specialist services

Your coverage includes services from specialists without a referral. Specialists are doctors or nurses who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage

Your plan covers prescription drugs.

Hospital services

You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your PCP or specialist must provide prior authorization for all inpatient hospital services and may need to provide prior authorization for some outpatient hospital services such as rehabilitative services, chemotherapy and infusion services.

Labs, X-rays or specialty imaging

Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).

Well-child visits
All well-child visits and immunizations are covered.

Maternity and pregnancy care
You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.

Mental health and substance use disorder
Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance use disorder treatment.

How your plan works

Receiving care inside the CareFirst service area

When you need care in Maryland, Washington, D.C. or Northern Virginia, select a provider in the CareFirst BlueChoice network to receive in-network coverage and pay the lowest out-of-pocket costs.

If you receive care within our service area but outside the BlueChoice network, your benefits will be paid at the **out-of-network** level, but you'll incur lower costs by using a participating national BlueCard PPO provider. To find a national participating provider, visit **bcbs.com**.

If you receive services from a provider outside of the BlueChoice or national BlueCard PPO provider network, you may have to:

- Pay higher out-of-pocket costs
- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

Receiving care outside the CareFirst service area

Members seeking care outside the CareFirst service area will pay the lowest costs by using a national BlueCard PPO provider. Members will still have the option to opt out of this network but will pay a higher out-of-pocket expense.

If you receive services from a provider outside of the national BlueCard PPO network when you are out of the CareFirst service area, you will have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a deductible and coinsurance/copays

The choice is entirely yours. That's the advantage of this plan.

Inside the CareFirst service area

In-network you pay: **$**
BlueChoice network

Out-of-network you pay: **$$**
BlueCard PPO network

Non-participating providers you pay: **$$$**
(Balance billing may apply)

Outside the CareFirst service area

In-network you pay: **$**
BlueCard PPO network

Non-participating providers you pay: **$$$**
(Balance billing may apply)

Hospital authorization

CareFirst BlueChoice providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by out of network providers and out-of-area admissions. To request authorization, call toll-free at 866-PREAUTH (773-2884).

Prior authorization is not required for emergency admissions or maternity admissions.

Your benefits

Step 1: Meet your deductible

You will be responsible for the cost of your medical care up to the amount of your deductible. However, this deductible does not apply to all services.

Examples of in-network services not subject to deductible*:

- Adult preventive visits with PCP
- Well-child care and immunizations with PCP
- OB/GYN visits and pap tests
- Mammograms
- Prostate and colorectal screenings
- Routine prenatal maternity services

Step 2: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met. However, the level of those benefits will depend on whether you see in-network or out-of-network providers. Depending on your particular plan, you may also have to pay a copay or coinsurance when you receive care.

You will have different deductible amounts for in-network versus out-of-network services. For example, when you see in-network providers, your expenses will only count toward your in-network deductible and out-of-network expenses will only apply to your out-of-network deductible.

Deductible requirements vary based on whether your coverage is an individual or family plan. If more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed information on deductibles.

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

Just like your deductible, you will have a different out-of-pocket maximum for in-network versus out-of-network benefits.

Please keep in mind that out-of-pocket requirements also differ if your coverage is an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

Labs, X-rays or specialty imaging

If you access laboratory services inside the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia you must use LabCorp as your lab test facility for in-network benefits. Services performed by any other provider, while inside the CareFirst service area will be considered out-of-network.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. For locations near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**.

If you access laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO facility and receive in-network benefits. To find laboratory service providers outside of the CareFirst service area, visit our *Find a Provider* tool (**carefirst.com/doctor**) and search by *Labs*.

If you need X-rays or other specialty imaging services inside the CareFirst service area, you must visit a participating freestanding/non-hospital diagnostic center such as Advanced Radiology. If you need X-rays or other specialty imaging services outside the CareFirst service area, you may use any participating BlueCard PPO facility and receive in-network benefits.

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

Out-of-area coverage

You have the freedom to take your healthcare benefits with you across the country. BlueCard PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same healthcare benefits while traveling outside of the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia. The BlueCard program includes 8,896 hospitals and more than 500,000 healthcare providers nationally.

Global coverage

If you travel outside of the United States for a period of less than six months, you have access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers. With BlueCross BlueShield Global Core*, you'll receive:

- Access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers—more than 7,000 physicians and more than 2,000 hospitals.
- 24/7 care support via telephone.
- Seamless claims processing/reimbursement designed for occasional or short-term travel, the Global Core connects members with their home plan benefits to provide basic medical coverage outside of the United States.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount CareFirst approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the CareFirst BlueChoice network cannot charge our members more than the allowed amount for any covered service.

BALANCE BILLING: Billing a member for the difference between the allowed charge and the actual charge.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the CareFirst BlueChoice network.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the CareFirst BlueChoice network.

PRIMARY CARE PROVIDER (PCP): The doctor or medical professional you go to for primary care and who coordinates or arranges other services you need.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association

SUM3179-1P (7/21)

Know Before You Go

Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It's important to understand your options so you can make the best decision when you or your family members need care.*

Primary care provider (PCP)

The best place to get consistent, quality health care is your primary care provider (PCP). If you have a medical issue, having a doctor who knows your health history often makes it easier to get the care you need.

24-Hour Nurse Advice Line

Registered nurses are available 24/7 to discuss your symptoms with you and recommend the most appropriate care. Call 800-535-9700 anytime to speak with a nurse.

CareFirst Video Visit

When your PCP isn't available and you need urgent care services, CareFirst Video Visit securely connects you with a doctor, day or night, through your smartphone, tablet or computer. In addition, you can schedule visits for other needs such as behavioral health support from a therapist or psychiatrist, guidance from a certified nutritionist or breastfeeding support from a lactation consultant. It's a convenient and easy way to get the care you need, wherever you are. Visit **carefirstvideovisit.com** to get started.

Convenience care centers (retail health clinics)

These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer care for non-emergency situations like colds, pink eye, strep tests and vaccinations. These centers usually have evening and weekend hours.

Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) provide treatment for injuries and illnesses that require prompt medical attention but are not life-threatening (sprains, minor cuts, flu, rashes, minor burns). These centers have doctors on staff and offer weekend/after-hours care.

Emergency room (ER)

Emergency rooms treat acute illnesses and trauma. Go to the ER right away if you or a family member have sudden symptoms that need emergency care, including (but not limited to): chest pain, trouble breathing or head trauma. Prior authorization is not needed for emergency room services.

* The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

When you need care

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs* may vary for a sample health plan depending on where you choose to get care.

	Sample cost	Sample symptoms	24/7	Rx
Video Visit *(urgent care services)*	$20	■ Cough, cold and flu ■ Pink eye ■ Ear pain	✔	✔
Convenience Care *(e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)*	$20	■ Cough, cold and flu ■ Pink eye ■ Ear pain	✘	✔
Urgent Care *(e.g., Patient First or ExpressCare)*	$60	■ Sprains ■ Cut requiring stitches ■ Minor burns	✘	✔
Emergency Room	$200	■ Chest pain ■ Difficulty breathing ■ Abdominal pain	✔	✔
24-Hour Nurse Advice Line	$0	■ If you are unsure about your symptoms or where to go for care, call 800-535-9700, anytime day or night to speak to a registered nurse.		

