

CITY OF NEW CARROLLTON PART TIME NEW HIRE PACKET



During Colonial times, the territory that is known as New Carrollton was called Terrapin Thicket, due to "a lot of turtles cavorting in the marshy land." The thicket's first landowner was Ninian Beall, an immigrant who earned his passage to the colonies as an indentured servant. When he was freed in 1677, Mr. Beall was given a parcel of land in the thicket. Upon his death at the age of 92 in 1717, he owned 13,000 acres extending from Upper

Marlboro to Georgetown.

In the mid 1920's, Edward L. Mahoney purchased 300 acres of the land, where he built his house in 1927. Shortly after establishing himself, Mahoney set up stables and a training track for his prize-winning horses. In 1939, he converted his track into the Old Lanham Raceway.

After Mahoney's death in 1957, his estate was purchased by New Carrollton's developer, Albert W. Turner and incorporated into the City. Albert Turner envisioned a completely planned suburban city that he wanted to blend well with the existing towns and communities in Prince George's County. The City's name, he realized, had to have deep roots in Maryland's heritage. He chose the name of the most notable figures in Maryland's history; Charles Carroll of Carrollton, a signer of the Declaration of Independence.

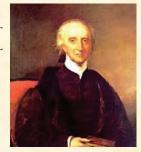
A bill was sponsored in the early 1950's and in the final hours of the 1953 General Assembly, on April 11, 1953, Senate Bill 475 was passed declaring the City of Carrollton an incorporated community with a charter under the laws of Maryland. Its government vested in the five councilmen at large, the first of whom were appointed by the General Assembly.

In 1970, Mayor King appointed a task force on City government, which prompted several major changes in the City's Charter. This change altered the City's basic form of government from a commission form of government to a mayor-city council form of government.

In 1971 the voters approved a proposal to lower the minimum voting age for city elections from 21 to 18, making New Carrollton the first city in Prince George's County to take such action. The Council also initiated action to remove the "freeholder" requirement from the city charter, which stipulated that elected officials of the city must be property owners. This action permitted tenants to be eligible for office, and this was another first in the County.

In the early 1990's, the City worked in cooperation with the General Services Administration of the U.S. Government and the Internal Revenue Service, on the design of the three new 10-story office buildings that are located across from the New Carrollton Metro station on Harkins Road. The buildings are occupied by over 4,000 employees of the Internal Revenue Service.

Recently, the City welcomed a redesigned Metro Points hotel at the intersection of Annapolis Road and 85th Avenue. The upscale hotel provides luxury accommodations, as well as a restaurant and meeting/event spaces. Additionally, new shops at the hotel usher in more dining options for visitors and residents, as well as office space and fitness facilities.





City of New Carrollton

Summary of Employee Benefits

July 1, 2019 to June 30, 2020

Elected Officials and Part-time Employees under 30 Hours

ELIGIBILITY REQUIRMENTS

- 1) You are a regular part-time employee; and
- 2) You have been employed by the City for 90 days.

You must sign-up for our medical, dental and vision coverage within thirty (30) days of eligibility or you have to wait until open-enrollment for insurance (usually held in July of each year). You may enroll outside of this period if you experience a qualifying event such as loss of coverage, birth or adoption of a child, and/or you get married.

3) Elected officials and part-time employees who work less than 30 hours per week are responsible for the full cost of their benefits. Most insurance premium payments must be paid directly to the City.

MEDICAL BENEFITS

Medical coverage is provided through the Cigna Open Access plan. Employees are allowed to seek treatment from primary care physicians and specialists without referrals. For full benefits, please see the Cigna Open Access Summary of Benefits.

This insurance plan comes with an annual deductible of \$100.00 for an individual and \$200.00 for a family. Employees are responsible for the full cost of the deductible.

MEDICAL MONTHLY RATES (07/01/2019 – 06/30/2020):

Individual: \$645.07

Individual & Child(ren): \$1193.35 Individual & Spouse: \$1483.65

Family: \$1806.17

DENTAL BENEFITS

The City of New Carrollton provides dental coverage through the United Concordia Dental plan. We currently participate in the Preferred Dentist Program. For full benefits, please see the Concordia Dental Summary of Benefits.

DENTAL MONTHLY RATES (07/01/2019 – 06/30/2020):

Individual: \$37.90

Individual & Child: \$53.06 Individual & Children: \$75.80 Individual & Spouse: \$79.59

Family: \$109.91

VISION BENEFITS

Vision coverage is provided through National Vision Administrators (NVA). For full benefits, please see the National Vision Administrators Summary of Vision Care Benefits.

VISION MONTHLY RATES (07/01/2019 – 06/30/2020):

Individual: \$5.21

Individual & Child): \$.7.30 Individual & Child(ren): 10.43 Individual & Spouse: \$10.95

Family: \$15.12

CONNECT CARE 3

Connect Care 3 provides health advocacy and nurse navigation services for minor to severe illnesses. These services are confidential and available at no charge. The Nurse Navigators listen to concerns, provide various options for care, and answer questions about illnesses and treatment options.

Contact Information

Connect Care 3 <u>www.connectcare3.com</u> 1-877-223-2350 800-423-2765

SUPPLEMENTAL LIFE INSURANCE AFLAC/Colonial Life

Supplemental Life Insurance

AFLAC provides supplemental insurance for personal sickness, accident, and disability. This is an employee-funded program. Forms and information can be obtained from the Human Resources Department and the program is handled by a City AFLAC representative.

Contact Information

AFLAC

Representative: Helen Lipchock helen lipchock@us.aflac.com

(301) 831-9096

Colonial Life provides supplemental insurance for personal sickness, accident, and disability. This is an employee-funded program. Forms and information can be obtained from the Municipal Center and the program is handled by a City Colonial Life representative.

Contact Information

Colonial Life

Representative: Karen Linder-Staubs

klinder04@comcast.net

(410) 663-2072

VOLUNTARY LIFE INSURANCE New York Life

Supplemental Life Insurance

New York Life offers voluntary permanent whole life insurance plans that employees can maintain even if they are no longer employed with the City. This is an employee-funded program. Information can be obtained from the Human Resources Department, and is handled by a City New York Life representative.

Contact Information
New York Life
Representative: Joyce G. Swinson
jgswinson@ft.newyorklife.com
(410) 740-3069

EMPLOYEE ASSISTANCE PROGRAM Business Health Services

An Employee Assistance Program (EAP) provides employees and their family members with free, confidential assistance to help with family, personal and work-related problems. THE EAP offers short-term counseling services, resources and other problem-salving solutions to employees in need. Brochures and business cards are available in the Human Resources Department.

Employees also have access to a complimentary benefit called Work/Life Services offered by Business Health Services. Work/Life Services assists employees who are in need of convenience care services, or dealing with childcare/eldercare issues, as well as legal or financial concerns. Employees can contact a BHS Care Coordinator at no charge for a consult and/or a list of quality resources.

Contact Information

Business Health Services

www.bhsonline.com 1-800-327-2251

LEGAL ASSISTANCE Legal Resources Plan

Employees may participate in a legal services plan that provides assistance on a variety of personal issues, including drafting wills; court representation for minor offenses; divorce and custody issues; as well as a variety of others. This plan is employee-funded.

Contact Information

Legal Resources Plan

www.legalresourcesplan.com

RETIREMENT BENEFITS

State of Maryland Pension Plan

The City of New Carrollton participates in the Maryland Pension Plan. Employees are required to submit 7% of their annual salary to their plan by a mandatory deduction from their paycheck. The City contributes a greater amount which varies yearly.

Contact Information

Alayna Rowlett <u>arowlett@newcarrolltonmd.gov</u> (301) 459-6100

457 Deferred Compensation Plan

Our 457 plan is administered through ICMA Retirement Corporation. A 457 plan is a deferred compensation plan maintained by state and local governments through which employees may defer a portion of their salaries until a later date, usually retirement. This is an employee-funded benefit. Applications and current rates are available from the Human Resources Department.

Contact Information

ICMA Retirement Corporation

www.icmarc.org

1-800-669-7400

CREDIT UNION SECU

The City of New Carrollton participates in the State Employees Credit Union of Maryland (SECU) Bank at Work program. All City employees are eligible to participate in this program. *Contact Information*

SECU

www.secumd.org (800) 879-7328

GYM MEMBERSHIP RETRO FITNESS

City of New Carrollton employees are able to join Retro Fitness in Lanham, Maryland for \$19.99 a month, zero enrollment fee, and enjoy an upgraded membership with unlimited classes.

Contact Information

Retro Fitness

www.retrofitness.com (240) 249-0048

CHILDCARE SERVICES NEW CARROLLTON EARLY LEARNING CENTER

The New Carrollton Early Learning Center offers full and part-time programs for children ages 2 to 11. All City employees are eligible to receive fifty percent (50%) off the registration fee at the New Carrollton Early Learning Center.

Contact Information

New Carrollton Early Learning Center www.newcarrollton-elc.com (301) 577-1868

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your dependents may continue group health insurance coverage without interruption for up to 18 or 36 months. If you are entitled to 18 months of continuation coverage, and you are determined to be disabled under the terms of the Social Security Act as of the date your employment terminated (or the date your hours were reduced), you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the employer at the address shown within 60 days after you receive a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage. During the additional 11 months of continuation coverage, your premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

If you elect to continue coverage under the health care plan, <u>you must pay the monthly premium</u> required for the coverage you elect to continue. The current monthly cost for this coverage will be communicated to you on your election form. The cost is subject to change. Failure to pay this amount in a timely manner will result in loss of coverage.

The continued coverage will cease at the end of the 18, 29, or 36-month period (whichever applies), or earlier when the following occurs:

- (a) the cost of continued coverage is not paid on time; or
- (b) that person becomes entitled to Medicare; or
- (c) that person becomes covered under another group health plan, unless that other plan contains an exclusion or limitation with respect to any pre-existing condition affecting you or a covered dependent; or
- (d) the Plan terminates for all employees.

For more information about COBRA, please contact the Human Resources Department.

LEAVE POLICY & OVERTIME

<u>Annual Leave</u>: All regular part-time employees, as designated by the mayor, who work at least 20 hours per week (1,040 per year) are entitled to vacation on a pro-rata basis. The length of the vacation will be determined on the same basis as for full-time employees, but the pay will be based on the employee's average number of part-time hours per week during the vacation accrual year. Part-time employees working less than 20 hours per week and temporary employees do not receive paid vacations.

<u>Sick Leave</u>: All regular part-time employees as designated by the Mayor, who work at least 20 hours per week (1,040 per year), will earn Sick Leave on a pro-rata basis. Part-time employees working less than 20 hours per week and temporary employees do not receive sick leave.

PAID HOLIDAYS

The following days are established as official holidays for City employees:

NEW YEAR'S DAY
MARTIN LUTHER KING'S BIRTHDAY
PRESIDENT'S DAY
MEMORIAL DAY
INDEPENDENCE DAY

LABOR DAY
VETERAN'S DAY
THANKSGIVING DAY
THE DAY AFTER THANKSGIVING
CHRISTMAS DAY

EMERGENCY LEAVE

Emergency Leave is defined as a death (or impending death) in the immediate family. Immediate family is defined as: the employee's spouse, children, step-children, parents, grandparents, brothers, or sisters, spouse's parents and grandparents, and any member of the employee's household.

Part-time employees may be granted up to three days of emergency leave with pay. Emergency leave will be granted upon the recommendation of the employee's supervisor. Part-time employees will receive pay on a pro-rata basis.

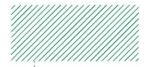
ADMINISTRATIVE LEAVE

Administrative leave may be granted to any part-time employee, as designated by the Mayor, by the Director of Public Works, the Chief of Police, or the City Administrative Officer for anyone of the following reasons:

- a) Performance of jury duty
- b) Subpoenaed court appearance
- c) For the purpose of voting, not to exceed two (2) hours
- d) For attendance in an official capacity as a representative of the City.
- e) For the purpose of taking educational courses related to the employee's work.

PROFESSIONAL DEVELOPMENT & EDUCATIONAL ASSISTANCE

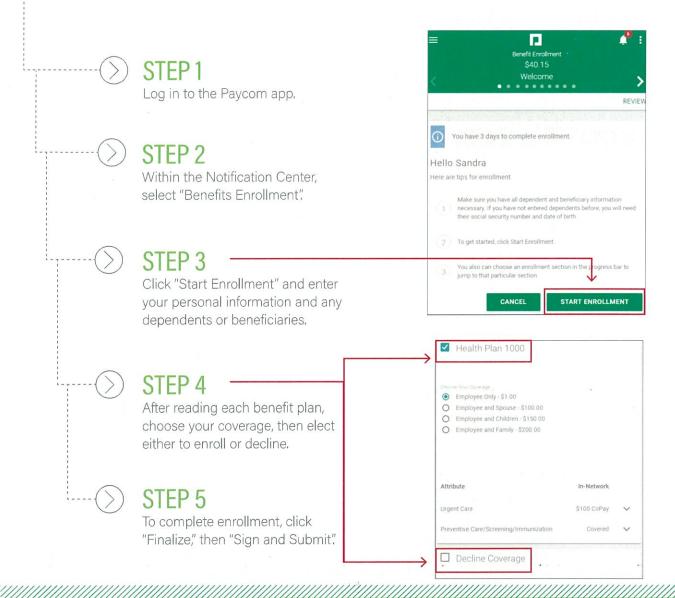
Employees are encouraged to pursue job-related seminars, trainings and workshops. The City will pay for these courses with prior approval from their supervisor.



BENEFITS ADMINISTRATION

Employees

HOW TO ENROLL IN BENEFIT PLANS USING THE APP





HELPFUL TIPS

- Have your dependent/beneficiary information ready, such as Social Security numbers, before beginning the enrollment process.
- As you go through the enrollment process, your selections will display and add up on the benefits summary tracker to the right.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149 (expires 5-31-2020)

PART A: General Information

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 Alayna Rowlett

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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.

3. Employer name	4. Employer Identification Number (EIN)			
City of New Carrollton	52-6330690	52-6330690		
5. Employer address 6016 Princess Garden Parkway	6. Employer phone number (301)459-6100			
7. City		8. 9	State	9. ZIP code
New Carrollton	MD		20784	
10. Who can we contact about employee health coverag Alayna Rowlett	e at this job?			
11. Phone number (if different from above) 12. Email address hr@newcarrollto			md.gov	
			-	

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

- •As your employer, we offer a health plan to:
 - ☐ All employees. Eligible employees are:

All regular full-time employees of the Employer working at least forty (40) hours per week and all regular part-time employees of the Employer working at least five (5) hours per day are eligible for coverage.

Retirees are eligible for continued coverage if they are sixty (60) years of age or more and have years of service of at least thirty (30) years. Eligibility continues until death of the retiree although the New

Carrollton Group Health Plan will become secondary to Medicare upon the participant becoming eligible for Medicare. The spouse and dependent children of the retiree are eligible for continued coverage until death of the retiree or they no longer meet the definition of an eligible dependent under this Plan.

- With respect to dependents:
 - We do offer coverage. Eligible dependents are:

To be eligible to enroll as a Dependent, a person must be: a) the lawful spouse of a Participant as defined by the laws of state in which the Employer is based; orb) the Participant's or Participant's lawful spouse's child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.