* The costs in this chart are for illustrative purposes only and may not represent your specific benefits or costs.

Did you know that **where** *you choose to get lab work, X-rays and surgical procedures can have a big impact on your wallet? Typically, services performed in a hospital cost more than non-hospital settings like LabCorp, Advanced Radiology or ambulatory surgery centers.*

To determine your specific benefits and associated costs:

- Log in to *My Account* at **carefirst.com/myaccount**;
- Check your Evidence of Coverage or benefit summary;
- Ask your benefit administrator; or
- Call Member Services at the telephone number on the back of your member ID card.

For more information and frequently asked questions, visit carefirst.com/needcare.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.

SUM3424-1P (3/21)

CareFirst
Family of health care plans

Talking to Your Doctor

Address your concerns and understand treatment options

Taking an active role in your healthcare and working with your doctor is an important part of achieving the best level of health for you. Research shows that active, assertive patients are more likely to follow a doctor's advice and recover more completely, when they understand their treatment and have a part in planning it. And it starts with good communication. Here are some tips to help you get the most out of your relationship with your doctor.

Be prepared—have your answers ready

If you're going to discuss a new problem with your doctor, you'll need to give some information. Jotting down some notes before your visit can help the doctor narrow down the diagnosis and develop a treatment plan.

To start, write down the answers to the following questions:

- What is your main problem?
- What are the key symptoms?
- When did your problem begin? Try to give the exact time.
- Have you had this problem before? If so, when? And what happened?
- What have you done to try and relieve the problem?
  - Have you used any medications? If yes, what kind? What happened?
- What makes this problem worse?
  - List activities, medications, foods or other situations.
- Are you allergic to any medications or have you recently taken a new medication?

- What may have caused the problem?
  - Does anyone around you have similar symptoms?
  - Did you eat some unusual food?
- What is your family history?
  - Is there a history of heart disease, high blood pressure, diabetes, breast cancer, etc. among your parents, grandparents, brothers or sisters?

Ask questions during your visit

You'll feel more prepared if you jot down a few questions to ask your doctor. Make sure you have the answers you need before you leave your doctor's office.

About my condition or disease

- What's my diagnosis?
- What caused my condition?
- Can it be treated?
- How will this affect me now and in the future?
- Should I watch for specific symptoms and notify you if they occur?
- Should I make any lifestyle changes?

About my treatment

- What treatment is available for my condition?
- When will treatment start? And how long will it last?
- What are the risks and side effects associated with this treatment?
- What are the benefits of this treatment? How successful is it?
- If my treatment includes taking medication, what should I do if I miss a dose?
- Are there foods, medications or activities I should avoid while I'm on this treatment?
- Are other treatments available?

About my tests

- What kinds of tests will I have?
- What do you expect to find out from these tests?
- When will I know the results?
- Do I have to do anything special to prepare for the tests?
- Do these tests have side effects or risks?
- Will I need more tests later?

Remembering what you've discussed with your doctor

Understanding and remembering what happened during your visit is essential to achieving the best possible care. So, here are a few more tips:

- Either you, a friend or family member should take notes.
- Ask your doctor to write down their instructions to you.
- Get printed material about your condition from your doctor.
- Want more information? Ask your doctor or your health care team—such as your nurse and pharmacist—for additional resources.

FOR MORE INFORMATION:

National Institutes of Health
nih.gov

U.S. Department of Health and Human Services
health.gov

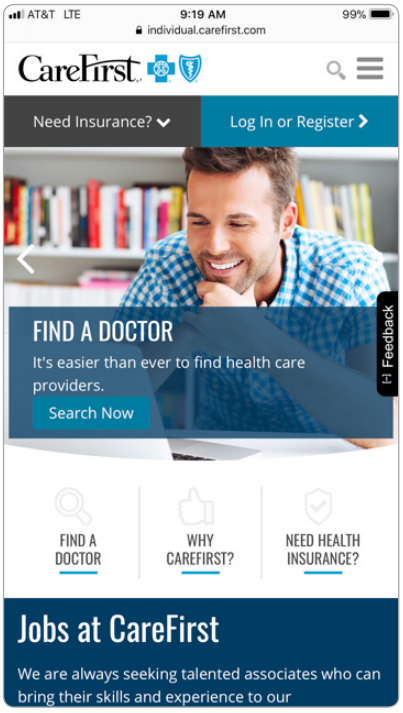
Source: National Institutes of Health

SUM3453-1E (3/20)

Your health care information is as close as your mobile device

Get the information you need wherever you go with *My Account*.[1]

- Find in-network doctors, specialists, urgent care centers and more—nationwide—including a map and directions to the location[2]
- Check plan information including
  - effective date,
  - copays,
  - deductible,
  - out-of-pocket status
  - Explanation of Benefits (EOBs), and
  - recent claims activity
- View, order or email member ID cards—for an explanation of the codes on your card, select *How to read my card*
- Use the Treatment Cost Estimator to calculate costs for services and procedures[3]
- Submit claims for out-of-network care
- Track your wellness program progress[4]
- Send a secure message via the *Message Center*
- Check *Alerts* for important notifications



Get connected today!

Type **carefirst.com** into your mobile web browser to access our mobile site or download our free app by searching for CareFirst in your favorite app store.

Available on the App Store

Google play

[1] Register for *My Account* at **carefirst.com/myaccount** to view your personal information.

[2] Location services must be enabled on your device.

[3] The estimated cost information provided is intended to be used as a reference tool for your convenience and is not a substitute for medical advice or treatment by a medical professional.

[4] If applicable for your plan.

SUM3255-1E (3/20)

Clarity
BENEFIT SOLUTIONS™

Health Reimbursement Arrangement (HRA)

AN INVESTMENT IN WELL-BEING

Your employer has made an investment in your physical wellness and financial security by offering a health reimbursement arrangement (HRA). This employer-funded benefit sets aside tax-free dollars that you can use to pay for healthcare costs that are not paid for by your insurance plan.

HRAS TYPICALLY **COVER OUT-OF-POCKET EXPENSES**, SUCH AS:

- Copayments and deductibles
- Specialty care providers
- Hospital expenses
- Labs and x-rays
- Out-patient procedures
- Prescription drugs
- Physical therapy
- Chiropractic care
- Vision care, glasses, and contacts
- Dental and orthodontics
- Over-the-counter medication with a prescription

Be sure to check your summary plan document for specific expenses your employer's HRA covers and other important plan rules.

LIFE IS A JOURNEY, ONE THAT SHOULD BE **LIVED WELL**

Learn more about us at **claritybenefitsolutions.com**

Tip: For translation to your preferred language, Google translate offers a free service that instantly translates to 100+ languages.

A LITTLE EXTRA HELP FOR HEALTHCARE EXPENSES

Your HRA is funded entirely by your employer to help lighten the financial load of copays, deductibles, prescriptions, and other medical expenses.

WAYS THEY CAN ACCESS THEIR FUNDS

Depending on the choices your employer has made, you have a few different ways to take advantage of your HRA. Be sure to check your summary plan documents for options your employer offers.

CLARITY BENEFIT CARD

Pay providers for qualifying healthcare expenses with a simple swipe of a card. If your card is for prescriptions only, use it at your pharmacy.

ONLINE PORTAL AND MOBILE APP

Have access to your account information, be able to submit claims and supporting documentation, or sign up for e-claims reimbursement in our online portal. You can also download the Clarity mobile app to have access on any mobile device.

CLARITY BENEFITCONNECT

Enroll to track deductible spend, substantiate card transactions, or automatically reimburse eligible expenses.

SUBMITTING PREVIOUS EXPENSES

At the end of the plan year, you'll have an additional window of time to submit a claim. You can use the online portal or mobile app to submit expenses incurred throughout the year, but please don't try to use your Clarity Convenience Card, as it will only work for expenses from the current plan year.

A SIMPLY SMARTER APPROACH
TO EMPLOYEE BENEFITS

Today, the benefits landscape is more confusing than ever, but it's also never been so essential. At Clarity, we believe life is a journey; one that should be lived well. So, we'll stop at nothing to bring clarity, and ensure you are ready for life. With state-of-the-art technology and world-class customer service, we'll handle the day-to-day so you can focus on what matters: your health.

HIPAA SEAL OF COMPLIANCE COMPLIANCY GROUP HIPAA VERIFIED

VERIFIED HIPAA SEAL OF COMPLIANCE™

Learn more about us at **claritybenefitsolutions.com**

Clarity BENEFIT SOLUTIONS™

Clarity
BENEFIT SOLUTIONS™

Flexible Spending Account with Rollover

HEALTHCARE FSA WITH ROLLOVER

Clarity Healthcare Flexible Spending Account (FSA) lets you set aside **up to $3,050 in** tax-free **funds** for health-related expenses not covered by your insurance plan, saving you about 30% on average. Plus, you can roll over a portion of your unused funds into next year.

YOUR **HEALTHCARE FSA** COVERS THINGS LIKE:

- ✓ Copays, deductibles and coinsurance
- ✓ Doctor and hospital visits
- ✓ Lab work and x-rays
- ✓ Prescription drugs and prescribed over-the-counter medications
- ✓ Dental and orthodontics
- ✓ Vision care, glasses and contacts
- ✓ Physical therapy and chiropractic care

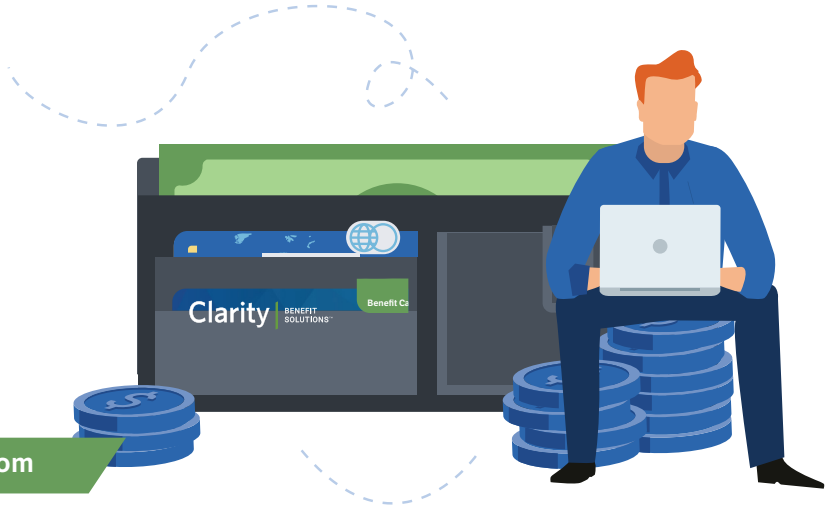
HOW IT WORKS:

1. You decide how much to set aside for the year, up to your plan's maximum
2. That amount is evenly divided by pay period and deducted from your paycheck before taxes - saving you about 30% on average
3. Your account is funded with the full amount at the start of the plan year, so you can pay for eligible expenses right away
4. Submit receipts and request reimbursement hassle free with the Clarity mobile app or online portal - or simply swipe your Clarity Benefits Card at the point of sale
5. At the end of the year, you can roll over a certain amount of unused funds to the next year. Please visit www.claritybenefitsolutions.com for more information.

See the full list of eligible expenses in the Clarity Employee Portal, and refer to your employer's plan for details about maximum contributions.

RELAX WITH ROLLOVER

Don't feel rushed to "use it or lose it" with your contributions Clairty's Healthcare FSAs let you roll over your unused funds for future expenses.



Learn more about us at **claritybenefitsolutions.com**

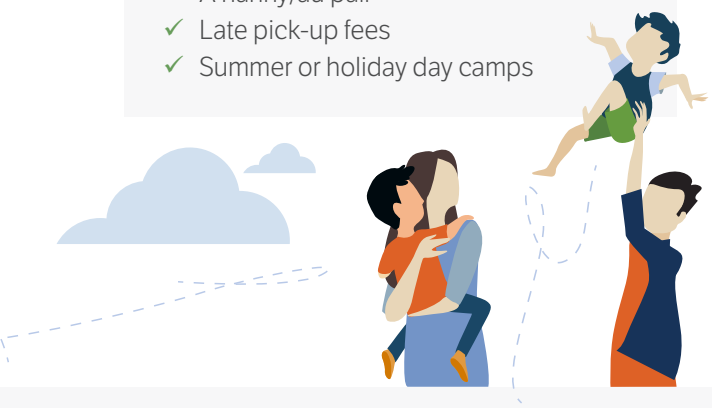
Tip: For translation to your preferred language, Google translate offers a free service that instantly translates to 100+ languages.

DEPENDENT CARE FSA

Your Dependent Care Account (DCA) lets you set aside up to $5,000 in tax-free funds to cover care-related expenses for your children and dependents.

YOUR **DEPENDENT CARE FSA** COVERS THINGS LIKE:

- ✓ Before and after school care for children 12 and younger
- ✓ Custodial care for dependent adults
- ✓ Licensed day care centers
- ✓ A nanny/au pair
- ✓ Late pick-up fees
- ✓ Summer or holiday day camps



HOW IT WORKS:

1. Choose how much to contribute, up to your plan's maximum contribution
2. That amount is evenly divided by pay period and deducted from your paycheck before taxes - **saving you about 30% on average**
3. As your account fills up, you can begin to use your funds on eligible expenses. Unlike a healthcare FSA, you must contribute funds before you can use them.
4. Submit receipts and request reimbursement hassle free with Clarity's online portal -- or simply swipe your Clarity Benefits Card at the point of sale
5. Any unused funds not claimed by the end of the **75-day grace period** will be forfeited

CLARITY MAKES **GETTING THE MOST OUT OF YOUR FSA** SIMPLY SMARTER

CLARITY BENEFIT CARD

Pay providers for qualifying healthcare expenses by swiping the Clarity Benefit card at the point of sale. The card can be used at any qualified service provider that accepts MasterCard.