- $\hfill\square$ We do not offer coverage.
- 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, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

	Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
]	 Yes (Continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue) No (STOP and return this form to employee)
14. [Does the employer offer a health plan that meets the minimum value standard*? Yes (Go to question 15) No (STOP and return form to employee)
f r v	For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? \$
	plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't , STOP and return form to employee.
ā	What change will the employer make for the new plan year? Employer won't offer health coverage Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.) How much would the employee have to pay in premiums for this plan? \$ How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

[•] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Creditable Coverage Disclosure Notice

Important Notice from City of New Carrollton About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of New Carrollton 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:

- 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. The City of New Carrollton has determined that the prescription drug coverage offered by Cigna Health and Life Insurance Co. is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current City of New Carrollton coverage will not be affected. The prescription drug coverage that is offered through the City of New Carrollton does not have an annual deductible. Participants are responsible for copayments that vary by the drug type and whether the prescription is filled at a retail pharmacy or through mail order. For prescriptions obtained at a participating retail pharmacy (up to a 30 day supply) the co-payments are: \$0 for Generic Drugs, \$25 for Brand-Name Formulary Drugs, and \$45 for Brand-Name Non-Formulary Drugs. For prescriptions obtained through mail order (up to a 90 day supply) the co-payments are:

\$0 for Generic Drugs, \$50 for Brand-Name Formulary Drugs, and \$90 for Brand-Name Non-Formulary Drugs. If you and your eligible dependents elect the Medicare Drug Plan, this plan will coordinate with Part D coverage; See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current City of New Carrollton coverage, be aware that you and your dependents will 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 the City of New Carrollton 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 City of New Carrollton Human Resources Department at (301)459-6100 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of New Carrollton changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/01/2018

Name of Entity/Sender: City of New Carrollton

Contact--Position/Office: Human Resources Administrator/HR Department 6016 Princess Garden Pkwy, New Carrollton, MD 20784

Phone Number: (301)459-6100

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co. For - Local Government Insurance Trust **Open Access Plus IN Plan**



Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Coinsurance	Your plan pays 100%
Contract Year Deductible	Individual: \$100 Family: \$200

- Copays always apply before plan deductible and coinsurance.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^).

Contract Year Out-of-Pocket Maximum

Individual: \$5,000 Family: \$10,000

- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

7/1/2019

ASO

Open Access Plus In-Network - Proclaim BE - New Carroltton OAPIN - 8725364, Version# 15

Benefit	In-Network			
Physician Services - Office Visits				
Physician Office Visit – Primary Care Physician (PCP)	\$15 copay, then your plan pays 100%			
Physician Office Visit – Specialist	\$30 copay, then your plan pays 100%			
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either as PCP or as Specialist).	the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e.			
Surgery Performed in Physician's Office - PCP	\$15 copay, then your plan pays 100%			
Surgery Performed in Physician's Office – Specialist	\$30 copay, then your plan pays 100%			
Allergy Treatment/Injections Performed in Physician's Office PCP	\$15 copay, then your plan pays 100% or actual charge (if less)			
Allergy Treatment/Injections Performed in Specialist Office	\$30 copay, then your plan pays 100% or actual charge (if less)			
Allergy Serum - PCP	Your plan pays 100%			
Allergy Serum - Specialist	Your plan pays 100%			
Dispensed by the physician in the office				
Cigna Telehealth Connection Services	\$15 copay, then your plan pays 100%			
 Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet delivered by contracted medical telehealth providers (see details on myCigna.com) 				
Preventive Care				
Preventive Care	Plan pays 100%			
 Includes coverage of additional services, such as urinalysis, EKG, a billed as part of office visit. 	and other laboratory tests, supplementing the standard Preventive Care benefit when			
Immunizations	Plan pays 100%			
Mammogram, PAP, and PSA Tests	Plan pays 100%			
Coverage includes the associated Preventive Outpatient Profession	• •			
Diagnostic-related services are covered at the same level of benefit				
Inpatient				
Inpatient Hospital Facility Services	After the plan deductible is met, your plan pays 100%			
Semi-Private Room: Limited to the semi-private negotiated rate Private Room: Limited to the semi-private negotiated rate Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):	Limited to the negotiated rate			
Inpatient Hospital Physician's Visit/Consultation	After the plan deductible is met, your plan pays 100%			
 Inpatient Professional Services For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	After the plan deductible is met, your plan pays 100%			

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Benefit	In-Network
Outpatient	
Outpatient Facility Services	After the plan deductible is met, your plan pays 100%
Outpatient Professional Services For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 100%
Short-Term Rehabilitation	\$30 copay, then your plan pays 100%
 Contract Year Maximums: Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Sp Limits are not applicable to mental health conditions for Physical, S 	
	an, accumulate to the applicable outpatient short term rehab therapy maximum.
Chiropractic Care	\$30 copay, then your plan pays 100%
Contract Year Maximum: • Chiropractic Care - 20 days	
Note: Therapy days, provided as part of an approved Home Health Care pla	an, accumulate to the applicable outpatient short term rehab therapy maximum.
Cardiac Rehabilitation	\$30 copay, then your plan pays 100%
	an, accumulate to the applicable outpatient short term rehab therapy maximum.
Other Health Care Facilities/Services	
Home Health Care	After the plan deductible is met,
 (includes outpatient private duty nursing subject to medical necessity) Unlimited days maximum per Contract Year 16 hour maximum per day 	your plan pays 100%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities	After the plan deductible is met,
Unlimited days maximum per Contract Year	your plan pays 100%
Durable Medical Equipment Unlimited maximum per Contract Year	After the plan deductible is met, your plan pays 100%
Breast Feeding Equipment and Supplies Limited to the rental of one breast pump per birth as ordered or prescribed by a physician Includes related supplies	Your plan pays 100%

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Benefit	In-Network
External Prosthetic Appliances (EPA)	After the plan deductible is met,
The state of the s	your plan pays 100%
Unlimited maximum per Contract Year	
Routine Foot Disorders	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascula	
Acupuncture Performed in Physician's Office - PCP	\$15 copay, then your plan pays 100%
Acupuncture Performed in Physician's Office - Specialist	\$30 copay, then your plan pays 100%
20 days maximum per Contract Year	
Hearing Aid	After the plan deductible is met,
	your plan pays 100%
Includes testing and fitting of hearing aid devices at Physician OfficeCoverage through age 19	e Visit cost share.
Wigs	After the plan deductible is met,
Unlimited maximum per Contract Year	your plan pays 100%
Medical Specialty Drugs	
Inpatient	
 This benefit applies to the cost of the Infusion Therapy drugs 	After the plan deductible is met,
administered in an Inpatient Facility. This benefit does not cover	your plan pays 100%
the related Facility or Professional charges.	
Outpatient Facility Services	
This benefit applies to the cost of the Infusion Therapy drugs	After the plan deductible is met,
administered in an Outpatient Facility. This benefit does not cover	your plan pays 100%
the related Facility or Professional charges.	
Physician's Office	
 This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover 	Your plan pays 100%
the related Office Visit or Professional charges.	
Home	
This benefit applies to the cost of targeted Infusion Therapy drugs	After the plan deductible is met,
administered in the patient's home. This benefit does not cover the related Professional charges.	your plan pays 100%

Place of Service - your plan pays based on where you receive services							
Note: Services where plan deductible applies are noted with a caret (^).							
Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility			
	In-Network	In-Network	In-Network	In-Network			
Laboratory	Covered same as plan's Physician's Office Services	Plan pays 100% ^	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100% ^			
Radiology	Covered same as plan's Physician's Office Services	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100% ^			
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services			

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility	Outpatient Professional Services	*Ambulance
Dellellt	In-Network	In-Network	In-Network
Emergency Care	\$125 per visit (copay waived if admitted) ^, then your plan pays 100%	Plan pays 100% ^	Plan pays 100% ^
Urgent Care	\$40 per visit ^, your plan pays 100%	Plan pays 100% ^	Not Applicable*

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities	1 /	
Denent	In-Network	In-Network	
Hospice	Plan pays 100% ^	Plan pays 100% ^	
Bereavement Counseling	Plan pays 100% ^	Plan pays 100% ^	

Note: Services provided as part of Hospice Care Program

Note: Services where plan deductible applies are noted with a caret (^).

Benefit	Initial Visit to Confirm Pregnancy	Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)
	In-Network	In-Network	In-Network	In-Network
Maternity	Covered same as plan's Physician's Office Services	Plan pays 100% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit

Note: Services where plan deductible applies are noted with a caret (^).

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Benefit	Physiciar	n's Office	Inpatient Fa	cility	Outpatient Facil	lity	Inpatient Professional Services	Outpatient Professional Services
	In-Net	twork	In-Netwo	rk	In-Network		In-Network	In-Network
Abortion (Elective and non-elective procedures)	Covered same Physician's O		Plan pays 100% [/]	۸	Plan pays 100% ^		Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services
Family Planning - Men's Services	Covered same Physician's O		Plan pays 100% [/]	۸	Plan pays 100% ^		Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services
Includes surgical s	services, such	as vasectomy	(excludes reversals	s)				
Family Planning - Women's Services	Plan pays 100)%	Plan pays 100%		Plan pays 100%		Plan pays 100%	Plan pays 100%
Includes surgical s Contraceptive dev			n (excludes reversa l by a physician.	als)				
Infertility	Covered same Physician's O		Plan pays 100% '	۸	Plan pays 100% ^		Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services
Infertility covered Unlimited maximu		nd radiology te	st, counseling, surg	gical treatm	ent, includes artificial i	nsemina	tion, in-vitro fertilization, GI	
TMJ, Surgical and Non- Surgical	Covered same Physician's O		Plan pays 100% ′	۸	Plan pays 100% ^		Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services
Services provided Unlimited maximu		case basis. Alv	vays excludes appl	iances & o	rthodontic treatment. S	ubject to	medical necessity.	
Note: Services wh	nere plan deduc	ctible applies a	re noted with a care	et (^).				
			Inpatient Hos	spital Facil	lity		Inpatient Profess	sional Services
Benef	iit	Tra Networ	ifeSOURCE nsplant k [®] Facility letwork		ifesource Facility In-Network		cigna LifeSOURCE Transplant Network [®] Facility In-Network	Non-Lifesource Facility In-Network
Organ Transplan	its	Plan pays 100)%	Plan pays	s 100% ^	Plan p		Covered same as plan's Inpatient Professional Services
					In-Network: \$10,000 r	maximur	n per Transplant	
Note: Services wh	nere plan deduc	ctible applies a	re noted with a care	et (^).				

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Benefit	Inpatient	Outpatient - Physician's Office	Outpatient - All Other Services
Dellellt	In-Network	In-Network	In-Network
Mental Health	Plan pays 100% [^]	\$30 copay	Plan pays 100% [^]
Substance Use Disorder	Plan pays 100%^	\$30 copay	Plan pays 100% [^]

Note: Services where plan deductible applies are noted with a caret (^).

Notes:

- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient Physician's Office includes Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient All Other Services includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.
- Detox is covered under medical.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy In-Network

Cost Share and Supply

Cigna Pharmacy Cost Share

- Retail up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery up to 90-day supply

Retail (per 30-day supply):

Generic: You pay \$0

Preferred Brand: You pay \$25 Non-Preferred Brand: You pay \$45

Retail (per 90-day supply):

Generic: You pay \$0

Preferred Brand: You pay \$50 Non-Preferred Brand: You pay \$90

Home Delivery (per 90-day supply):

Generic: You pay \$0

Preferred Brand: You pay \$50 Non-Preferred Brand: You pay \$90

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- Patient is responsible for the applicable cost share based upon the tier of the dispensed medication.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription after 3 Retail fills. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.

Drugs Covered

Prescription Drug List:

Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Prescription smoking cessation drugs are covered.

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Pharmacy Program Information

Pharmacy Clinical Management

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Out-of-Network Emergency Services Charges

- 1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
- 2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

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Additional Information

One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing In-Network: Coordinated by your physician

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.

Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists **Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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Exclusions

What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
 - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
 - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
 - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
 - o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

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Exclusions

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop
 computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

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Exclusions

- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Massage therapy.

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

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

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator

PO Box 188016

Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201 1.800.368.1019, 800.537.7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.



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Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

French Creole - ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese - ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224(TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

нов, позвоните по номеру 1.800.244.6224 (ТТҮ: 711).	Persian (Farsi) حتاوج خدمات كمك زبان ي به صورت كريان به شما ارائ ه م في ود. براى
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Coverage Period: 07/01/2019 - 06/30/2020

Coverage for: Individual/Individual + Family | Plan Type: OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: \$100/individual or \$200/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-network <u>preventive care</u> & immunizations, office visits, in-network <u>prescription drugs</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>in-network providers</u> \$5,000/individual or \$10,000/family Combined medical/behavioral and pharmacy <u>out-of-pocket limit</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit <u>Deductible</u> does not apply	Not covered	None
	Specialist visit	\$30 <u>copay</u> /visit <u>Deductible</u> does not apply	Not covered	None
If you visit a health care provider's office or clinic	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	Not covered	None None None You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

Common	Services You May Need	What You Will Pay		Livitations Forestions 9 Others
Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	No charge/prescription (retail 30 days), No charge/prescription (retail 90 days); No charge/prescription (home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	\$25 copay/prescription (retail 30 days), \$50 copay/prescription (retail 90 days); \$50 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$45 copay/prescription (retail 30 days), \$90 copay/prescription (retail 90 days); \$90 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
- Surgery	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care Emergency medical transportation	\$125 copay/visit No charge	\$125 copay/visit No charge	Per visit copay is waived if admitted None
If you have a hospital stay	Urgent care Facility fee (e.g., hospital room)	\$40 <u>copay</u> /visit No charge	\$40 copay/visit Not covered	None None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay/office visit** No charge/all other services **Deductible does not apply	Not covered	None
	Inpatient services	No charge/admission	Not covered	None

Common	Services You May Need	What You Will Pay		
Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	No charge	Not covered	Primary Care or Specialist benefit
	Childbirth/delivery professional services	No charge	Not covered	levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery facility services	No charge	Not covered	Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Home health care	No charge	Not covered	16 hour maximum per day
If you need help recovering or have other special health needs	Rehabilitation services	\$30 <u>copay</u> /visit** ** <u>Deductible</u> does not apply	Not covered	Coverage is limited to annual max of: 90 days for Rehabilitation services; 36 days for Cardiac rehab services; 20 days annual max for Chiropractic care services Limits are not applicable to mental
				health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	\$30 <u>copay</u> /visit** ** <u>Deductible</u> does not apply	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	Not covered	None
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge/inpatient; No charge/outpatient services	Not covered	None
If your shild poods dontal	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
or eye care	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)

- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.

• Hearing aids (coverage through age 19)

- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture (20 days)
- Bariatric Surgery (if you qualify for coverage)
- Chiropractic care (20 days)

Infertility treatment

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>. Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact the program for this <u>plan's</u> situs state: Maryland Office of the Attorney General at 877-261-8807. However, for information regarding your own state's consumer assistance program refer to <u>www.healthcare.gov</u>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$100
Specialist copayment	\$30
■ Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,800
In this example, Peg would pay:	

Cost Sharing		
Deductibles	\$100	
Copayments	\$20	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$10	
The total Peg would pay is	\$130	

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$100
 Specialist copayment 	\$30
■ Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*

Diagnostic tests (blood work)

Total Example Cost

The total Joe would pay is

Prescription drugs

Durable medical equipment (glucose meter)

In this example, Joe would pay	<i>ı</i> :
Cost Sharing	
Deductibles	\$100
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$200

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*

Diagnostic test (x-ray)

\$7,400

\$400

Durable medical equipment *(crutches)*Rehabilitation services *(physical therapy)*

Total Example Cost	\$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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

Plan Name: New Carroltton OAPIN Ben Ver: 15 Plan ID: 8725364

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

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

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator

PO Box 188016

Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201 1.800.368.1019, 800.537.7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.



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Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

French Creole - ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese - ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224(TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

нов, позвоните по номеру 1.800.244.6224 (ТТҮ: 711).	Persian (Farsi) توج خدمات كمك زبان ي به مورت كريان به شما ارائ ه م ود. براى
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TAKING THE GUESSWORK OUT OF CHOOSING A PROVIDER

Cigna Care Designation



The Cigna Care Designation helps take some of the guesswork out of choosing a health care provider. Using standard, industry-accepted measures and information, Cigna regularly evaluates its in-network providers in 21 of the most common categories. Our results show providers who have a proven history of achieving good quality outcomes, while also being cost-effective. Providers with top results earn the Cigna Care Designation.

3 Primary care categories

Family Practice Internal Medicine Pediatrics



18 Specialties

Allergy/Immunology
Cardiology
Cardiothoracic Surgery
Dermatology
Ear, Nose and Throat
Endocrinology
Gastroenterology
General Surgery
Hematology/Oncology

Nephrology
Neurology
Neurosurgery
OB/GYN
Ophthalmology
Orthopedics and Surgery
Pulmonology
Rheumatology
Urology

Cigna provides a variety of quality and cost information to help you make more informed decisions about your health. We make it easy to find providers who have achieved top results on our cost-efficiency and quality measures by adding the Cigna Care Designation symbol to the online provider directory. The directory can be accessed through **myCigna.com**.

I need to see a doctor for allergies, but I'm not sure where to begin.

Picking a doctor out of a list seems random and overwhelming.