ONLINE PORTAL AND MOBILE APP

See your account information, submit claims and support documentation or sign up for e-claims reimbursement. You can also use the Clarity mobile app to have access on any mobile device.

CLARITY BENEFITCONNECT (HEALTHCARE FSA ONLY)

Enroll to track deductible spend, substantiate card transactions or automatically reimburse eligible expenses.

A SIMPLY SMARTER APPROACH TO EMPLOYEE BENEFITS

Today, the benefits landscape is more confusing than ever, but it's also never been so essential. At Clarity, we believe life is a journey; one that should be lived well. So, we'll stop at nothing to bring clarity, and ensure you are ready for life. With state-of-the-art technology and world-class customer service, we'll handle the day-to-day so you can focus on what matters: your health.

VOTED ONE OF THE 30 FASTEST GROWING TECH COMPANIES IN 2020

Learn more about us at **claritybenefitsolutions.com**

Clarity BENEFIT SOLUTIONS™

UNUM
Better benefits at work.

McLean School
Transformative.

Critical Illness Insurance

can pay money directly to you when you're diagnosed with certain serious illnesses.

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a benefit payment in one lump sum. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions. If you have a different condition later, you can receive another benefit.
- This insurance pays you once for each eligible illness. However, the diagnoses must be at least 90 days apart, and the conditions can't be related to each other.

What's covered?

- Heart attack
- Blindness
- Major organ failure
- End-stage kidney failure
- Benign brain tumor
- Coronary artery bypass surgery (pays at 25% of lump sum benefit)
- Coma that lasts at least 14 consecutive days
- Stroke whose effects are confirmed at least 30 days after the event
- Occupational HIV
- Permanent paralysis of at least two limbs due to a covered accident

Coverage is also included for:

- Cancer
- Carcinoma in situ — pays 25% of your coverage amount. (Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.)

Why should I buy coverage now?

- It's more affordable when you buy it through your employer.
- The cost is conveniently deducted from your paycheck.
- You can keep coverage if you leave the company or retire. You'll be billed at home.

What else is included?

A Wellness Benefit

Every year, each family member who has Critical Illness coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms
- And other tests listed in your policy

Please refer to the policy for complete details about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Effective date of coverage: Coverage becomes effective on the first day of the month in which payroll deductions begin. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Who can get coverage?

Coverage is guaranteed up to the stated amount. If you don't sign up now but decide to apply later, you may have to answer medical questions.

You	Choose from $5,000 to $50,000 in increments of $5,000. Coverage is guaranteed up to $20,000 if you apply during this enrollment. You can get coverage up to $50,000, but you may have to answer a few health questions.
Your spouse	Spouses from ages 17 and up can get from $5,000 to $30,000 in increments of $5,000, as long as you have purchased coverage for yourself. Coverage is guaranteed up to $10,000 if they apply during this enrollment. They can get coverage up to $30,000, but they may have to answer a few health questions.
Your children	Dependent children from newborns to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses, plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Unum has been a leading provider in **group disability benefits** for over **4** decades.[1]

- #1 Individual Disability[2] Whole/Universal Life[3]
- #2 Group Disability[4]
- #3 Voluntary Benefits[5] Critical Illness[6]

1 Employee Benefit Plan Review, "Group Accident & Health Surveys 1976-1990" (1977-1991); Gen Re, "U.S. Group Disability Market Surveys 1991-2013" (1992-2014); LIMRA, "U.S. Group Disability Insurance 2014-2016 Annual Sales and In Force" (2015-2017).
2 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
3 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).
4 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
5,6 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).

Exclusions and limitations

Waiting period

The benefit for this coverage is subject to a 30-day waiting period following the effective date of the insured's coverage. This does not apply to coma, occupational HIV and permanent paralysis or specific covered childhood diseases.

Pre-existing conditions

Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of a sickness or injury, whether diagnosed or not, for which you received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed drugs or medicine to be taken in the 12 months just prior to your effective date) will not be paid during the first 12 months the policy is inforce.

Reduction of benefits

Any coverage inforce prior to the insured's 70th birthday will be reduced on the policy anniversary date following the insured's 70th birthday. The insured's face amount will be reduced to 50% of the face amount the insured had prior to the policy anniversary date. Any coverage inforce after the policy anniversary date following the insured's 70th birthday will not be subject to a benefit reduction on subsequent policy anniversary dates.

Exclusions and Limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not; or
- Participating in war or any act of war, whether declared or undeclared; or
- We will not pay an initial diagnosis benefit for a critical illness with a date of diagnosis during the benefit waiting period.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the:

- Date this policy is canceled;
- Date you are no longer in an eligible group;
- Date your eligible group is no longer covered;
- Date of your death;
- Last day of the period for which you made any required contributions; or
- Last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy.

Coverage on your dependent children ends on the earliest of the date your coverage under this policy ends or the date a dependent child no longer meets the definition of dependent children.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form CI-1 or contact your Unum representative.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

unum
Better benefits at work.

McLean School
Transformative.

Accident Insurance

can pay you money for covered accidental injuries and their treatment.

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

What's included?

Wellness Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms

Sickness Hospital Confinement Benefit

This optional benefit pays a daily amount if you're in the hospital for a covered illness. It's available to each family member who has Accident coverage. You can receive $200 per day. Coverage for children is 75% of that amount.

– The benefit has a 12-month pre-existing condition limitation. You and your spouse need to answer some health questions to receive this benefit.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Ages 17 and up
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

Unum has been a leading provider in **group disability benefits** for over **4** decades.[1]

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- #2 Group Disability[4]
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4 LIMRA, "4Q 2017 U.S. Workplace Disability Insurance Inforce (2018), based on inforce premium.
5,6 Eastbridge, "U.S. Worksite/Voluntary Sales Report: Carrier Results for 2016" (2017).

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Accident Insurance

See Schedule of Benefits for a complete listing of what is covered.

THIS IS A LIMITED BENEFITS POLICY.

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;
- loss to which a contributing cause was the insured's commission of or attempt to commit a felony; this exclusion applies only to accidental death and/or dismemberment claims;
- loss to which a contributing cause was the insured being engaged in an illegal occupation. This exclusion applies only to accidental death and/or dismemberment claims;
- being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.
  In addition to the exclusions listed above, Unum will also not pay the catastrophic accidental dismemberment or catastrophic accidental loss benefit for the following injuries that are caused by or are the result of:
- an insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- injuries to a dependent child received during the birth.

Sickness Hospital Confinement Benefit exclusions

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- treatment for dental care or dental care procedures;
- elective procedures and/or cosmetic surgery or reconstructive surgery, unless it is a result of trauma, infection or other diseases;
- having a pre-existing condition as described and limited by this benefit;
- hospital confinement caused by, contributed to by, or resulting from your mental illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer's disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this policy;
- any hospital confinement of a newborn following the birth unless the newborn is sick or injured.

Pre-existing conditions for the Sickness Hospital Confinement Benefit

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of a pre-existing condition or any medical or surgical treatment for that condition for which the date of confinement is in the first 12 months after the insured's coverage effective date. Pre-existing condition means a sickness or symptoms of a sickness, whether diagnosed or not, for which the insured received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine or had been prescribed drugs or medicine to be taken during the 12 months just prior to the insured's coverage effective date.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy. Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS IS A LIMITED BENEFITS POLICY

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GA-1 et al. or contact your Unum representative.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

Accident Insurance – Schedule of Benefits

Covered injuries	Benefit amount
Fractures	
Open Reduction (dependent on location of injury)	$150 to $7,500
Closed Reduction (dependent on location of injury)	$75 to $3,750
Chips	25% of closed amount
Dislocations	
Open Reduction (dependent on location of injury)	$300 to $6,000
Closed Reduction (dependent on location of injury)	$150 to $3,000
Burns	
At least 10 square inches, but less than 20 square inches	2nd degree – $0 3rd degree – $2,500
At least 20 square inches, but less than 35 square inches	2nd degree – $0 3rd degree – $5,000
35 or more square inches of the body surface	2nd degree – $1,000 3rd degree – $10,000
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit
Skin graft for any other accidental traumatic loss of skin	
At least 10 square inches, but less than 20 square inches	$150
At least 20 square inches, but less than 35 square inches	$250
35 or more square inches of the body surface	$500
Concussion	$150
Coma	$10,000
Ruptured disc	$800
Knee cartilage	
Torn with surgical repair	$750
Exploratory surgery or cartilage shaved, only	$150
Laceration	$25–$600
Tendon/ligament and rotator cuff	
Surgical repair of one	$800
Surgical repair of two or more	$1,200
Exploratory surgery without repair	$150
Dental work, emergency	
Extraction	$100
Crown	$300
Eye injury	$300

Accident coverage is a limited policy.

Emergency and hospitalization benefits	Benefit amount
Ambulance (ground, once per accident)	$400
Air ambulance	$1500
Emergency room treatment	$150
Emergency treatment in physician office/urgent care facility	$75
Hospital admission (admission or intensive care admission once per covered accident)	$1,000
Intensive care admission (same as above)	$1,500
Hospital confinement (per day up to 365 days)	$200
Intensive care confinement (per day up to 15 days)	$400
Medical imaging test (once per accident)	$200
Outpatient surgery facility service (once per accident)	$300
Pain management (epidural, once per accident)	$100

Treatment and other services	Benefit amount
Surgery benefit	
Open abdominal, thoracic	$1,500
Exploratory (without repair)	$150
Hernia repair	$150
Physician follow-up visit (2 visits per accident)	$75
Chiropractic visit (up to 3 visits per calendar year)	$25
Therapy services (up to 10 per accident)	
Occupational therapy	$25
Speech therapy	$25
Physical therapy	$25
Prosthetic device or artificial limb	
One	$750
More than one	$1,500
Appliance (once per accident)	$100
Blood, plasma and platelets	$400
Travel due to accident Transportation of more than 50+ miles from residence; 3 trips per accident; max 1,200 miles per round trip	$0.40 per mile
Lodging (per night up to 30 days per accident)	$150
Rehabilitation unit confinement (per day up to 15 days; max 30 days per calendar year)	$100

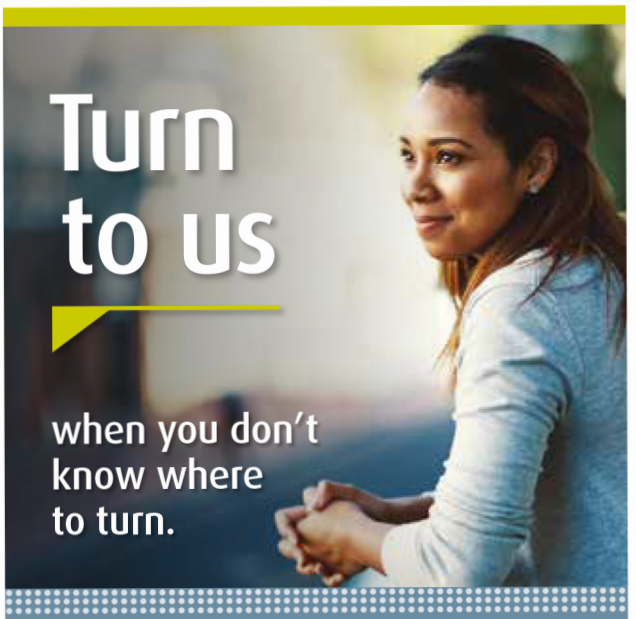
Accidental death and other covered losses	Benefit amount
Accidental death*	
Employee	$50,000
Spouse	$20,000
Child	$10,000
*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee–$150,000; spouse–$60,000; child–$30,000	
Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet; or	$15,000
Loss of one hand and one foot; or	$15,000
Loss of one hand or one foot;	$7,500
Loss of two or more fingers, toes or any combination; or	$1,500
Loss of one finger or toe	$750
Catastrophic accidental dismemberment† — once per lifetime, not payable with catastrophic loss Loss of both hands or both feet; or loss of one hand and one foot	
Employee (prior to age 65)	$100,000
Spouse and child	$50,000
Employee (ages 65–69)	$50,000
Spouse and child	$25,000
Employee (70+ years old)	$25,000
Spouse and child	$12,500
Accidental loss — paralysis, sight, hearing and speech Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Permanent paralysis; or	$15,000
Loss of sight of both eyes; or	$15,000
Loss of sight of one eye; or	$7,500
Loss of the hearing of one ear	$7,500
Catastrophic accidental loss† — once per lifetime, not payable with catastrophic dismemberment Permanent paralysis; or loss of hearing in both ears; or loss of the ability to speak; or loss of sight of both eyes	
Employee (prior to age 65)	$100,000
Spouse and child	$50,000
Employee (ages 65–69)	$50,000
Spouse and child	$25,000
Employee (70+ years old)	$25,000
Spouse and child	$12,500
†Catastrophic accidental loss benefit — payable after fulfilling a 365 day elimination period.	

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

The information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GA-1 or contact your Unum representative.

Level 2 with AD&D



Confidential solutions are at your fingertips with the Employee Assistance Program

unum
Better benefits at work.

Employee Assistance Program — Work/Life Balance

Toll-free 24/7 access:

- **1-800-854-1446** (multi-lingual)
- **www.unum.com/lifebalance**

Confidential

Help, when you need it most

- Stress
- Depression
- Addiction
- Child care
- Elder care
- Legal questions
- Grief and loss
- Family relationships and parenting
- Even reducing your medical/dental bills!

Help is easy to access

- **Online/phone support:** Unlimited, confidential, 24/7.
- **In-person:** 3 visits with a Licensed Professional Counselor* are available at no additional cost to you. Your counselor may refer you to resources in your community for ongoing support.