How do I get information about the quality of a doctor's care?

How can I be sure I'm paying a reasonable price?







Evaluation

Cigna evaluates providers based on criteria we believe to be markers of quality and cost-efficiency.

Quality. We use three quality indicators to review providers in our network.

- Group Board Certification determines if boardcertified physicians provide most of the care in a physician group.
- National Committee for Quality Assurance (NCQA) Physician Recognition shows providers who received recognition in any of the four NCQA Physician Recognition Programs: diabetes, heart/stroke, physician practice connections or patient-centered medical home.
- > Evidence-Based Medicine (EBM) rules span 43 diseases and preventive care conditions, and may apply to the care provided by providers in 15 specialties. The quality of a provider's care is evaluated using a claims-based assessment based on 91 EBM rules.

Cost-efficiency. Individual providers and group practices are evaluated for their cost-efficiency using industry-standard Episode Treatment Group methodology that:

- Determines the average cost of treating an episode of care for each of the reviewed medical conditions and surgical procedures; then
- Compares that cost with the costs of other providers and medical groups of the same specialty in the same geographical market.

Receiving the Cigna Care Designation

Participating physicians may receive the Cigna Care Designation if the provider or physician group:

- Is located in one of the 74 markets that currently participate in this program.
- > Practices in one of the 21 assessed specialties.

- Meets Cigna group board certification criteria.
- > Has treated a minimum of 30 Cigna customers.
- Performance meets nationally endorsed criteria, with top results for both quality and cost-efficiency results as compared with their peers in the market.

Always reviewing and improving

Determining how providers earn the Cigna Care Designation and the methodology used to evaluate the quality and cost-efficiency of a provider's care may change. Just as we continue to review and evaluate our doctors, we review the process regularly as industry standards change and evolve.

Finding a Cigna Care Designation doctor



When a provider earns the Cigna Care Designation, we show the results in our online health care directory on **myCigna.com**. Specifically:

- We show the Cigna Care Designation symbol.
- > We show quality information for providers.
- We rank providers for cost-efficient care using stars, with three stars being the highest rating.





Ratings reflect a partial assessment of quality and cost-efficiency based on Cigna claims data, and should not be the sole basis for decision making (as such measures have a risk of error). You are encouraged to consider all relevant factors and to consult with your treating health care provider when choosing a professional or facility for care. Quality designations and ratings found in Cigna's online directories are not a guarantee of the quality of care provided to individual patients. Health care providers are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna.

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Cigna One Guide®



Now it's easier for you to take control of your health and health spending.

Cigna One Guide service can help you make smarter, informed choices and get the most from your plan. It's our highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support, tools and reminders can help you stay healthy and save money.

Your One Guide team is a click away to help you:

Understand your plan

- > Know your coverage and how it works
- > Get answers to all your health care or plan questions

Get care

- > Find an in-network doctor, lab or urgent care center
- Connect to health coaches, pharmacists and more
- > Stay on track with appointments and preventive care
- Take advantage of dedicated one-on-one support for complex health situations

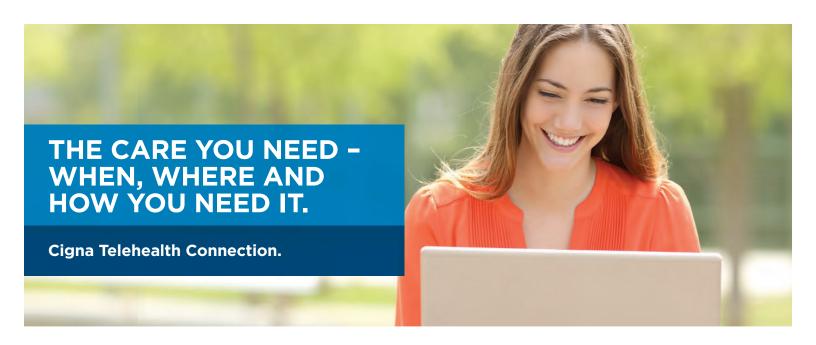
Save and earn

- Maximize your benefits and earn incentives (if provided by your employer)
- Get cost estimates and service comparisons to avoid surprises



Together, all the way.





Choice is good. More choice is even better.

Cigna provides access to two telehealth services as part of your medical plan - Amwell and MDLIVE.

Cigna Telehealth Connection lets you get the care you need - including most prescriptions (when appropriate) - for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both Amwell and MDLIVE, you can speak with a doctor for help with:

Sore throats Headaches

Stomachaches

- > Colds and flu
- Allergies
- Rashes
- Fevers

- Acne

- Shingles
- > Bronchitis
- Urinary tract infections and more



Amwell and MDLIVE are only available for medical visits. For covered services related to mental health and substance use disorder, you have access to the Cigna Behavioral **Health** network of providers.

- **>** Go to myCigna.com to search for a telehealth provider under Specialty in the Behavioral Directory link
- > Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

The cost savings are clear.

Televisits with Amwell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Together, all the way.



Choose with confidence.

Amwell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

AmwellforCigna.com*

855.667.9722



MDLIVEforCigna.com*

888.726.3171



Signing up is easy!



Connect to both Amwell and MDLIVE through myCigna.com. No separate login needed.



Complete a medical history using their virtual clipboard.



Download the MyCigna App and you'll be able to access both telehealth providers on your smartphone/mobile device.**



On the go? Register for the MyCigna® App today and you'll be able to access both Telehealth providers through the app.



- * Availability may vary by location and plan type and is subject to change. See vendor sites for details.
- **The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Amwell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services, websites and mobile apps are provided exclusively by Amwell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. Amwell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A primary care provider referral is not required for Amwell/MDLIVE services.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (CHC-TN), and Cigna HealthCare of Texas, Inc. Policy forms: OK – HP–APP–1 et al (CHLIC); OR – HP–POL38 02–13 (CHLIC); TN – HP–POL43/HC–CER1V1 et al (CHLIC), GSA–COVER, et al (CHC–TN). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your <u>plan</u> or <u>health insurance</u> policy. Some of these terms also might not have exactly the same meaning when used in your policy or <u>plan</u>, and in any case, the policy or <u>plan</u> governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or <u>plan</u> document.)
- <u>Underlined</u> text indicates a term defined in this Glossary.
- See page 6 for an example showing how <u>deductibles</u>, <u>coinsurance</u> and <u>out-of-pocket limits</u> work together in a real life situation.

Allowed Amount

This is the maximum payment the <u>plan</u> will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or <u>plan</u> review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

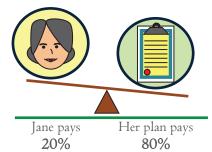
When a <u>provider</u> bills you for the balance remaining on the bill that your <u>plan</u> doesn't cover. This amount is the difference between the actual billed amount and the <u>allowed amount</u>. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an <u>out-of-network provider</u> (<u>non-preferred provider</u>). A <u>network provider</u> (<u>preferred provider</u>) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care <u>provider</u> to your health insurer or <u>plan</u> for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus



pay coinsurance *plus* (See page 6 for a detailed example.) any <u>deductibles</u> you owe. (For example, if the <u>health insurance</u> or <u>plan's</u> allowed amount for an office visit is \$100 and you've met your <u>deductible</u>, your coinsurance payment of 20% would be \$20. The health insurance or <u>plan</u> pays the rest of the allowed amount.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a <u>plan</u> covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. Family cost sharing is the share of cost for <u>deductibles</u> and <u>out-of-pocket</u> costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your <u>premiums</u>, penalties you may have to pay, or the cost of care a <u>plan</u> doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual <u>plan</u> you buy through the <u>Marketplace</u>. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may



Jane pays 100%

Her plan pays 0%

(See page 6 for a detailed example.)

also have separate deductibles that apply to specific services or groups of services. A <u>plan</u> may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care <u>provider</u> for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: I) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an <u>emergency medical condition</u>. Types of emergency medical transportation may include transportation by air, land, or sea. Your <u>plan</u> may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an <u>emergency medical condition</u> and treat you to keep an <u>emergency medical condition</u> from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for <u>emergency medical conditions</u>.

Excluded Services

Health care services that your <u>plan</u> doesn't pay for or cover.

Formulary

A list of drugs your <u>plan</u> covers. A formulary may include how much your share of the cost is for each drug. Your <u>plan</u> may put drugs in different <u>cost sharing</u> levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different <u>cost sharing</u> amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or <u>plan</u>.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a <u>premium</u>. A health insurance contract may also be called a "policy" or "<u>plan</u>".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some <u>plans</u> may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the <u>allowed amount</u> for covered healthcare services. Your share is usually lower for in-<u>network</u> covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to <u>providers</u> who contract with your <u>health insurance</u> or <u>plan</u>. In-network copayments usually are less than <u>out-of-network copayments</u>.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in <u>cost sharing</u> during the <u>plan</u> year for covered, in-<u>network</u> services. Applies to most types of health <u>plans</u> and insurance. This amount may be higher than the <u>out-of-pocket limits</u> stated for your <u>plan</u>.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the <u>individual</u> responsibility requirement. Minimum essential coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the <u>plan</u> covers. If you're offered an employer <u>plan</u> that pays for at least 60% of the total allowed costs of benefits, the <u>plan</u> offers minimum value and you may not qualify for <u>premium tax credits</u> and <u>cost sharing reductions</u> to buy a <u>plan</u> from the <u>Marketplace</u>.

Network

The facilities, <u>providers</u> and suppliers your health insurer or <u>plan</u> has contracted with to provide health care services.

Network Provider (Preferred Provider)

A <u>provider</u> who has a contract with your <u>health insurer</u> or <u>plan</u> who has agreed to provide services to members of a <u>plan</u>. You will pay less if you see a <u>provider</u> in the <u>network</u>. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the <u>allowed amount</u> for covered health care services to <u>providers</u> who don't contract with your <u>health insurance</u> or <u>plan</u>. Out-of-network coinsurance usually costs you more than <u>innetwork coinsurance</u>.

Out-of-network Copayment

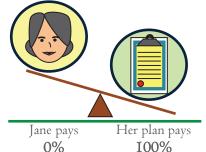
A fixed amount (for example, \$30) you pay for covered health care services from <u>providers</u> who do **not** contract with your <u>health insurance</u> or <u>plan</u>. Out-of-network copayments usually are more than <u>in-network</u> <u>copayments</u>.

Out-of-network Provider (Non-Preferred Provider)

A <u>provider</u> who doesn't have a contract with your <u>plan</u> to provide services. If your <u>plan</u> covers out-of-network services, you'll usually pay more to see an out-of-network provider than a <u>preferred provider</u>. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the <u>plan</u> will usually pay 100% of the



(See page 6 for a detailed example.)

allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or <u>plan</u> that a health care service, treatment plan, <u>prescription drug</u> or <u>durable medical equipment (DME)</u> is <u>medically necessary</u>. Sometimes called prior authorization, prior approval or precertification. Your <u>health insurance</u> or <u>plan</u> may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your <u>health insurance</u> or <u>plan</u> will cover the cost.

Premium

The amount that must be paid for your <u>health insurance</u> or <u>plan</u>. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private <u>health insurance</u>. You can get this help if you get <u>health insurance</u> through the <u>Marketplace</u> and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly <u>premium</u> costs.

Prescription Drug Coverage

Coverage under a <u>plan</u> that helps pay for <u>prescription</u> <u>drugs</u>. If the plan's <u>formulary</u> uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in <u>cost sharing</u> will be different for each "tier" of covered <u>prescription drugs</u>.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including <u>screenings</u>, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The <u>plan</u> may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your <u>primary care provider</u> for you to see a <u>specialist</u> or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your <u>primary care provider</u>. If you don't get a referral first, the <u>plan</u> may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of <u>preventive care</u> that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A <u>provider</u> focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of <u>prescription drug</u> that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a <u>formulary</u>.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what <u>providers</u> in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the <u>allowed</u> amount.

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require <u>emergency room care</u>.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Coinsurance: 20% Out-of-Pocket Limit: \$5,000

January 1st Beginning of Coverage Period

December 31st End of Coverage Period



Jane pays 100%

Her <u>plan</u> pays 0%

Jane hasn't reached her \$1,500 deductible yet

Her <u>plan</u> doesn't pay any of the costs. Office visit costs: \$125 Jane pays: \$125 Her plan pays: \$0











Jane pays 20%

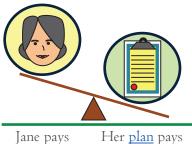
Her <u>plan</u> pays 80%



more

costs





Her plan pays I00%

Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100

Jane reaches her \$5,000 out-of-pocket limit

0%

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

2019 Annual Notices

Inside this issue:

Summary of Benefits and Coverage (SBC)

Special Enrollment | Rights Notice

WHCRA 2 Enrollment Notice

Notice of 2 Availability of Notice of Privacy

Patient 2 Protections Notice

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Medicaid and
CHIP

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Information

Introduction

This brochure includes the annual notices that should be distributed to all employees and dependents. This newsletter contains important information so we encourage you to read all sections.

If you have any questions regarding any items contained in this newsletter, please contact your Human Resources office or plan administrator for more information.

We hope you find this information helpful and informative.

Summary of Benefits and Coverage

The Health Care Reform law states that all groups must implement the requirement that health plans and health insurers provide consumers with a Summary of Benefits and Coverage (SBC). The stated purpose of the SBC is to "accurately describe the benefits and coverage under the applicable plan or coverage," which will allow participants to better compare plan terms and benefits.

In addition, all group health plans will have to distribute a brief standard summary of benefits and must use and distribute a uniform glossary containing definitions for common terms (e.g. "copay", "deductible", etc.).

This should be distributed annually, no later than December 1st and within seven days per any employee request. The medical SBC will be created by the insurance carrier and provided to each group for distribution.

In addition, if your group has a stand-alone HRA or FSA that covers expenses beyond excepted benefits, then the plan sponsor, not the insurance carrier, will create and distribute that SBC.

Health Care REFORM

Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.



2019 Annual Notices Page 2



WHCRA Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator at the phone number on the back of your carrier ID card.

Patient Protections Disclosure Notice

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier by calling the number on the back of your ID card

FOR GROUPS WITH HMO PLANS:

The employer's group health plan generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier by calling the number on the back of your ID card.

Notice of Availability of Notice of Privacy Practices

Your group health plan (the Plan) is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations to maintain the privacy of your protected health information (PHI) and to provide plan participants with notice of its legal duties and privacy practices with respect to PHI. PHI is any individually identifiable information that is received or maintained by the Plan in electronic, written, or oral form that pertains to your past, present or future mental or physical condition, the provision of health care services for that condition, and the payment for those services.

The Plan is required by law to tell you:

The Plan's uses and disclosures of your PHI;

The Plan's duties with respect to your PHI;

Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and

The person to contact for further information about the Plan's privacy practices.

A copy of the Notice of Privacy Practices is available to all individuals whose PHI will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your Human Resources office or plan administrator.



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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 are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not 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, you may 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, you may contact your state Medicaid or CHIP office at **I-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you may ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you may contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free I-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, 2018. You should contact your state for further information on eligibility.

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: I-800-701-0710

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: I-800-541-2831

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: I-800-692-7462

To see if any more states have added a premium assistance program since January 31, 2018 or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov

I-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)



Notice of Dependent Enrollment Limitations



Newborns: Must be enrolled within **30 days** of birth. If they are not enrolled within this time frame, they are not eligible until the next open enrollment period. If no open enrollment period exists, they are not eligible until a Life Status Event occurs (which may not occur in many instances).

Adoption/Judgments/Decrees/Etc.: Must be enrolled as of effective date listed on legal documentation. Refer to Plan Document on day limitation (i.e. 30 or 60 days to enroll).

Newborns' Act Disclosure

Group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with child-birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.



BENECON

Dependent Enrollment Limitations

Expecting?

Please make note of this Newborn Limitation Notice. Please address any questions or concerns about this notice with your HR Representative.

My employer (**does**) offer Open Enrollment. The effective date is the first of the year.



Benecon

Mailing address: P.O. Box 5406 Lancaster, PA17606 Phone: 717-723-4600 Fax: 717-735-0133



Newborns: Remember to **promptly** enroll your newborn with your HR Representative upon their birth to ensure that they are enrolled. Paperwork must be received and processed by the carrier <u>within the first 30 days of their date of birth</u>. If they are not enrolled within this time frame, they will not be eligible to be enrolled until the next open enrollment period. <u>It is not necessary to wait for the SS# it is not needed to process the enrollment and can be added later.</u>

Special Enrollments Rights: If you are eligible but not enrolled in your employer's health plan, you may enroll yourself, your spouse, and your new child upon the birth, adoption, or placement for adoption of a new child. Special enrollment is available regardless of whether the employer offers open enrollment or not. To be eligible you must request special enrollment in the plan within 30 days of the event. Coverage is effective the date of birth, adoption or placement for adoption.

Adoption/Judgment's/Decrees/Etc.: Eligible for enrollment as of the effective date listed on legal documentation and the documentation should be provided to your HR representative within 30 days of the event.

United Concordia[®] Dental

Dental Benefits Summary for LGIT Health – High Plan

Network: Concordia Advantage Plus

	CONCORDIA	CONCORDIA FLEX PLAN	
Benefit Category ¹	In-Network ²	Non-Network ²	
Class I – Diagnostic/Preventive Services			
Exams			
Bitewing X-rays			
All Other X-rays	4000/	100%	
Cleanings & Fluoride Treatments	100%		
Sealants			
Palliative Treatment			
Class II – Basic Services			
Basic Restorative (Fillings)			
Simple Extractions			
Space Maintainers		100%	
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures			
Endodontics	100%		
Nonsurgical Periodontics			
Surgical Periodontics			
Complex Oral Surgery			
General Anesthesia			
Class III – Major Services			
Inlays, Onlays, Crowns	50%	50%	
Prosthetics (Bridges, Dentures)	30%	30%	
Orthodontics for dependent children to age 19			
Diagnostic, Active, Retention Treatment	50%	50%	
Maximums & Deductibles (cumulative of network and non-network)			
Annual Program Deductible (per person/per family)	None	None	
Annual Program Maximum (per person)	\$2,000	\$2,000	
Lifetime Orthodontic Maximum (per person)	\$1,200	\$1,200	
Reimbursement	Advantage Plus	Advantage	

Representative listing of covered services - certificate of coverage provides a detailed description of benefits.

UnitedConcordia.com • 1-800-332-0366

^{1.} Unmarried dependent children covered to age 19. Unmarried dependent students covered to age 25.

^{2.} Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee. United Concordia Dental's standard exclusions and limitations apply.

Your NVA Vision Benefit Summary

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every 12 Months	Covered 100%	Reimbursed Amount • Up to \$32
Lenses Once Every 12 Months Single Vision Bifocal Trifocal Lenticular	Standard Glass or Plastic Covered 100%	 Up to \$26 Up to \$36 Up to \$46 Up to \$72
Frame Once Every 12 Months	Retail Allowance Up to \$60 (20% discount off balance)*	- Up to \$30
Contact Lenses Once Every 12 Months	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	■ Up to \$85 Retail① (15% discount (Conventional) or 10% discount (Disposable) off balance)**	■ Up to \$85
Medically Necessary***	Covered 100%	• Up to \$225

MLGHC (Plan F) Effective 07/01/2010 Revised 07/01/2014 **Group Number #51381 How Your Vision Care Program Works**

Eligible members and dependents are entitled to receive a vision examination and one pair of lenses and a frame or contact lenses once every 12 months from last date of service.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 51381000101 or the group number on the identification card and enter in your search parameters. It's that

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club or Contact Fill (NVA Mail Order) and may be prohibited by some manufacturers. ***Pre-approval from NVA required.

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

\$10 Solid Tint

- \$50 Progressive Lenses Standard*
- \$12 Fashion / Gradient Tint \$10 Standard Scratch-Resistant Coating
- \$65 Transitions Single Vision Standard \$70 Transitions Multi-Focal Standard
- \$12 Ultraviolet Coating
- \$25 Polycarbonate (Single Vision)
- \$40 Standard Anti-Reflective
- \$20 Glass Photogrey (Single Vision)
- \$30 Polycarbonate (Multi-Focal)
- \$30 Glass Photogrey (Multi-Focal)
- \$30 Blended Bifocal (Segment)

\$75 Polarized

\$55 High Index \$100 Progressive Lenses Premium*

*Fixed pricing not available on certain brands

Options not listed will be priced by NVA providers at their R&C retail price less 20%. In MD, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:

- -Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
- -View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. <u>Medically necessary contact lenses</u> includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

In MD, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Your NVA EyeEssential [®] Plan Discount – In Network Only		
Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less \$10	\$12 Solid Tint/ Gradient Tint
Contact Lens Fitting:	Retail Less 10%	\$50 Standard Progressive Lenses \$75 Polarized Lenses \$65 Transitions Single Vision Standard
Lenses:	Glass or Plastic	\$70 Transitions Multi-Focal Standard \$15 Standard Scratch Coating
Single Vision	\$35.00	\$12 UV Coating
Bifocal	\$55.00	\$35 Polycarbonate
Trifocal or Lenticular	\$70.00	\$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	Member Cost:	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 5/07. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. PO Box 2187 Clifton, NJ 07015

Web: <u>www.e-nva.com</u> • Toll-Free: 1.800.672.7723

NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.





HOW CONNECTCARE3 WORKS



Contact ConnectCare3

Reach out to ConnectCare3 when you have a diagnosis you don't fully understand or have a health goal you need assistance reaching.

Patient Advocate

The Patient Advocate is your first point of contact when you call ConnectCare3.



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Nurse Navigation

Nurses will research all available treatment options, top specialists and treatment facilities for your specific diagnosis. They will guide you through an informed decision making process.

Health Coaches

Our Health Coaches and Registered Dietitian will work with you to achieve your health goals which may include tobacco cessation, exercise programming, or nutritional counseling.



Exceed Expectations

Health Coaches provide guidance and education on healthier lifestyles. Nurses provide objective, unbiased guidance and support.

For assistance with a diagnosis or to work on a health goal, contact **ConnectCare3** by calling **877-223-2350** or by emailing us at **info@connectcare3.com**.



ConnectCare3

Patient Advocates Nurse Navigators Health Coaches Registered Dietitian





Would like help preparing for

physician appointments

Would like health education on

living a healthier lifestyle

Aflac for The City of New Carrollton employees

The City of New Carrollton is now making the following Aflac insurance policies available to its employees:



Short-Term Disability

In the case of illness or injury, it helps you maintain your standard of living and helps you pay your bills.



Accident

For a covered accident, Aflac policyholders receive cash benefits for use as they see fit. This plan helps provide a financial cushion if an accident occurs.



Hospital Confinement Indemnity

Helps with the non-covered expenses of a hospital stay.





Cancer/Specified-Disease

Aflac's cancer/specified-disease insurance policies are designed to pay cash benefits that can be used to help offset cancer-related expenses and to help with a variety of daily living expenses.

For more information about policy benefits, limitations, and exclusions, please call your Aflac insurance agent/producer,

Helen Lipchock, at (301) 325-2184 or email Helen _Lipchock@us.aflac.com.

This is a brief product overview only. Plans may not be available in all states. Benefits are determined by situs state and plan level selected.

Aflac for The City of New Carrollton Employees:

- Aflac is different from major medical insurance; it's insurance for daily living.
- Aflac pays you cash benefits, unless assigned, to use as you see fit.
- Aflac benefits can help with unexpected expenses.
- Aflac insurance policies belong to you—not your company.
- Aflac offers competitive rates.
- Aflac processes claims quickly—usually within four days.1
- Thanks to the Aflac Duck, nine out of ten people in the United States know the Aflac name.²

¹Company statistics, December 31, 2011.

²Aflac 2011 Year in Review.



We've got you under our wing.

Coverage is underwritten by American Family Life Assurance Company of Columbus.

In New York, coverage is underwritten by American Family Life Assurance Company of New York.

Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

To: Employees of City of New Carrollton

We have a wonderful opportunity for you! **City Of New Carrollton** and Colonial Life & Accident Insurance Company are proud to offer you exciting choices in your benefits program.

As a valued employee of City of New Carrollton, you may be eligible to apply for personal insurance products. Participation in these benefit plans is voluntary; however, we feel it is very important for you to understand the many advantages of the products City of New Carrollton and Colonial Life are making available to you:

- The ability to choose benefits to meet your individual needs.
- The convenience of premium payment through payroll deduction.
- The ability to take most coverages with you if you change jobs or retire.
- The ability to provide coverage for you and your family, with most products.

Listed below are the Colonial Life plans for which you can apply. With most products, benefits are paid directly to you, unless you specify otherwise, and most benefits are paid regardless of other coverage you may have with other insurance companies.

Accident Insurance – helps offset unexpected medical expenses, such as deductibles and co-payments, that can result from a fracture, dislocation or other covered accidental injury. New updated accident plan is now available with additional features. Spouse disability income offered as a rider. Sickness hospital income offered as a rider on a guaranteed issue basis regardless of health.

Cancer Insurance – helps offset the out-of-pocket medical and nonmedical expenses related to cancer that most medical plans may not cover. This coverage also provides benefits for specified cancer-screening tests.

Critical Illness Insurance – complements your major medical coverage by providing a lump-sum benefit you can use to help pay the direct and indirect costs related to a covered critical illness.

Disability Insurance – replaces a portion of your income to help make ends meet if you are totally disabled due to a covered accident or covered sickness. This coverage helps you to maintain your lifestyle. See your agent for guaranteed issue regardless of health history for new hires within the last 12 months.

Hospital Confinement Indemnity Insurance – provides a lump-sum benefit for covered hospital confinement and covered outpatient surgery to help offset the gaps caused by copayments and deductibles in most major medical plans.

Life Insurance – enables you to tailor coverage for your individual needs and helps provide financial security for your family members. A long term care rider for nursing home, assisted living, adult day care and home health care needs. Inexpensive term insurance can be purchased for 10, 20 and 30 year periods.

Whole life is available on a guaranteed issue basis to all employees.

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SW102 69863

Flexible Spending Accounts (FSAs) will be available again this year through a partnership with Ameriflex. These accounts allow you to put dollars aside in a medical or dependent care reimbursement account on a pretax basis. Eligible expenses may be reimbursed when needed. FSAs are beneficial because they can reduce your taxable income and increase your takehome pay. Our Colonial representative will meet with you to assist in maximizing your tax savings and enrolling in the plan.

Dependent Care Reimbursement Plan – allows you to put aside dollars, on a pretax basis, for the care of a child under the age of 13 or an adult who is incapable of self-care. You are then reimbursed for your eligible expenses from this account, thereby saving you tax dollars.

Health Care Reimbursement Plan – allows you to set aside money, on a pretax basis, for known out-of-pocket medical expenses, such as deductibles, co-insurance, eyeglasses, dentist, etc. These eligible expenses are then reimbursed to you from the account, thereby saving you tax dollars.

Soon, a Colonial Life benefits representative will visit your workplace to explain how these benefits can help protect you and your family. It is important that you take a few minutes to learn about the advantages of personal insurance benefits and to determine if all of your insurance needs are currently being met. We strongly encourage you to participate in this exciting opportunity!

You are not required to make any purchases, however, you will be asked to sign an electronic **Election Form** indicating your response to keep our plan in compliance. Benefits and FSA's will be effective on July 1, 2019- June 30, 2020

Feel free to reach out to our Colonial representative, Karen Linder-Staubs, at 410-663-2072.

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand. Policies have exclusions and limitations that may affect benefits payable. For cost and complete details, please see your Colonial Life benefits representative. Policies or provisions may vary or be unavailable in some states.





New York Life's workplace benefits products are an affordable way to help protect you and your family from financial strain due to unexpected hardships. We offer a variety of solutions that go beyond your typical employee benefits.

Talk to your New York Life agent to determine the right amount of coverage for you.

New York Life Insurance Company

51 Madison Avenue New York, NY 10010

www.newyorklife.com

15088.122018 SMRU1794967 (Exp.11.05.2020)



Employee's Whole Life Chronic Care Rider

Accelerated life benefits for chronic illness.

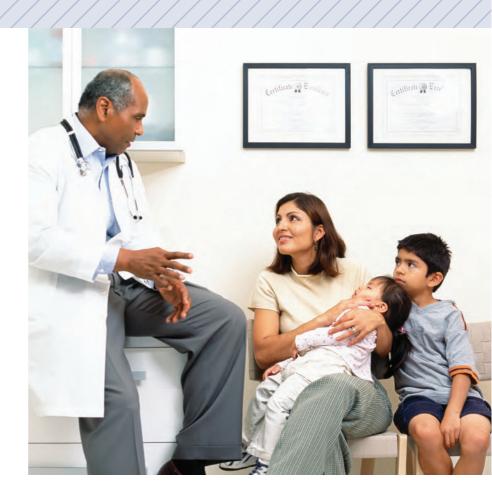


Let's make your Employee's Whole Life insurance policy do more.

We have added a proven, cost-effective way for you to protect the lifestyle and future you have worked so hard for. The primary purpose of your life insurance policy is to pay a death benefit. Our new Chronic Care Rider (CCR) can help it do even more.

You can protect your loved ones—and their future.

For a modest cost, our Chronic Care Rider—which can be purchased with an Employee's Whole Life (EWL) policy—is an easy and economical way for you to protect yourself from the financial hardships a chronic illness may cause.



Here's how it works...

The Chronic Care Rider provides a "living benefit" that lets the insured accelerate a portion of the EWL base face amount in the event the insured becomes chronically ill. At issue, the policy owner decides how much face amount to set aside for the Chronic Care Rider Benefit Pool.¹ In the event of a chronic illness, the policy owner elects an accelerated payout. The benefits will be paid on a monthly basis over a period of 25 months. Best of all, benefit payments are sent directly to the insured tax-free, and the money can be used however they want.



¹ The policy owner needs to allocate a minimum of \$20,000 for the Chronic Care Rider Benefit Pool, while also ensuring a minimum of \$5,000 in death benefit remains after CCR benefits are claimed.

Some questions to consider...



Who is eligible for the Chronic Care Rider?

Employee policy owners between the ages of 18 and 70 may elect the Chronic Care Rider on their Employee's Whole Life policy.

Why would an employer want to elect the Chronic Care Rider?

The Chronic Care Rider provides a living benefit that can help pay for extended chronic care needs. The CCR is affordable, easily accessible, flexible, and its benefits are paid tax-free.



A few more questions to consider...

Is separate underwriting required?

Yes, in addition to the EWL application, a simple supplemental form consisting of three health and lifestyle questions is necessary. The policy must be rated class 5 or higher and the face amount must be at least \$25,000 with a minimum residual death benefit of \$5,000.





How much does the Chronic Care Rider cost?

The exact cost of the rider will vary depending on a number of factors, such as age and risk class.

Will the Chronic Care Rider premiums increase?

Chronic Care Rider premiums will never increase. Just like the premiums on the base policy, the CCR premiums are quaranteed to remain level.





Does the rider expire?

No. The rider is in effect as long as the base policy is in force.

What are the requirements for filing a chronic illness claim?

If a licensed health care practitioner certifies that the insured cannot perform at least two of the six activities of daily living, the insured is eligible to file a claim after a 90-day waiting period.

The six activities or daily living are bathing, continence, dressing, eating, toileting, and transferring. The chronic care payments start after the claim is approved, and continue throughout the course of the payment period elected, as long as the client (policy owner) certifies annually that the insured is chronically ill.



The policy owner needs to allocate a minimum of \$20,000 and cannot allocate more than \$95,000 for their Chronic Care Rider Benefit Pool across all New York Life Employee's Whole Life policies with the Chronic Care Rider. The policy owner also needs to ensure that at least a \$5,000 death benefit will remain after CCR benefits are paid. Paid-Up additions, term riders, and the Accelerated Death Benefit rider are not eligible to be accelerated. Once the insured is certified as chronically ill as described in the policy, and meets the 90 day elimination period, the policy owner will begin receiving an unrestricted cash benefit, with no receipts or plan of care needed. The primary purpose of life insurance policies is death benefit protection and cash value accumulation, with certain riders available at a cost that provide the client with additional policy features, such as additional protection for future chronic illness expenses. This rider should be used for the primary purpose of accelerating a portion of the policy base face amount in case the insured becomes chronically ill.

This is a life insurance rider providing for an accelerated payment of the base policy face amount in the event that you are certified chronically ill as described in the policy.