Who is covered?

The program is available to you, your spouse, dependent children, parents and parents-in-law. It's provided to you at no additional cost as part of your insurance plan.

For more information:
visit www.unum.com/lifebalance
or call us at 1-800-854-1446 (multi-lingual).

* The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

Unum's Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

unum.com

EN-2059 (4-18) FOR EMPLOYEES

unum

This is not a medical insurance card.

Keep this card with you at all times. It gives you immediate access to a full range of confidential Work-life Balance services for you and your family. If you need additional cards, contact your workplace plan administrator.

unum.com

Better benefits at work.

Portability and conversion:
How employees can continue their life insurance

Decisions to make, steps they can take.

When employees' life insurance coverage is ending — either because they are leaving the company, they've become disabled, or they are no longer eligible for coverage — there are steps they can take to preserve their life coverage.

When can an employee convert or port life insurance?

This table shows the circumstances under which they are eligible to convert or port their coverage.

	Can convert coverage	Can port coverage
Retiring from the company	X	X
Employment has been terminated	X	X
Hours have been reduced so no longer qualify for your coverage	X	X
Leaving because of an illness or injury that impacts life expectancy	X*	X***
Employer has cancelled the group policy, or Unum has made changes that make them ineligible for coverage	X**	

Important: After coverage ends, employees have just 31 days to apply.

If employees have questions:
Please refer them to (800) 421-0344.

Depending on their circumstances, employees have two options for keeping their coverage:

1. Conversion

Change their group term life coverage to an individual whole life policy, which builds cash value. They pay the premium at individual rates. The right to convert their policy is guaranteed by law under certain circumstances.

2. Portability

Take their group term life coverage with them and pay for it at group rates. This coverage does not build any cash value. This option is also called "porting" coverage.

Employer role and responsibility:

Notify employee of continuation opportunity within 31 days of the loss of coverage date.

Convert	Port
Complete Section 1 of the state-specific life conversion form (rates included on the form).	Complete Section 1 of the life/AD&D portability form (rates available through AskUnum@unum.com if needed).
Have employee complete Section 2 of the conversion form.	Have employee complete Section 2 of the life/AD&D portability form.

Next steps

Have employee submit their initial premium payment† with the appropriate form within 31 days after their coverage ends to:

Unum Life Insurance Company of America
Portability and Conversion Unit
2211 Congress Street
Portland, ME 04122

Remind employees that they need to designate a beneficiary and sign and date the election form.

They have four ways to pay:
Monthly auto-pay by ACH or quarterly, semi-annually or annually by check or money order.

Communication decisions are provided directly to employees.

* State variations apply.

** Available only if you have been insured under the plan for at least five years. You can convert to a policy with a maximum benefit of $10,000.

***Portability may be available if the policy does not include the sickness and injury provision. Refer to the certificate of coverage for more information.

† In NY premiums are not required at the time when the portability application is sent in.

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MK-3619 (12-16)

Group life insurance is underwritten by Unum Life Insurance Company of America, Portland, Maine
In New York, underwritten by First Unum Life Insurance Company, New York, New York

Questions your employees may have	Conversion	Portability
Coverage available to convert or port	Life insurance only	Life insurance and AD&D
Dependents' options		
When can dependents convert or port coverage?	Dependents can convert their coverage if the employee is eligible to convert, or if the employee dies while covered under the group plan. Dependents can convert even if the employee does not.	• Dependents can port their coverage if the employee ports. • If the employee dies, the spouse must port coverage in order to port children's coverage. • Spouses can port coverage for themselves and their children if they are divorced from the employee. However, children's coverage can be ported under the employee's or spouse's coverage, but not both. Once children lose their dependent status, their coverage ceases.
Can dependents be added after coverage is converted or ported?	**No.** Dependents who did not convert their coverage when the employee did can't be added or convert their coverage later.	**Yes.** Dependents may be added at any time for the amounts allowed under the group plan (subject to evidence of insurability).
Maximum coverage amounts		
What are the maximum coverage amounts for employees?	Maximum coverage amount is the amount for which you were insured under the group plan. If you have been insured for at least 5 years and your employer has cancelled the group policy, or Unum has made changes that make you ineligible for coverage, the maximum will be the lesser of: • $10,000; or • Your coverage amount under the plan minus any other group coverage that your employer makes available with 31 days.	The maximum coverage amount is the lesser of: • Your group maximum benefit; • 5X your annual salary; or • $750,000 from all Unum life and AD&D plans combined. If your group policy offers a "retiree" class or coverage, you can port the difference between the group and retiree coverage amounts. AD&D cannot exceed the ported life amount.
What are the maximum coverage amounts for dependents?	Same as for employees.	**Spouse:** The highest amount of life insurance available for your spouse under the plan; or 50% or 100% of the employee's ported coverage depending on the group contract; or $750,000 from all Unum group life and accidental death and dismemberment plans combined, whichever is less. **Child:** The highest amount of life insurance available for your child under the plan; or 50% or 100% of the employee's amount (varies by contract); or $20,000, whichever is less (actual amount may differ based on plan design). AD&D cannot exceed the ported life amount.
Rate and coverage changes		
Will my rates change?	Your rate will be different when you convert the policy from a group to an individual policy. After that, you will pay the same premium for the life of the policy.	Your rate may change when you port the coverage. Also, because life premiums are based on age, your premiums will automatically increase every 5 years after you port.
Will my coverage be reduced as I get older?	**No.** Your benefit will remain the same.	**Yes.** Employee and dependent coverage will reduce on an age-related schedule, according to the group plan. **Note:** The employee can convert the difference between the age-reduced coverage amount and the prior amount.
Can I increase my coverage?	**No.** Once you have converted your coverage, you cannot increase it.	**Yes.** Life insurance coverage may be increased with evidence of insurability (medical exam and/or questions) up to the maximums shown above. You may also decrease your coverage, as long as it remains within plan guidelines.

For complete details, refer to the policy.

MK-3619 (12-16)

LEGAL RESOURCES®

PROTECT YOURSELF AND YOUR FAMILY FOR ONLY $10.00 PER PAY PERIOD!

The Legal Resources Legal Plan provides 100% coverage on a broad range of legal services. Whether it's an every day legal need or unexpected life event, you can relax...you're covered.

Enroll online with your other benefits.

The annual cost is less than what you would pay for just one hour of attorney's time!

Examples of Legal Life Events

20s

- Renting an apartment
- Traffic violations
- Courtroom representation
- Auto purchase agreement
- Advice and consultation

30s

- Getting married
- Buying a home
- Preparing a will
- Power of attorney for spouse
- Contractor disputes

40s

- Teenage drivers
- Home refinance
- Power of attorney for parents
- Elder Law advice
- Property disputes

50s

- Estate planning
- Family issues
- Landlord disputes
- Insurance claims
- HOA hearings

60s

- Revision or review of will
- Advance medical directive
- Estate advice
- Home sale or purchase
- Warranty disputes

FULLY COVERED SERVICES

LEGAL RESOURCES COVERS 100% OF THE ATTORNEY FEES FOR FULLY COVERED LEGAL SERVICES[1]

General Advice and Consultation
- Unlimited in-person or telephone advice and consultation for fully covered services

Family Law
- Uncontested domestic adoption
- Uncontested divorce
- Uncontested name change

Elder Law
- Estate advice
- Powers of attorney for members' parents

Criminal Matters[2]
- Defense of misdemeanor
- Misdemeanor defense of juveniles

Fully covered for first offense involving alcohol or illegal drugs

Wills and Estate Planning
- Will preparation and periodic updates
- Advance medical directive
- Financial powers of attorney
- Contingent trust for minor children

Traffic Violations
- Traffic infractions and misdemeanors
- Speeding
- Reckless driving
- Driving under the influence

1st Offense

Civil Actions
- Representation as defendant
- Representation as plaintiff
- Insurance matters
- Initial administrative hearing
- Small Claims Court advice

Preparation and Review of Routine Legal Documents
- Unlimited pages and occurrences

Real Estate
- Purchase, sale, or refinance of primary residence
- Deed preparation
- Tenant-Landlord matters
- Landlord-Tenant consultation

Consumer Relations and Credit Protection
- Warranty disputes
- Billing disputes
- Collection agency harassment

Identity Theft
- Prevention assistance
- Education services
- Identity recovery assistance

Don't see your legal need listed?
You're Still Covered!

The Legal Resources Plan offers a **25% discount**[3] on any less common legal needs, ***including pre-existing legal matters!***

HOW THE PLAN WORKS

1 Choose a law firm that best suits your needs from our highly rated law firm network. Use our Law Firm Finder at LegalResources.com to find a firm near you.[4] If you need to transfer to another Plan Law Firm, call Member Services.

2 Certified paralegals in our Member Services Department provide backup and support to assist you with any coverage or attorney-related questions.

WHAT QUESTIONS ARE MEMBERS ASKING?

Does the plan cover dependents?

Yes! Legal Resources defines a "covered person" as someone related to the participating employee, also called the "Primary Member".

Are pre-exisiting issues covered?

Yes! Pre-existing matters are covered at a significant discount off the hourly rate of the attorney. It is very important to join Legal Resources before you have a legal need to enjoy the maximum savings from the plan.

Are there any out of pocket expenses?

The Legal Resources Plan covers all attorney fees for fully covered services. However, you are responsible for non-attorney expenses such as court costs, filing fees or any fines assessed.

QUALITY | VALUE | SERVICE | PEACE OF MIND

Please call our Member Services Department with any questions. **We look forward to serving you and your family.**

800.728.5768

LegalResources.com

legalresources Legal Resources

LEGAL® RESOURCES

Relax... you're covered.®

1 Member is responsible for all non-attorney costs such as filing fees, fines, court costs, etc. The Plan covers the individual, spouse, and qualifying dependents. 12-month commitment required. Courtroom representation, when necessary, is fully covered through General District Court for claims in excess of $400. The definition of General District Court may vary by state.

2 Offenses involving illegal drugs, alcohol (except 1st offense DUI), and firearms are covered at a 25% discount.

3 Since your employer is the participating sponsor, you may not use the Plan in a dispute with your employer.

4 Timing of selection may vary based on your location or your employer's enrollment procedures.

LEGAL PLAN BENEFIT

McLean School of Maryland

With over 70% of Americans having a legal need each year, Legal Resources gives you and your family access to an attorney for everyday needs. Whether your legal matter is expected or unexpected, you'll have immediate and ongoing access to our network of highly rated law firms.

You pay no attorney fees for all Fully Covered Services, which include will preparation, traffic court, advice and consultation, real estate matters, uncontested divorce, billing disputes, and more! Pre-existing legal matters are even covered at a 25% discount.

READY TO ENROLL?

ENROLL ONLINE WITH YOUR OTHER BENEFITS.

NETWORK

LAW FIRM FINDER

USING LR IS EASY

PROVIDER STANDARDS

COVERAGE

PLAN BROCHURE

ENROLLMENT VIDEO

LEGAL LIFE EVENTS

RESOURCES

VISIT OUR WEBSITE

CONTACT US

TESTIMONIALS

LR SEMINARS

Required Notices

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. You may obtain a copy of the plan's Notice of Privacy Practices by contacting Human Resources.

HIPAA Special Enrollment Notice

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

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

To request special enrollment or obtain more information, contact:

Sarir Dehnadi, Accountant
8224 Lochinver Lane
Potomac, MD 20854
301-299-8277
sdehnadi@mcleanschool.org

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998

(WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to your Summary of Benefits & Coverage for more information on the deductibles and coinsurance that may apply to these benefits. If you would like more information on WHCRA benefits, call your plan administrator at 301-299-8277.

Qualified Medical Child Support Orders

The Plan Administrator will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which:

1. Relates to the provision of child support related to health benefits for a child of a Participant of a group health plan;
2. Is made pursuant to a state domestic relations law; and,

Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

Qualified Medical Child Support Orders - continued

The Plan Administrator will promptly notify the participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. A participant or beneficiary can request a copy of the Plan's procedures and the Plan Administrator will provide a copy of these procedures free of charge. Within 30 days of receipt of a medical child support order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify the participant and each alternate recipient of that determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party will be treated as a claimant and the claims procedure of the Benefit Plan will be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

A Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

A QMCSO will not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93). Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

Patient Protection Notice – Prohibition on Rescission

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, for Plan Years beginning on or after September 23, 2010, a group health Plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. Under the new standard for rescissions, Plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact. These provisions generally provide that a health insurance issuer in the group and individual markets cannot cancel, or fail to renew, coverage for an individual or a group for any reason other than those enumerated in the statute (that is, nonpayment of premiums; fraud or intentional misrepresentation of material fact; withdrawal of a product or withdrawal of an issuer from the market; movement of an individual or an employer outside the service area; or, for bona fide association coverage, cessation of association membership).

These interim final regulations clarify that, to the extent that an omission constitutes fraud, that omission would permit the plan or issuer to rescind coverage under this section. For purposes of these interim final regulations, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Coverage may not be cancelled unless prior notice is provided. These interim final regulations provide that a group health Plan, or health insurance issuer offering group health insurance coverage, must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. Even though prior notice must be provided in the case of a rescission, applicable law may permit the rescission to void coverage retroactively.

The Genetic Nondiscrimination Act of 2008 (GINA)

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo. Genetic information does not include information about the sex or age of any individual.