This rider is not intended to be a federally tax-qualified long-term care insurance contract under Internal Revenue Code (IRC) Section 7702B. Therefore, the premiums payable for this rider do not qualify as long-term care insurance

premiums and are not deductible from gross income for federal income tax purposes. This rider, however, is subject to the federal per diem limits set forth in IRC Section 7702B. Under this rider, New York Life will not pay clients more than the federal per diem limits. If the benefit option elected exceeds the current IRC per diem limits, the benefit period will be extended accordingly. Assuming the amount you receive in the aggregate from all applicable policies does not exceed the federal per diem limits set forth in IRC Section 7702B, the benefits provided by the Chronic Care Rider are intended to be excludable from federal gross income under Section 101 (g) of the IRC.

Receipt of an accelerated death benefit may affect client eligibility for Medicaid or other government benefits or entitlements and may have income tax consequences. Accelerating benefits before applying for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Clients can contact the appropriate social service agency (e.g., the Medicaid Unit of your local Department of Public Welfare or the Social Security Administration Office) for more information.

In Oregon, the Employee's Whole Life Chronic Care Rider form number is ICC17-217-486R. In Oregon, the policy form number for New York Life Employee's Whole Life is ICC17-217-52P.

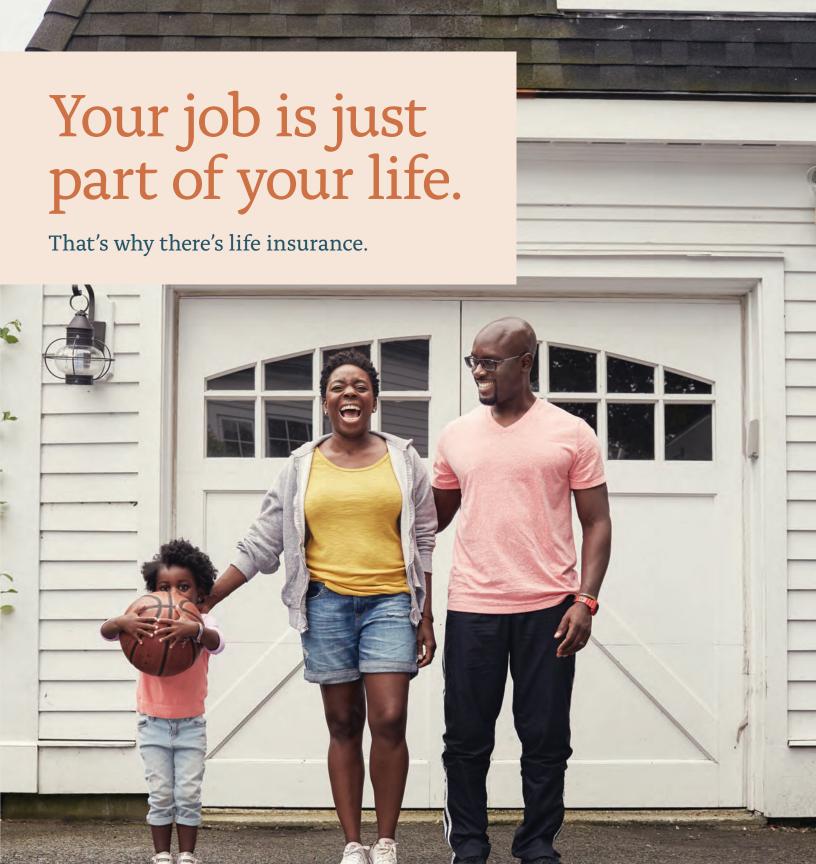
New York Life Insurance Company

51 Madison Avenue New York, NY 10010 www.newyorklife.com

15037.112017 SMRU1751277 (Exp.02.01.2020)

New York Life Workplace Benefits









Benefits

that make a difference.

Hassle-free application process.

You are eligible if your between age 16–70, worked for your employer at least six months, and work at least 30 hours per week. There are no physical exams and limited or no medical questions asked.

Lifelong coverage.

You own the policy. It remains with you regardless of where you work or even if you retire—as long as the premiums are paid when due.

Convenient payments.

Your premiums are automatically deducted from your paycheck.

Affordability.

You benefit from competitive rates and liberalized underwriting.



Work is about more than just a paycheck.

It's about security and benefits that help you provide for yourself and the important people in your life.

New York Life offers you a valuable complement to your employment benefits—permanent, affordable life insurance. Even if you already have group term life insurance, you can get this extra protection with the convenience of automatic payroll deduction.

Most group term life insurance policies last only as long as you work for that employer.

New York Life Employee's Whole Life Insurance lets you take your insurance policy with you when you change jobs or retire. And since it's permanent insurance, you will enjoy other benefits like building cash value and you'll be eligible to earn dividends.¹

Guaranteed² cash value.

Your policy builds cash value, which you can access through policy loans and withdrawals,³ to help pay for unexpected emergencies.

Expandable coverage.

Your spouse/domestic partner, children, and even grandchildren (ages 15 days to 25 years) may be eligible for coverage.

Portable.

Your coverage stays with you even if you change jobs. Take it with you throughout your life. It's your policy. It's not tied to any specific employer or group plan.

Grows with you.

You will be eligible to receive dividends, 1 you can increase your coverage, or add policies for both you and your qualified family members during future enrollment periods.



Complete this section with your agent to determine what amount of coverage is best for you.

Your age			
Face amount		Premium	
\$5,000 Minimum		\$	
\$25,000		\$	
\$50,000		\$	
\$100,000		\$	
\$	_ maximum	\$	
\$	other	\$	
Spouse age			
Face amount		Premium	
\$5,000 Minimum		\$	
\$25,000 Maximum		\$	
\$	other	\$	
Child/Grandchild age			
Face amount		Premium	
\$5,000 Minimum		\$	
\$25,000 Maximum		\$	
\$	other	\$	
Child/Grandchild age			
Face amount		Premium	
\$5,000 Minimum		\$	
\$25,000 Maximum		\$	
\$	other	\$	
Child/Grandchild age			
Face amount		Premium	
\$5,000 Minimum		\$	
\$25,000 Maximum		\$	
\$	other	\$	
Child/Grandchild age			
Face amount	_	Premium	
\$5,000 Minimum		\$	
\$25,000 Maximum		\$	
\$	other	\$	

The minimum face amount for Employee's Whole Life is \$5,000. The maximum face amount for employees is \$100,000 for Guaranteed Issue and \$150,000 for Simplified Issue. The maximum face amount for spouses is \$25,000 for Guaranteed Issue and \$50,000 for Simplified Issue. The maximum face amount for children or grandchildren is \$25,000.

Why New York Life.

We aspire to be an industry leader in the workplace by providing valuable protection and peace of mind for employees and their families. We've been protecting policy owners since 1845, in good times and bad. New York Life has also received the highest financial strength ratings currently awarded to any U.S. life insurer.

A++ AAA Aaa AA+
Superior Exceptionally Exceptional Very Strong

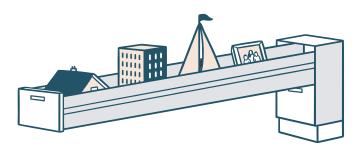
A.M. Best Fitch Moody's Standard & Poor's

Source: Independent Third-Party Ratings Reports, as of 7/30/18.

Professional service and support from a

New York Life agent.

Our nationwide network of agents is one of the most experienced and well regarded in the business. Our agents make it their personal mission to connect with you individually, and, in many cases, help address your financial needs beyond what is being offered at the workplace. This attention to personal service defines who we are as a company.



Here are some of the other solutions we can offer you:







New York Life Workplace Benefits

New York Life Employee's Whole Life is issued by New York Life Insurance Company. This program is not intended to be subject to the Employee Retirement Income Security Act of 1974 (ERISA). The employer does not contribute to or endorse the program. Employee participation is completely voluntary.

In Oregon, the Employee's Whole Life policy number is ICC17217-52P.

New York Life Insurance Company

51 Madison Avenue New York, NY 10010 www.newyorklife.com 15090.122018 SMRU1794165 (Exp.01.25.2021)



 $^{^1} Dividends, which provide an opportunity for cash value growth, are not guaranteed. \\$

² Guarantees are based on the claims paying ability of the issuer.

³Access to the policy's cash value reduces the death benefit and cash value of the policy. Policy loans accrue interest. Any outstanding loans plus interest or partial withdrawals will reduce the policy's death benefit and cash value by the amount of the loan plus interest or the partial withdrawals.

Employee Assistance Summary of Services



by bhs.

What is an EAP?

Provided by BHS, your Employee Assistance Program (EAP) provides you and your household members with **free**, **confidential**, **in-the-moment support** to help with personal or professional problems that may interfere with work or family responsibilities.

What Happens When You Call the EAP?

A Care Coordinator (master's level clinician) will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator may resolve your need within the initial call; assess your need as a short-term issue, which can be resolved by an EAP counselor within the available sessions; assess your need as requiring long-term care and assist with connecting you to a community resource or treatment provider available through your health insurance plan.*

Common Reasons to Call Your EAP

Relationships	Transitions	Risks	Challenges
Boss/	Birth/Death	Burnout/Anger	Daily
Co-worker	Health/	Depression/	responsibilities
Customers	Illness	Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal thoughts	Parenting
Spouse/Kids	Promotion/ Retirement	Substance abuse	Stress/ Conflict

PROGRAM FEATURES:



Program Cost

This is a FREE* benefit provided and paid for by your employer at no cost to you.



Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.

Information about your problem cannot be released without your written permission.



Available 24/7

Services are available 24-hours a day, 7-days a week via a toll-free number.

Help is just a phone call away.

800-327-2251

MyBHS Portal

The mobile-friendly MyBHS customer portal provides access to a variety of trusted online well-being resources.

Features:

- **✓** Announcements
- **✓** Program Information
- ✓ News & Tips
- √ Access to Live Chat
- **✓** BHS Focus Newsletter
- **✓** Café Series Webinars



To access MyBHS Portal:

- 1. Go to portal.BHSonline.com
- 2. Enter MyBHS username:
- 3. Click LOGIN



^{*} If you require a referral for long-term treatment, costs may be incurred. These are often covered by your health insurance plan.

√ Resource Library

√ Training Center



Childcare Referral Services

Balancing work and family life can be difficult. Fortunately, your EAP can aid in making this part of life easier. Childcare referral services are an additional benefit provided by your employer at no cost to you. Upon calling BHS, you will be linked to a Care Coordinator who will provide resources tailored for your specific childcare needs.

BHS offers a wide variety of childcare referrals for services, including:

- Family daycare homes and group homes
- Emergency and back-up care
- Nurseries and preschools
- Nanny and au pair services
- Summer camps
- Before and after school programs
- Adoption and special needs



Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.



Program Cost

Childcare Referral Services are a free benefit provided and paid for by your employer at no cost to you.

Within three business days, your BHS Care Coordinator will provide via e-mail or U.S. Postal Service:

- A listing of providers that meet your criteria
- A Guide to Quality Childcare
- Brochures and tip sheets tailored for your specific childcare issue

For more information about Childcare Referral Services, call our toll free number or visit us online.





Eldercare Referral Services

Choosing the right eldercare services for your loved ones can be stressful, especially when keeping their happiness in mind. Fortunately, your EAP can help in making this process easier. Eldercare referral services are an additional benefit provided by your employer at no cost to you. Upon calling BHS, you will be linked to a Care Coordinator who will provide pre-screened, up-to-date, national resources tailored for your specific eldercare needs.

BHS offers a wide variety of eldercare referrals for services, including:

- In-home care: medical and nursing rehabilitation services
- Home-based services: nutrition, Meals on Wheels, cleaning and repair
- Inpatient services: nursing homes, intermediate care facilities, respite care and assisted living facilities
- · Housing: retirement communities and subsidized housing
- Older adult services: support/advocacy groups, volunteer opportunities and adult daycare
- Transportation services

Within three business days of your call, your BHS Care Coordinator will provide via e-mail or U.S. Postal Service:

- · A listing of providers that meet your criteria
- AARP publications
- Brochures and tip sheets tailored for your specific eldercare issue



Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.



Program Cost

Eldercare Referral Services are a free benefit provided and paid for by your employer at no cost to you.

For more information about Eldercare Referral Services, call our toll free number or visit us online.





Financial Consultation Services

In need of financial consultation services? Your EAP can help. Financial consultation services are an additional benefit provided by your employer at no cost to you. Upon calling BHS, you will be linked to a Care Coordinator who will conduct a needs assessment and connect you to BHS' team of highly-trained financial counselors to provide unlimited telephonic consultation and resources about your specific financial issue. If you determine you need ongoing assistance with your financial situation, BHS can then provide local referrals.

BHS offers a wide variety of financial resources and services, including:

- Debt management and consolidation
- College funding

- Retirement funding
- Credit counseling
- Budgeting

Unlimited telephonic financial consultation:

- You and your household members can access unlimited telephonic financial counseling, information and education from BHS' team of highly-trained financial counselors.
- You may contact a financial counselor as many times as needed about the same issue for up to one year.



Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.



Program Cost

Financial Consultation Services are a free benefit provided and paid for by your employer at no cost to you.

For more information about Financial Consultation Services, call our toll free number or visit us online.





Legal Consultation Services

Finding appropriate legal services is easy with BHS. Legal consultation services are an additional benefit provided by your employer at no cost to you. Upon calling BHS, you will be linked to a Care Coordinator who will conduct a needs assessment and connect you to a qualified attorney to provide you with resources and an in-office or telephonic consultation about your specific legal issue. If you determine you need further assistance, you will receive 25 percent off the attorney's hourly rate. Note: BHS does not consult on work-related issues.

We offer a wide variety of legal resources and services, including:

- The right attorney with expertise specific to your legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- · Concierge help navigating the legal world

BHS legal benefits include:

- Free 30-minute consultations
- In office or telephonic with local plan providers
- 25 percent off the attorney's hourly rate when an hourly rate is quoted for services beyond consultation
- Each consultation must be over a new legal topic
- Document review up to six pages
- Simple dispute resolution call or letter



Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.



Program Cost

Legal Consultation Services are a free benefit provided and paid for by your employer at no cost to you.

For more information about Legal Consultation Services, call our toll free number or visit us online.







City of New Carrollton

PROTECT YOURSELF AND YOUR FAMILY

Your employer is offering an opportunity to enroll in the Legal Resources Legal Plan as part of your benefits. **Don't let this opportunity get away!**

Few employee benefits offer so much for so little. As a Legal Resources Member, you'll have immediate and ongoing access to **comprehensive legal coverage**, **services**, **and expertise** that will easily save you money — and could save you a whole lot more.

PEACE OF MIND FOR ONLY

\$19.00 PER MONTH (\$8.77 PER PAYCHECK)

COVERS YOU AND YOUR FAMILY

ENROLLMENT DEADLINE

EFFECTIVE DATE

HOW TO ENROLL LAW

FIRM FINDER

MAY 29, 2019
JULY 1, 2019

ENROLL ONLINE COMPANY CODE: 2528 PASSWORD: CNCLEGAL

PAPER FORM

For Network Law Firms outside DC, Maryland and Northern VA, please enter access code 7330012 when prompted or call member Services at 800.728.5768.

LEARN MORE



OVERVIEW & MEMBER STORIES



FAOs



FIND A LAW FIRM



CONTACT US



DON'T MISS THIS OPPORTUNITY TO JOIN



CITY OF NEW CARROLLTON

ONLY \$19.00 PER MONTH (\$8.77 per paycheck)

THE ONE-TIME \$20 ENROLLMENT FEE WAIVED ENROLL NOW!

Join Legal Resources and pay no attorney fees (or a fraction of the cost) when a legal need arises.

WHY LEGAL RESOURCES?



pay no attorney fees

Covers a broad range of legal services in full



exceptional law firm network

Over 13,000 attorneys nationwide — call your firm directly anytime you have a legal need



it's valuable

Annual cost = less than what an attorney typically charges for just one hour



superior customer service

Certified Paralegals answer calls and questions

WHAT IS COVERED?*

WHO IS COVERED?



General Advice & Consultation



Wills & Estate Planning



Purchase, Sale, and Refinance of Primary Residence



Divorce & Child Custody



Traffic Violations (incl. DUI)



Consumer Disputes



Courtroom Representation



Identity Theft Assistance

and much more...

* Attorney fees covered 100% or discounted up to 25% depending on the legal matter. For specific coverage information, please call Member Services at 800.728.5768. Member is responsible for all non-attorney costs such as filing fees, court costs, fines, etc.

You, your spouse and dependent children (up to age 19 or 23, if full-time student)

ENROLLMENT DEADLINE: MAY 29, 2019

COVERAGE STARTS: JULY 1, 2019

WANT MORE INFORMATION?

COME TO THE ANNUAL BENEFITS OPEN ENROLLMENT FAIR!

Wednesday, May 22, 2019 10:00 AM - 2:00 PM

- » Visit legalresources.com
- » For further questions OR would like to enroll, please contact your Human Resources department.

QUESTIONS?

SAIMA RAZZAOUE

ACCOUNT MANAGER

301.654.9490



COMPREHENSIVE, AFFORDABLE AND NDEMAND

City of New Carrollton

Legal Plan

<u>Legal Resources®</u> provides 100% coverage for you, your spouse, and qualified dependents for the most often needed legal services, protecting you and your family from the high cost of attorney fees. Whether your legal matter is for an everyday legal need or a result of an unexpected life event, you'll have immediate and ongoing access to a network of top-rated law firms in your area.

You pay no attorney fees for all <u>Fully Covered Services</u>, which include will preparation, traffic court, advice and consultation, real estate matters, divorce, billing disputes, and more!

- Legal Plan Brochure
- Legal Plan Enrollment Video
- Law Firm Finder **If prompted for an access code, please enter 7330012**
- Legal Plan FAQ's
- Legal Resources Website
- Legal Life Events
- Parent Coverage Information
- Enroll Online company code: 2528 password: cnclegal
- Print Paper Enrollment Form Here

Plan Price: \$19.00 per month (\$8.77 per paycheck)

This summary is intended to provide a general overview of coverage. For specific questions, please call Member Services at 800.728.5768.

Participating employees agree to a 12 month commitment. If you become non-benefits eligible or leave employment you may continue coverage by setting up direct billing with Legal Resources. Coverage remains the same.

For Network Law Firms outside DC, Maryland and Northern VA, please enter access code 7330012 when prompted or call member Services at 800.728.5768.





Legal Resources is an employee benefit that provides high-quality legal services to our members, enabling them to lead lives free of major legal expenses.

LOW COST, GREAT VALUE

With Legal Resources, you get comprehensive legal coverage on a broad range of services for an affordable low monthly rate. There are no co-pays and the cost of the plan does not change, no matter how often you use it.

FULLY COVERED SERVICES

The most often needed legal services are covered at 100%. That means you, your spouse and qualifying dependents pay no attorney fees when using these services.

OUALITY ATTORNEYS

Members have access to a network of top-rated, full-service law firms locally and **over 13,000 attorneys nationwide**.

HOW MUCH WILL YOU SAVE?

With the average attorney charging \$200-400 per hour, Legal Resources can help you and your family avoid anticipated and unanticipated attorney fees — saving not only money, but valuable time as well.

COMMONLY USED LEGAL SERVICES	WHAT NON-MEMBERS PAY	WHAT MEMBERS PAY ^{2,3}
Legal advice and consultation	\$200-400 per hour	
Will preparation	\$500-750 per person	The Park Street
Purchase, sale or refinance of primary residence	\$400-700	
Traffic court representation (including 1st offense DUI)	\$750-1,500	
Uncontested divorce representation	\$1,250-2,000	
Tenant dispute with landlord	\$200-400 per hour	
Uncontested domestic adoption (including name change)	\$1,000-1,500	
Review of a financial contract or lease	\$200-400 per hour	
District court representation in a civil action	\$200-400 per hour	
Defense of child in juvenile court (misdemeanor)	\$875-1,500	

FULLY COVERED SERVICES

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



General Advice and Consultation

Family Law

Elder Law

Estate advice

or illegal drugs

Uncontested divorce

Uncontested name change

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

Uncontested domestic adoption

Powers of attorney for Members'

 Misdemeanor defense of juveniles Fully covered for first offense involving alcohol

Criminal Matters³

Defense of misdemeanor



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



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

This SUMMARY OF COVERAGE is intended to provide a broad general overview of plan coverage and is not a contract. Coverage may vary by organization. For specific coverage questions, please call Member Services at 800.728.5768. Member is responsible for all non-attorney costs such as filing fees, court costs, fines, etc.



With coverage for teen-age dependents, real estate transactions and other estate/family law matters, this is a 'no brainer.' It's a great value for the peace of mind it provides. Jeffrey L., Plan Member

YOUR LEGAL NEEDS WILL BE COVERED!

Don't see your legal need listed? Have a pre-existing matter?

The Legal Resources Plan covers pre-existing legal matters as well as ANY less commonly needed legal service at a 25% discount.4

HOW THE PLAN WORKS

- Become a member by authorizing a low monthly payroll deduction through your employer during enrollment.
- 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.5
- Receive your welcome kit with member identification cards and information about your law firm.

- Call when you need legal services. Simply say, "I am a Legal Resources member."
- Certified paralegals in our Member Services Department provide you with dedicated, ongoing support and assist you with any coverage or attorney-related concerns.
- If you ever need to transfer to another Plan Law Firm, simply call Member Services.



LEGAL RESOURCES HAS BEEN PROVIDING COMPREHENSIVE LEGAL SERVICES AND REPRESENTATION FOR OUR MEMBERS AND THEIR FAMILIES FOR OVER 20 YEARS.

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

44 With this being my first real job, I felt it worthwhile to have these benefits and couldn't be happier. I venture to say that I use the Legal Resources Plan more than my health care plan. This is the best investment I've made in a long time.

Andrew T., Plan Member

FIND OUT MORE

Visit our website for a more complete description of the Legal Resources Plan and all of the services we provide. There, you will find attorney profiles and a Law Firm Finder, which will direct you to law firms convenient to your home or work.

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





f legalresources legal_resources



Relax... you're covered.®

- Demonstrates the potential savings the Legal Resources Plan can provide and does not represent actual payments but rather an average standard fee or hourly rate a network attorney would charge for that service.
- 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.
- 3 Offenses involving illegal drugs, alcohol (except 1st offense DUI) and firearms are covered at a
- 4 Since your employer is the participating sponsor, you may not use the Plan in a dispute with your employer.
- 5 Timing of selection may vary based on your location or your employer's enrollment procedures. ©2014 Legal Benefits Inc., Virginia Beach, VA. Legal Resources® is Legal Benefits Inc. and all its subsidiaries.





CITY OF NEW CARROLLTON- Open Enrollment

- 1. Your effective date of coverage is July 1, 2019.
- 2. Payroll deductions are \$19.00 per month (\$8.77 per paycheck).
- If you live in Northern VA/MD/DC, select a law firm from the list provided. You
 must select a law firm from the state in which you reside. If you live outside of
 these areas, call Legal Resources at 800-728-5768 to be directed to an attorney
 in your area.
- 4. Please return your completed application to your benefits administrator by May 29, 2019.

	Ę	5. Que	estions: contact	Saima Razzaque,	Account N	Manager, at 301-6	54-94	90.
Member Informa	tion							
Last Name		First Name		MI	Date of Birth			
Address			1		Social	L Security Number		
City					State	Zip		
Home Phone		W	ork Phone		Cell Pho	Cell Phone		
Home/Personal Email				Work Email				
Employer Name		De	epartment/Location	n		Date of Employm	ent	
Dependent Infor		eside w	ith you and full time s	students up to age 23 qu	ualify as depe	endents)		
Last Name		First N	lame		МІ	Date of Birth	Sex	Relationship
					•	•	•	•
Payroll Deduction	n Authorization	and	Law Firm S	Selection				
Yes, I want to enroll in mation I have received membership packet. that I am signing up for per my employer's open I understand that I am neous costs associate fines assessed, etc. I including termination for during the term of enroll mation I have received.	d and subject to the tell agree to pay for the or a 12 month contracten enrollment policies not responsible for atted with any legal matter understand that if I carom my employer, tha	erms a plan v et for a unless torney ers pe incel n	and conditions via payroll deduct a legal services is notified thirty of the fuertaining to menty contract for a	in the Legal Resoluction at the amount plan. This annual (30) days prior to a covered service or a covered famous preason within	ources Maunt and frall membershe expirates. Howeld it membershes 12 month	ester Plan Contra equency stated be ership shall renevation date. ever, I am respon er, such as court s of my effective	ct pro pelow v auto sible costs date	ovided in my and I agree omatically or for miscella- s, filing fees, of coverage,
Member Name		M	ember Signature			Date		
COST	Law Firm Selection or	. Code	(Leave blank if you want I	_egal Resources to select a law	firm closest to vo	our residence or if no law firms	are listed	in your area)
\$ 19.00 Per Month Waived Enrollment Fee			, , , , , , , , , , , , , , ,					,
For additional in	formation, please c	all Le	egal Resource	es at 800-728-57	68 or vis	it www.legalres	ourc	es.com

For additional information, please call Legal Resources at 800-728-5768 or visit www.legalresources.com <u>Please return this completed form to your Human Resources/Benefits Administrator.</u>

		OFFICE USE ONLY	
EFFECTIVE DATE:	AGENT: _		Member ID



CITY OF NEW CARROLLTON- Open Enrollment

- 1. Your effective date of coverage is July 1, 2019.
- Payroll deductions are \$19.00 per month (\$8.77 per paycheck)
 If you live in Northern VA/MD/DC, select a law firm from the list provided. You must select a law firm from the state in which you reside. If you live outside of these areas, call Legal Resources at 800-728-5768 to be directed to an attorney in your area.
- 4. Please return this form to Human Resources or enroll online by May 29, 2019. To enroll online, go to www.legalresources.com and click "Enroll Now" then enter company code: 2528 password: cnclegal

		. Quc	stions. contact	Saima Nazzaque, A	occurr iv	lanager, at 00 1-00	J- J-	50.
Member Informat	tion							
Last Name		First Name		МІ	Date of Birth			
Address					Social S	Security Number		
City					State	Zip		
Home Phone		Wo	ork Phone		Cell Pho	one		
Home/Personal Email				Work Email				
Employer Name		De	partment/Locatio	n		Date of Employm	ent	
Dependent Inform (Your spouse, unmarried children		side wit	h you and full time :	students up to age 23 qual	ify as depe	ndents)		
Last Name		First Na	ame		МІ	Date of Birth	Sex	Relationship
	<u>'</u>				•	•	•	
Payroll Deduction	n Authorization a	and I	Law Firm S	Selection				
Yes, I want to enroll in mation I have received membership packet. I that I am signing up for per my employer's ope I understand that I am neous costs associated fines assessed, etc. I including termination from during the term of enrolling to the service of th	I and subject to the te agree to pay for the por or a 12 month contract on enrollment policies un not responsible for atte d with any legal matte understand that if I car from my employer, that	rms a plan v for a inless orney ers per ncel m	and conditions in payroll deduction legal services notified thirty fees for the furtaining to menty contract for an appropriate the service of the service o	in the Legal Resounction at the amour plan. This annual (30) days prior to the overed services or a covered family any reason within 1	rces Ma It and fro I membe I membe I membe I membe I membe I membe I month	ester Plan Contra equency stated b ership shall renevation date. ever, I am respon er, such as court s of my effective	ct pro below v auto sible costs date	ovided in my and I agree omatically or for miscella- s, filing fees, of coverage,
Member Name		Ме	ember Signature			Date		
COST \$ 19.00 Per Month Waived Enrollment Fee	Law Firm Selection or	Code	(Leave blank if you want	Legal Resources to select a law fin	m closest to yo	ur residence or if no law firms	are listed	in your area)

For additional information, please call Legal Resources at 800-728-5768 or visit www.legalresources.com Please return this completed form to your Human Resources/Benefits Administrator.

	OFFICE USE ONLY	
EFFECTIVE DATE:	_AGENT:	Member ID



NORTHERN VIRGINIA, MARYLAND & D.C. LAW FIRM NETWORK

WASHINGTON, D.C.

NORTHERN VIRGINIA

	ALEXANDRIA		LOUDOUN COUNTY	0004	AXELSON, WILLIAMOWSKY, BENDER & FISHMAN, P.C.
0015	ROSENBLUM & ROSENBLUM 333 North Fairfax Street, Suite 204 Alexandria, VA 22314	0214	BECKMAN SCHMALZLE GEORGELAS & ROSS, PLC 29 North King Street Leesburg, VA 20176	0003	700 12th Street, NorthWest, Suite 700 Washington, D.C. 20005 BULMAN, DUNIE, BURKE & FELD, CHTD
	ARLINGTON COUNTY	0204	WOEHRLE, DAHLBERG, JONES & YAO, PLLC 19 East Market Street Leesburg, VA 20176		4610 Elm Street Bethesda, MD 20815
0150	BUSHMAN LAW GROUP 2800 Shirlington Road, Suite 503 Arlington, VA 22206		PRINCE WILLIAM COUNTY	0027	KARP, WIGODSKY, NORWIND, KUDEL & GOLD, P.A. 5335 Wisconsin Ave. NW, Suite 440 Washington, D.C. 20015
0206	WOEHRLE, DAHLBERG, JONES & YAO, PLLC 2007 15th Street North Arlington, VA 22201	0006	THE MANASSAS LAW GROUP, P.C. 9255 Lee Avenue Manassas, VA 20110	0220	KARP, WIGODSKY, NORWIND, KUDEL & GOLD, P.A. 2101 L Street #400 Washington, D.C. 20037
	FAIRFAX COUNTY	0187	WOEHRLE, DAHLBERG, JONES & YAO, PLLC		wasiiiigtoii, b.c. 2003/
0016	FRIEDLANDER, FRIEDLANDER & EARMAN, P.C. 1364 Beverly Road, Suite 201 McLean, VA 22101		12872 Harbor Drive Woodbridge, VA 22192		
0106	THE LAW OFFICES OF KIDWELL & KENT Woodson Square, 9695 C Main Street Fairfax, VA 22031		FREDERICKSBURG CITY		
0212	KURYLO GOLD & JOSEY, PLC	0211	KURYLO GOLD & JOSEY, PLC 910 Littlepage Street, Suite A Fredericksburg, VA 22401		
	297 Herndon Parkway, #103 Herndon, VA 20170	0185	WOEHRLE, DAHLBERG, JONES & YAO, PLLC		
0218	KURYLO GOLD & JOSEY, PLC 10560 Main Street, Penthouse #10 Fairfax, VA 22030		2016 Lafayette Boulevard, Suite 101 Fredericksburg, VA 22401		
0219	MELONE LAW, P.C. 12110 Sunset Hills Road, Suite 600 Reston, VA 20190	0213	STAFFORD COUNTY KURYLO GOLD & JOSEY, PLC 385 Garrisonville Road, #203 Stafford, VA,22554		
0111	PAUL P. VANGELLOW, P.C. 6109A Arlington Boulevard Falls Church, VA 22044		Statistical Hyperbook		

0188 WOEHRLE, DAHLBERG, JONES & YAO, PLLC 10615 Judicial Drive, Suite 102

Fairfax, VA 22030



NORTHERN VIRGINIA, MARYLAND & D.C. LAW FIRM NETWORK

MARYLAND

	ANNE ARUNDEL COUNTY				MONTGOMERY COUNTY
0021	LAW OFFICE OF MICHAEL L. WILSMAN 565 Baltimore Annapolis Boulevard Severna Park, MD 21146	0215	BECKMAN SCHMALZLE GEORGELAS & ROSS, PLC 15 North Court Street, Suite 201 Frederick, MD 21701	0005	AXELSON, WILLIAMOWSKY, BENDER & FISHMAN, P.C. 1401 Rockville Pike., Suite 650 Rockville, MD 20852
0083	STANCO & ROBINSON 1610 West Street #205 Annapolis, MD 21401	0072	KARP, WIGODSKY, NORWIND, KUDEL & GOLD, P.A. 317 Patrick Street, Frederick, MD 21701	0003	BULMAN, DUNIE, BURKE & FELD, CHTD 4610 Elm Street Bethesda, MD 20815
	BALTIMORE CITY/COUNTY	0180	WAMPLER & SOUDER LLC	0088	
0022	COOPER & TUERK, L.L.P. 201 North Charles Street, Suite 2300 Baltimore, MD 21201		170 West Patrick Street Frederick, MD 21701		GOLD, P.A. 2273 Research Boulevard, Suite 200 Rockville, MD 20850
0023	SCHWARTZ & GREENBAUM, LLC		HOWARD COUNTY	0179	WAMPLER & SOUDER LLC 12114-B Heritage Park Circle
0020	409 Washington Avenue, Suite 300 Towson, MD 21204	0028	AXELSON, WILLIAMOWSKY, BENDER & FISHMAN, P.C. 10211 Wincopin Circle, Suite 620		Silver Spring, MD 20906
0010	McFarland & Masters 920 Frederick Road		Columbia, MD 21044		PRINCE GEORGE'S COUNTY
	Catonsville, MD 21228	0221	BERGER & BURNS, LLC 3701 Court House Drive		BRENNAN, MCKENNA & LAWLOR, CHARTERED
	CHARLES COUNTY		Ellicott City, MD 21043	0142	6305 lvy Lane, Suite 700 Greenbelt, MD 20770
0133	MUDD, MUDD & FITZGERALD, P.A. 107 Centennial Street, 2rd Floor La Plata, MD 20646		HARFORD COUNTY	0143	14416 Old Mill Road, Suite 101 Upper Marlboro, MD 20772
	FREDERICK COUNTY	0025	KARAS & BRADFORD 325 South Main Street Bel Air, MD 21014	0181	WAMPLER & SOUDER LLC 14452 Old Mill Road, #301 Upper Marlboro, MD 20772
0104	ARTHUR W. BOYCE, P.A. 308 West Patrick Street, Frederick, MD 21701 Available in Washington and Carroll Counties			0100	KARP, WIGODSKY, NORWIND, KUDEL & GOLD, P.A. Fort Washington Professional Park 11414 Livingston Road Fort Washington, MD 20744
0018	AXELSON, WILLIAMOWSKY, BENDER & FISHMAN, P.C. 5100 Buckeystown Pike, Suite 250				

Frederick, MD 21704

Service Retirement

There are two types of service retirement: normal and early. Normal service retirement provides full benefits, while early service retirement provides a reduced benefit. Your eligibility for either type of service retirement depends on two factors: your service credit and age.