Compliance with Applicable Laws

The Plan Sponsor will administer the Benefit Plans in compliance with federal and state laws. Any interpretation of this document or the Benefit Plan Description incorporated by reference that is prohibited by federal or state law is void and will not be relied on for the administration of this Plan. The Plan Sponsor will administer the Benefit Plans in compliance with:

1. The Mental Health Parity Act (MHPA) and The Mental Health Parity and Addiction Equity Act (MHPAEA) ERISA § 712, requiring parity in certain mental health and substance use disorder benefits;
2. The Women's Health and Cancer Rights Act of 1998 (WHCRA) ERISA § 713(a), imposing requirements for coverage of reconstructive surgery and other complications in connection with mastectomy;
3. ERISA § 609(c) coverage for adopted children;
4. ERISA § 609(d) coverage of costs of pediatric vaccines;
5. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
6. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (applies to any group health plan sponsored by the Plan Sponsor);
7. The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
8. The Genetic Information Nondiscrimination Act (GINA);
9. The Health Information Technology for Economic and Clinical Health Act (HITECH);
10. Michelle's Law; and,
11. The Family and Medical Leave Act of 1993 (FMLA).

Salary Redirection Agreement

McLean School of Maryland offers some benefit options on a pre-tax basis. During each open enrollment period, you may choose to retain, change, add, or delete the stated pre-tax benefits listed in this benefits guide through the open enrollment process.

Once you authorize your benefit elections, you're acknowledging that you understand the insurance premiums and/or flexible spending account election amounts that will be deducted beginning with the first pay period after the plan effective date (January 1, 2025).

You also acknowledge that you understand these deductions will be continuous and in an amount equal to the insurance premiums and/or flexible spending account election amounts for each payroll period throughout the year (January 1, 2025 – December 31, 2025), unless you experience a change in status as governed by federal regulations.

You also acknowledge that:

1. Your pre-tax contributions for payment of benefits reduce your compensation for Social Security tax purposes and, therefore, your Social Security benefits may be decreased.
2. You cannot change or revoke your Salary Redirection Agreement for premiums between the first day of the plan year (January 1, 2025) and the last day of the plan year (December 31, 2025), unless a change in status occurs. The Salary Redirection Agreement change must be caused by and consistent with a change in status.
3. Coverage under a selected benefit plan or insurance policy does not begin when the benefits enrollment is submitted. The terms, conditions and coverage effective date are determined under the separate benefit plan or insurance policy chosen.

There are two exceptions to the rules above. Health Savings Account (HSA) and Commuter Benefit elections are withheld pre-tax but can be modified at any time throughout the year. These are not subject to the same limitations set forth in Section 125 of the Internal Revenue Code.

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.

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

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, 2024. 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 Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	CALIFORNIA – Medicaid 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 (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) https://www.healthfirstcolorado.com/ 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	FLORIDA – Medicaid https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 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	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki: http://dhs.iowa.gov/Hawki 1-800-257-8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 1-855-459-6328 / KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov 1-877-524-4718 Kentucky Medicaid: https://chfs.ky.gov/agencies/dms	LOUISIANA – 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)
MAINE – Medicaid https://www.mymaineconnection.gov/benefits/s/?language=en_US 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	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

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

MINNESOTA – Medicaid 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	MISSOURI – Medicaid http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 / Omaha: 402-595-1178
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	NEW HAMPSHIRE – Medicaid 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. 5218
NEW JERSEY – Medicaid and CHIP Medicaid: 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	NEW YORK – Medicaid https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	NORTH DAKOTA – Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	OREGON – Medicaid http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx – Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND – Medicaid and CHIP http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	VIRGINIA – Medicaid and CHIP 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

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

WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	WEST VIRGINIA – Medicaid and CHIP https://dhhr.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 https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	WYOMING – Medicaid 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, 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.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the January 1, 2025 - December 31, 2025 Plan Year with respect to mental health or substance use disorder benefits, please contact your plan administrator at:

Sarir Dehnadi, Accountant
8224 Lochinver Lane
Potomac, MD 20854
301-299-8277

General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

General Notice of COBRA Continuation Coverage Rights - continued

When is COBRA continuation coverage available?

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

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

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

Sarir Dehnadi, Accountant
8224 Lochinver Lane
Potomac, MD 20854
301-299-8277
sdehnadi@mcleanschool.org

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

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

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

General Notice of COBRA Continuation Coverage Rights - continued

Are there other coverage options besides COBRA continuation coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period (https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods) to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your plan informed of address changes

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

Plan Contact Information

Sarir Dehnadi, Accountant
8224 Lochinver Lane
Potomac, MD 20854
301-299-8277
sdehnadi@mcleanschool.org

Important Notice About Your Prescription Drug Coverage and Medicare (Creditable Notice)

Please Note: This notice only applies to you if you are eligible for Medicare. If any of your dependents are eligible for Medicare, you are responsible for providing this notice to them.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with McLean School of Maryland and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. McLean School has determined that the prescription drug coverage offered by its health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current McLean School health plan coverage will not be affected. The prescription drug coverage plan provisions under the group health plan will remain in force even if you elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current McLean School health plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with McLean School and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through McLean School changes. You also may request a copy of this notice at any time.

Important Notice About Your Prescription Drug Coverage and Medicare - continued

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Date:	January 1, 2025
Name of Entity/Sender:	Sarir Dehnadi
Contact Position/Office:	Accountant
Address:	8224 Lochinver Lane Potomac, MD 20854
Phone:	301-299-8277
Email:	sdehnadi@mcleanschool.org

Notice Regarding Wellness Program

BlueRewards is a voluntary wellness program available to all employees enrolled in a CareFirst medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a RealAge Test that asks a series of questions about your health-related activities and behaviors. You are not required to complete the RealAge Test, however, employees who choose to participate in the wellness program will receive an incentive of up to $175 for completing the various activities. Additional incentives of $30-$200 may be available for employees that qualify for and who participate in certain health-coaching activities. You are encouraged to share the information you obtain from the RealAge Test, as well as your health coaching (if applicable) with your doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and McLean School may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness vendor will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive.

Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the wellness vendor to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Sarir Dehnadi, Accountant
8224 Lochinver Lane
Potomac, MD 20854
301-299-8277
sdehnadi@mcleanschool.org

New Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

New Health Insurance Marketplace Coverage Options and Your Health Coverage – continued

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name McLean School of Maryland			2. Employer Identification Number (52-1117092
3. Employer Address 8224 Lochinver Lane			4. Employer Phone Number 301-299-8277
5. City Potomac		6. State MD	7. Zip Code 20854
8. Who can we contact about employee health coverage at this job? Sarir Dehnadi, Accountant			
9. Phone Number (if different from above)		10. Email Address sdehnadi@mcleanschool.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☑ All eligible employees. Eligible employees are:
    All full-time employees working 20 hours or more per week.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    Spouse, domestic partners and dependent children under age 26.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.healthcare.gov to find out if you can get a tax credit to lower your monthly premiums.

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This guide is intended to provide summary information regarding the benefits available to you as an employee of McLean School of Maryland. More detail is available in the Summary Plan Descriptions (SPDs)as well as the contracts and insurance policies, which govern each benefit. Every effort has been made to ensure that the summary information contained in this document matches the information provided by the carriers. Should there be any discrepancy between this benefit guide and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. No warranty or guarantee is made regarding the accuracy of the content listed in this benefits guide. McLean School of Maryland reserves the right to modify, amend, suspend or terminate any plan at any time, and for any reason without prior notification.