Normal: At least 90 years of combined age and years of eligibility service. For example:

- Age 57 with 33 years of service,
- Age 60 with 30 years of service or
- Age 63 with 27 years of service

Active members with at least 10 years of eligibility service become eligible for normal service retirement at age 65.

Early: Age 60 with at least 15 years of eligibility service.

When you retire, you will be able to choose from a number of payment options. These options range from the Basic Allowance, which provides the highest monthly allowance for you alone, to options that reduce your monthly payment but provide varying degrees of protection to your beneficiary(ies) upon your death.

During Retirement

As a retiree, once you have been retired one full year as of July 1, your retirement allowance may be adjusted each July to help your benefit payments keep pace with inflation.

If You Leave Employment Before Retirement

If you should leave employment once you have accrued at least 10 years of eligibility service, you are vested and have earned the right to receive a future benefit based on your service at termination. If you withdraw any of your contributions at termination, you will forfeit the right to a future benefit.

If you are not vested at the time of termination and you don't anticipate returning to membership, you should contact the agency to receive a refund of any contributions with interest you may have made.

Resources

Visit the State Retirement Agency online at sra.maryland.gov for newsletters, member handbooks, retirement benefit estimators, printable forms and updates on the system's financial performance.

To visit the office or write a letter:

State Retirement Agency 120 East Baltimore Street Baltimore, MD 21202-6700

Email inquiries to sra@sra.state.md.us

To speak with a retirement benefits specialist:

410-625-5555 or 1-800-492-5909



MARYLAND STATE RETIREMENT

Butterfly photo courtesy of Sue Muller Howard County Department of Recreation & Parks

sra.maryland.gov

Welcome to the

Employees' & Teachers' Pension System*



Baltimore Checkerspot Butterfly Maryland State Insect

* For members enrolled on or after July 1, 2011

Maryland State Retirement and Pension System 120 East Baltimore Street Baltimore, MD 21202-6700

> 410-625-5555 1-800-492-5909

sra.maryland.gov

Welcome!

The Maryland State Retirement and Pension System has a long history of providing retirement benefits to employees and teachers of Maryland state and municipal employers.

This overview deals with the highlights of the Employees' and Teachers' Pension System for members enrolled on or after July 1, 2011. Please refer to the pension system handbook on our website at sra.maryland.gov for more details about any of these topics.

A retirement coordinator, usually someone in your human resources department, can help you file enrollment forms and answer basic questions about your benefits. The Maryland State Retirement Agency also maintains a staff of retirement benefits specialists to answer questions from members and retirees.

Enrollment

Membership in the Employees' and Teachers' Pension System is mandatory. You must enroll by submitting an *Application for Membership* (Form 1), a *Designation of Beneficiary* (Form 4) and a valid proof of birth date. The forms are available from your retirement coordinator.

If you have membership credit in another Maryland state or Maryland local retirement/pension system, you may be able to transfer that service credit to your new plan. To qualify for the transfer, your employment must be continuous and you must apply within one year of becoming a member in your new system. Contact a retirement benefits specialist if this situation applies to you.

Employee Contributions

You contribute seven percent of your annual compensation to the Pension System.

Service Credit

You earn service credit toward your retirement benefits each day you work and pay your required contribution. Your service credit and age determine when you are eligible for retirement and how much your retirement benefit will be.

Eligibility service is used to determine when you are eligible for a benefit. You earn one year of eligibility service during any fiscal year when you work a minimum of 500 regular hours, excluding overtime.

The amount of your retirement benefit is based on creditable service which is determined on the hours you work in a fiscal year. A full-time employee will earn one month of creditable service for each month of employment.

Your Benefits

The Pension System provides survivor, disability and service retirement benefits. More information on your benefits is available online at sra.maryland.gov.

Survivor Benefits

The Pension System provides valuable beneficiary protection for members who die during active membership.

If a member dies after accruing at least one year of eligibility service, or dies in the course of duty, the beneficiary(ies) receives a one-time payment of the member's annual salary plus the member's accumulated contributions and interest.

If a member is eligible to retire or has at least 25 years of eligibility service at the time of death, his or her

surviving spouse may be eligible to receive a monthly benefit in lieu of the one-time payment if the spouse is the sole primary beneficiary.

In lieu of the survivor benefits mentioned here, if a member of the Employees' and Teachers' Pension System is <u>killed</u> in the line of duty, a monthly allowance of two-thirds of the member's average final compensation will be paid to the surviving spouse (if no spouse, to the member's children under age 26 or disabled children. If no spouse, children under age 26 or disabled children, the benefit is paid to the member's dependent parent for life.) Plus, a return of the member's accumulated contributions with interest is paid to the designated beneficiary.

Disability Benefits

If you are permanently and totally disabled from performing your job duties, as determined by the System's medical board, you may be eligible for a lifetime monthly disability retirement benefit.

Types of Disability Retirement

There are two types of disability benefits:

Ordinary: Any permanently disabling physical or mental condition.

Accidental: Any permanently disabling condition caused by injuries sustained from an accident on the job.

To file for ordinary disability, you must have accrued five years of eligibility service. As an active member, you are eligible to file for accidental disability from your first day on the job provided you file within five years of the date of the accident.

Your retirement coordinator can provide you with the necessary forms to file for a disability retirement benefit.

sra.maryland.gov sra.maryland.gov sra.maryland.gov

MARYLAND STATE RETIREMENT AGENCY 120 EAST BALTIMORE STREET BALTIMORE, MD 21202-6700



APPLICATION FOR MEMBERSHIP

FOR RETIREMENT USE ONLY

FORM 1 (REV. 7/19)

SECTION ONE — TO BE COMPLETED BY APPLICANT	
APPLICANT'S SOCIAL SECURITY NUMBER GENDER (M or F)	DATE OF BIRTH Month Day Year
APPLICANT'S NAME	Day Teal
HOME ADDRESS Initial	Last
Number and Street	
City	Zip Code
Home Phone Number Home Email Address	
 Have you ever been a member of the Maryland State Retirement and Pension System Have you ever been a member of the Optional Retirement Plan (ORP)? Are you presently receiving a retirement allowance from the Maryland State Retireme Are you presently a member of another State or local retirement or pension system of Maryland or any political subdivision of Maryland? IMPORTANT: If yes, read carefully the transfer provisions on the back of this form and the you attached acceptable proof of birth date as described on the back of this form. I certify that all statements made on this application are correct. I authorize any requiprescribed rate. And if I am presently a member of another State or local retirement understand the transfer provisions. 	nt and Pension System?Yes ☐ No ☐ perated under the laws ofYes ☐ No ☐ d then initial here: n?Yes ☐ No ☐ dired deductions from my salary at the
Applicant's Complete Signature Date	
SECTION TWO — TO BE COMPLETED BY RETIREMENT COORDINATOR	
SECTION TWO — TO BE COMPLETED BY RETIREMENT COORDINATOR A. IS THE APPLICANT A PERMANENT EMPLOYEE?	Yes □ No □
A. IS THE APPLICANT A PERMANENT EMPLOYEE?	percent
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? Month_	percent DayYear
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? Month C. What is the applicant's complete job classification or title?	percent DayYear
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? Month C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible?	percent Day YearYes □ No □
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? Month What is the applicant's complete job classification or title?	Day Year Percent Yes □ No □ No STOP and complete Form 60 Election
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? Month_ C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers	DayYear
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers E. What is the applicant's annual salary? \$	Day Year Percent Day Year
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A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers E. What is the applicant's annual salary? What is the applicant's annual salary? If applying for membership in the Law Enforcement Officers' Pension System, does the applicant is eligible to request a transfer of service credit between retirement or pension.	percent Day Year No □
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? Month_ C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers E. What is the applicant's annual salary? \$ What is the applicant's a F. If applying for membership in the Law Enforcement Officers' Pension System, does the applicant's annual salary?	percent Day Year No □
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers E. What is the applicant's annual salary? \$ What is the applicant's a If applying for membership in the Law Enforcement Officers' Pension System, does the applicant is eligible to request a transfer of service credit between retirement or pension employment, have you reviewed the transfer provisions on page two with the applicant?	Day Year No □ No □ No □ Correctional Officers' Retirement
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers E. What is the applicant's annual salary? What is the applicant's annual salary? If applying for membership in the Law Enforcement Officers' Pension System, does the applicant is eligible to request a transfer of service credit between retirement or pension employment, have you reviewed the transfer provisions on page two with the applicant? INDICATE SYSTEM: Teachers' Pension Employees' Pension	Day Year No □ No □ No □ Correctional Officers' Retirement
A. IS THE APPLICANT A PERMANENT EMPLOYEE? If part-time, what percentage of time is the applicant employed? B. When did applicant begin present continuous service? C. What is the applicant's complete job classification or title? D. Is applicant's current position Optional Retirement Plan (ORP) eligible? If yes and the applicant checked "Yes" to question 2 above (individual previously participated Not to Participate in the Teachers'/Employees' System by Faculty or Administrative Officers E. What is the applicant's annual salary? \$ What is the applicant's a nnual salary? \$ What is the applicant's annual salary? G. If the applicant is eligible to request a transfer of service credit between retirement or pensemployment, have you reviewed the transfer provisions on page two with the applicant? INDICATE SYSTEM: Teachers' Pension Employees' Pension State Police Retirement Law Enforcement Of # OF RETIREMENT CONTRIBUTIONS	percent Day Year Year No Day No Day Year No Day

INSTRUCTIONS

<u>Purpose of this Form:</u> The Application for Membership form provides the Maryland State Retirement Agency ("Agency") with the information necessary to properly enroll new members in the Maryland State Retirement and Pension System ("System").

Instructions for Applicant (Section One):

- 1. Use a pen, print clearly, and provide the information requested in **Section One**, including: your Social Security number, gender, date of birth, first name, middle initial, last name, home address including city, state, and zip code, home telephone number and home email address.
- 2. Review and answer all of the questions in **Section One**. Note that if you answer "Yes" to question #4, you must read the important information at the bottom of this page on Transfer Provisions, and then initial in the space provided.
- 3. Sign and date the form.
- 4. Make a copy of the form for your records and submit the form to your retirement coordinator along with a visible and readable copy of your proof of birth date document. Acceptable documents validating your date of birth include: your valid driver's license, Maryland identification card, birth certificate, and United States passport.
- 5. It is <u>strongly recommended</u> by the Agency that at the same time you submit your completed *Application for Membership* form to your retirement coordinator that you also submit a completed *Designation of Beneficiary* form. The *Designation of Beneficiary* form allows you to name the person (beneficiary) or persons (beneficiaries) that you want to receive any death benefits payable if you die while a member of the System.

<u>Instructions for Retirement Coordinator (Section Two):</u>

- Review the applicant's answers to questions 1-5 in Section One.
 If the applicant answered "Yes" in question 3, please call the Agency to determine if he or she should be enrolled in the System.
- 2. Use a pen, print clearly, and answer questions A G in **Section Two**. Pay particular attention to questions D and G. If in question D, you have indicated that the applicant's current position is eligible to participate in the Optional Retirement Plan (ORP) and the applicant has indicated in question 2 from **Section One** that he or she has ever previously participated in the ORP then the applicant is NOT eligible for enrollment in the System.
 If in question G, you have indicated that the applicant is eligible to transfer service credit then you must review the Transfer Provisions on page two of the form with the applicant.
- Indicate the retirement or pension system of participation for the applicant by checking the appropriate box.
- 4. Enter the required information in the employee agency code, number of retirement contributions to be deducted per year, and the system box.
- 5. Sign and date the form.
- 6. Make a copy of the completed form and the proof of birth date document for your files, and mail the original form and a copy of the proof of birth date document to the Agency.

Transfer Provisions for Service Credit Earned in Another Maryland State or Maryland Local Retirement or Pension System

If an applicant was previously a member of the Maryland State Retirement and Pension System or a member of another retirement or pension system administered by a political subdivision within Maryland (e.g. county government, city government, etc.), and their current employment requires a membership change in a retirement or pension system, the applicant may be eligible to transfer their service from their previous retirement or pension system to their new retirement or pension system with the Maryland State Retirement and Pension System.

To be eligible to transfer service credit, the following requirements must be met:

- 1. The applicant's employment must be continuous, meaning a change in jobs without a break in employment.
- 2. The transfer of service must be completed within one (1) year of the applicant becoming a member of the new retirement of pension system.

To transfer service credit from one retirement or pension system within the Maryland State Retirement and Pension System to another retirement or pension system within the Maryland State Retirement and Pension System, a completed *Election to Transfer Service* (Form 37) must be submitted to the Agency.

To transfer service credit from a retirement or pension system outside of the Maryland State Retirement and Pension System (e.g. a county, city, or local government system) to a retirement or pension system within the Maryland State Retirement and Pension System to another retirement, a completed *Request to Purchase Previous Service* (Form 26) and *Election to Transfer Service* (Form 37) must be submitted to the Agency.

If you need help to complete this form or require clarification, please call 410-625-5555 or 1-800-492-5909.

Page 2 of 2 FORM 1 (REV. 7/19)

MARYLAND STATE RETIREMENT AGENCY 120 EAST BALTIMORE STREET BALTIMORE, MARYLAND 21202-6700

DESIGNATION OF BENEFICIARY

() 8/9 Law Enforcement Officers' Pension System

IMPORTANT : Please return completed form to the instructions first. Fill in all sections. Retain	o the address listed above. Print clearly and read a copy for your records.	FOR RETIREMENT USE ONLY FORM 4 (REV. 7/19
APPLICANT'S SOCIAL SECURITY NUMBER	CHECK ONE: ☐ Active ☐ Vested ☐ Re	etired (If retiring, retirement date)
		2, 3, 5 or 6, STOP . You cannot use this form. You
APPLICANT'S NAME		
HOME ADDRESS First	Initial Last	
Number and Street		
City		State ZIP Code
		-
PRIMARY BENEFICIARY(IES) All money sha to the primary beneficiary(ies) who are living a		☐ Check if you used an additional Form 4 to name additional primary beneficiaries.
	, I I I	
BENEFICIARY'S NAME RELATIONSH	Gender: L Birthdate:L ⅢP (M or F)	Month Day Year
First		
BENEFICIARY'S ADDRESS		
	Gender: Birthdate:	
BENEFICIARY'S NAME RELATIONSH	IIP Gerider.[Birtidate.[Month Day Year
First	Initial Last	
BENEFICIARY'S ADDRESS		
CONTINUENT RENEFICIA BY//FOX 15 all and		7.011-15
CONTINGENT BENEFICIARY(IES) If all prima be paid in equal shares to the following persor		Check if you used an additional Form 4 to name additional contingent beneficiaries.
BENEFICIARY'S NAME RELATIONSH	Gender: Birthdate: LIIP (M or F)	Month Day Year
	<u></u>	
	Initial Last	
	IIIIIai Last	
BENEFICIARY'S ADDRESS		
	Gender: Birthdate:	
BENEFICIARY'S NAME RELATIONSH		Month Day Year
First	Initial Last	
BENEFICIARY'S ADDRESS		
on behalf of my estate, heirs and assigns that the payment	authorize the Maryland State Retirement Agency to pay the deatt made by the agency will release the agency from any further obliga	n benefit to my designated beneficiary or beneficiaries. I agree ation regarding this benefit. I direct the agency to pay the death
benefit to my estate if I have not designated any beneficiar	y or if all of the primary and contingent beneficiaries I have name	d die before me. I understand that I may change beneficiaries
certain payment due to a minor shall be made only to the le	n with the Maryland State Retirement Agency. Any new Designat gal guardian of that minor. SIGN IN THE PRESENCE OF A NOTA	ARY PUBLIC. (Form not valid unless notarized.)
	Date Signed	
<u> </u>	This form must be signed and	
	Ţ	
Please check (✓) for your system:	State of County of On this day of , 20	(or City of Baltimore)
() 1 Teachers' Retirement System		be affixed J
() 2 Employees' Retirement System	personally appeared	, known to me E IS BEING ACKNOWLEDGED *
() 2C Correctional Officers' Retirement System	(or satisfactorily proven) to be the person whose name is subs	scribed to the within instrument and acknowledged that
() 3 State Police Retirement System	(he/she) executed the same for the purposes therein containe	
() 6 Teachers' Pension System (Incl. Bifurcated)	Signature of Notary Public Printed Name of Notary Public	My Commission Expires
() 7 Employees' Pension Sys. (Incl. Bifurcated)	* IMPORTANT: If the name of the ir	
() 8/9 Law Enforcement Officers' Pension System	acknowledged is not filled in, this form v	

PLEASE READ THESE INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THIS FORM

1. Important terms/definitions:

- Active Member: a member who is currently employed by a participating employer, including a member who is currently on a Qualifying Leave of Absence
- b. Vested Member or Former Member: a member or former member who is no longer employed by a participating employer, but who is eligible to receive a deferred vested allowance based on the number of years of service credit earned during employment
- **c. Retiree:** an individual who has separated from employment with a participating employer and receives a monthly retirement allowance
- d. Primary Beneficiary: person(s) to receive any benefits payable on your death
- Contingent Beneficiary: person(s) to receive any benefits payable upon your death only if all of the primary beneficiaries die before your death

2. Purpose of this form:

This Form applies to the Employees' and Teachers' Retirement and Pension Systems, Correctional Officers' Retirement System, Law Enforcement Officers' Pension System and State Police Retirement System.

If you are an <u>Active Member</u> or a <u>Vested Member</u> <u>or Former Member</u>, use this form to name or change the person or persons you want to receive any payable death benefits. The beneficiary(ies) of an active member may be entitled to a one-time payment equal to your annual salary at death plus any member contributions with accumulated interest. The beneficiary(ies) of a vested member or former member may be entitled to payment of any member contributions with accumulated interest.

Important note for active members who are married: If you die as an active member and you meet certain requirements related to your age and/or the years of service, your spouse may be eligible to elect to receive a monthly survivor allowance instead of the standard death benefit payable for members who die during employment. If you want your spouse to be eligible to make this election, you must name your spouse as your sole/only primary beneficiary.

If you are a **Retiree**, use this form to change your beneficiary(ies) only if you chose the Basic Allowance, Option One or Option Four at retirement. If you chose Option Two, Three, Five or Six at retirement, STOP. You may not use this form to change your beneficiary. Changing your beneficiary under Options Two, Three, Five or Six is a two-step process. You must first submit a Request for Calculation of Joint Survivorship by a Retiree Considering Changing a Beneficiary (Form 66) in order to receive an estimate of your recalculated allowance based on the new proposed beneficiary. This form is available on the Retirement Agency website at sra.maryland.gov or by calling a retirement benefits specialist. When you receive a written estimate of the recalculated allowance, you will be provided with a different form (Form 67) to complete and submit if you decide to change your beneficiary.

Important note for participants of more than one State system: If you participate in more than one system, you must properly complete and submit a *Designation of Beneficiary* (Form 4) for <u>each</u> system. Members of the Judges' Retirement

System please use Form 4.1. Members of the Legislative Retirement System please use Form 55.

3. Number of beneficiaries:

Fill out only the spaces needed. If you need space for more beneficiaries, complete another form and check the box or boxes to show that you have used a second form.

4. Full names of beneficiaries:

Give the full names of your beneficiaries. For example, "Mary Jones" not "Mrs. John Jones."

5. Who can be a beneficiary:

Beneficiaries do not need to be related to you.

Minors: You may name a minor (child less than 18 years of age) as a beneficiary, but in some cases payments can only be made to the legal guardian of a minor. You cannot use this form to name a legal guardian for minor children.

Your estate: You may name "my estate" as your sole primary beneficiary. Do not name a personal representative of your estate as your beneficiary. Instead, use the space for the beneficiary's address to show the address of the person or business that will administer your estate. If your estate is named as the primary beneficiary, do not designate contingent beneficiaries.

Trustee: If you have established an Agreement of Trust or Testamentary Trust, you may name "Trustee as appointed by Agreement of Trust or Will" in the space provided for the beneficiary's address. Give the address of the Trustee or of the person or business that will administer the trust.

Church or charitable organization: List the complete corporate or legal name.

6. How benefits are divided among your beneficiaries: Any benefits due at your death are paid in equal shares to the living primary beneficiaries named on your Designation of Beneficiary form. If you name multiple primary beneficiaries, and one of the primary beneficiaries dies before you, the total benefits due at your death are divided in equal shares among the remaining primary beneficiaries. If all of the primary beneficiaries are deceased on your death, any benefits are payable in equal shares to your contingent beneficiaries who are then living. A deceased beneficiary's share of your total benefits cannot be paid to that deceased beneficiaries listed on your Designation of Beneficiary form

7. Notarization

This form is not valid unless notarized by a Notary Public.

Properly completed forms should be mailed to: Maryland State Retirement Agency, 120 E. Baltimore St., Baltimore, MD 21202-6700

Important note for all individuals filing this form: This form must be filed with the Maryland State Retirement Agency and is not considered to be filed if it is not submitted to the MSRA, but instead submitted to the employing agency. MSRA shall use the last form properly completed and filed with MSRA on or before the date of death to determine who is entitled to receive any benefits owed.

GET TO KNOW YOUR 457 PLAN

Your pension and Social Security may go far, but you will likely need more income for a truly comfortable future. That's where your 457 deferred compensation plan comes in — see why it matters to you!

It's easy to contribute

- Make automatic paycheck contributions.
- Change your contributions any time.

2 Get tax benefits along the way

- Pre-tax contributions lower your tax bill, lessening the impact to your take-home pay.
- Delay all taxes, until you take money out.

3 A wide range of investments are available

- You control investment decisions, choosing from available options.
- Consider a diversified target-date fund or build your own portfolio. Get help with Guided Pathways® www.icmarc.org/quidedpathways.

4 Take out what you need

- You control withdrawals upon separation from service with your employer.*
- Only 457 plans have no early withdrawal penalty regardless of your age.**
- Depending on your plan's rules, withdrawal and loan options may be available while you're still working.
- ** The penalty may apply to non-457 plan assets rolled into a 457 plan and subsequently withdrawn prior to age 59½.

HOW MUCH CAN I CONTRIBUTE?

For 2019, you can save as much as:

- **\$19,000**
- \$25,000 if age 50 or over
- ▶ \$38,000 if you qualify for pre-retirement catch-up contributions.

Reminder: you may be able to contribute accrued sick or vacation leave.

Can't save that much? Even small savings can really add up — start with as little as \$10 per paycheck.

The sooner you save, the more your money can grow — see how at www.icmarc.org/costofdelay.

Already enrolled? Aim to save more—see how at www.icmarc.org/savingsboost.

GET HELP ONLINE

- Manage your account www.icmarc.org/login
- Tips and tools to help you save, invest, and retire www.icmarc.org/education

Your ICMA-RC representative can help.

Cheryl Munroe 1.800.729.4457. ext.1 cmunroe@icmarc.org BUILDING PUBLIC SECTOR
RETIREMENT SECURITY



YOUR RETIREMENT SECURITY CHECKLIST

What I'd like to discuss... **ICMA-RC** Resources My Retirement Plan ☐ Am I saving enough? How will an ☐ IRA – flexible, tax-advantaged way to save increase affect my take-home pay? more for retirement or other financial goals www.icmarc.org/ira Catch-up contributions – am I eligible to save more than the normal limits? ☐ Guided Pathways® – helps you decide how much to save and how to invest www.icmarc.org/guidedpathways ☐ Investment options — what should I know about diversification and risk? Financial Plans – step-by-step help for overall financial security Beneficiaries – what should I consider when www.icmarc.org/financialplans updating my beneficiary designations? Premier Services – additional resources ☐ Withdrawals – what are my options and for higher-balance participants how long will my savings last? www.icmarc.org/premier Your Information Phone: Name: _____ Email: Employer: _____ Your ICMA-RC Retirement Plans Specialist — Your ICMA-RC CERTIFIED FINANCIAL PLANNER™ help with your retirement account questions help with your overall personal finances Cheryl Munroe 202.682.6443. cmunroe@icmarc.org





457 DEFERRED COMPENSATION PLAN EMPLOYEE ENROLLMENT FORM

- Use this form to open an account with ICMA-RC. Read the instructions on the back before completing this form. Please print legibly in blue or black ink.
 To make legal changes (i.e., change of name, marital status, or beneficiary changes) use the Employee Information Change Form.
 To make address changes, investment allocation changes or fund transfers, please visit Account Access (www.icmarc.org) or use VantageLine (800-669-7400).

 Return this form to your employer promptly. 	Your employer must provide this form to ICMA-R	C <u>before</u> the payroll date of your first deferral.
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 Return this form 	to your employer promptly. Your employer n	nust provide this	form to IUMA-RC <u>before</u> ti	ne payroll date	of your first deferral.			
1 Required Par- ticipant	Employer Plan Number Employer Plan Name Social Security Number Date of Birth / / (mm/dd/yyyy)							
Information	Full Name of Participant (Last, First, MI)							
Information in this box must be completed to avoid processing delays.	Gender						(mm/dd/yyyy) Rehired?	
30.070.	Check if you							
	CityStateStateState							
	Daytime Phone Number () Evening Phone Number ()							
	Job Title: Email Address							
2			<u> </u>				0/ / **	
E Beneficiary	<u> </u>	Date of Birth	Relationship	to you	Social Security	y Number	% of benefit	
Designation	Primary Beneficiaries:		Spouse D Other: _				_ [
Note: Please		1 1	Spouse D Other:_				_	
make sure per- cent amounts	Contingent Beneficiaries, if any:		-				Total = 100%	
total 100%, Use whole percent-	Contingent Beneficialles, if any:	1 1	☐ Spouse ☐ Other:_					
ages. Please see		1 /	Spouse D Other:_					
instructions on			,				Total = 100%	
reverse side.								
3 Amount of Deferral	I authorize my employer to defer% or \$ from my pay each pay period to be contributed to my ICMA-RC account, starting on / (effective date). Please indicate which type(s) of deferrals are included in the above amount: Normal deferral Catch-up contributions: Please indicate ONE of the following types of catch-up rules you are using: "pre-retirement" provision OR "age 50" provision							
4 Allocation of Contributions	Option #1 - "Managed Accounts" – By electing this option, you agree to have your account professionally managed by ICMA-RC. If you elect this option, do not complete Option #2. Please provide all information below (incomplete information will cause a delay in your Managed Accounts enrollment): Annual Salary: \$ Your Annual Plan Contribution % or \$ Additional Employer Annual Contribution (if applicable) Desired Retirement Income (% of existing after-tax salary) % (100% is recommended) Social Security Income - Check this box if you wish to include an estimate of Social Security benefits as part of Managed Accounts							
Please choose <u>one</u> of the following options							ole) sh to	
	Option #2 Input the fund codes and allocation percentages (must total 100%) to show how contributions to your account will be invested. A list of			ALLOCATION				
				Code	Percent (Code	Percent	
	funds and codes can be found on the <i>Investment Options Sheet</i> . Read Section 4 of the form instructions for information on how assets will be invested in the absence of accurate and complete instructions.							
	Note: Please use whole percentages.				TC	DTAL = 100%		
F	I acknowledge that I have read and a	gree to the dis	closure on the back of	this form. (S	ee Instructions 5 & 6	6.)	···	
5 Employee								
Signature	Participant Signature		Date		Employee I		yer Use Only)	
6							· · · · · · · · · · · · · · · · · · ·	
Employer's					******			
Authorization	Authorized Employer Official's Signature		Date					



457 DEFERRED COMPENSATION PLAN EMPLOYEE ENROLLMENT FORM INSTRUCTIONS

Before you complete this form, please read the accompanying literature so you understand the plan's provisions. After you enroll, and your account at ICMA-RC has been established, you can make future changes to your account such as address and/or fund transfers using Account Access (www.icmarc.org) or VantageLine (800-669-7400).

IMPORTANT NOTE: Please do not delay in submitting this form. If we do not have your form by the time we receive your first deferral, we will be unable to invest your retirement plan assets, and they will be returned to your employer.

You will receive a Welcome Letter from ICMA-RC confirming that your enrollment is complete. You will also receive quarterly statements. Please review these carefully and notify ICMA-RC immediately of any errors.

- 1. PARTICIPANT INFORMATION Please complete this section carefully. The employer plan number is available from your employer or ICMA-RC Investor Services at 800-669-7400.
- 2. BENEFICIARY DESIGNATION Print beneficiaries' names and Social Security Numbers and designate their relationship to you and the percentage to be received.

Beneficiary percentages are invalid if your request omits percentages or includes percentages that do not equal 100% or were expressed with fractions.

To update your beneficiary information, please use the *Employee Information Change* form. You can download a pdf of the form by accessing our Web site at www.icmarc.org/forms. Please note that beneficiary information cannot be provided over the telephone.

The IRS has certain rules governing disbursement of funds to beneficiaries. These rules are outlined in your employer's plan and in ICMA-RC's Participant and Beneficiary Withdrawal Packets.

If none of your primary beneficiaries are living upon your death, your assets will be distributed to your estate unless you have designated a contingent beneficiary.

Note: If a Social Security Number is not provided for beneficiaries, and/or ICMA-RC cannot locate the named beneficiaries, the account balance will be paid to your estate.

SPECIAL CERTIFICATION FOR PARTICIPANTS IN COMMUNITY PROPERTY STATES - If you are married and live in a Community Property state, you must generally name your spouse as your beneficiary, unless your spouse waives this right. ICMA-RC cannot be responsible for an employee's failure to properly designate a beneficiary in accordance with state law requirements and the employee's failure to provide the certification required by this enrollment process. Please be advised that failure to meet state law requirements with respect to your beneficiary designation may result in your beneficiary designation being invalid, and the payment of benefits to someone other than your designated beneficiary. If you choose to name a beneficiary that is not your spouse, you and your spouse will need to complete the Community Property Spousal Waiver form. Contact 800-669-7400 for more information and to request the waiver form.

3. AMOUNT OF DEFERRAL - IRS regulations allow you to defer the lesser of (1) a dollar limit in effect for that year. If you are age 50 or older, you may make additional annual catch-up contributions of a dollar limit in effect for that year, or (2) the full 100% of your gross income after subtracting any Section 414(h) picked-up contributions (mandatory employee contributions to 401 qualified retirement plans made with pre-tax dollars). In addition, the "Pre-Retirement" catch-up provision allows eligible participants to contribute additional amounts during the three years prior to the calendar year of their declared normal retirement age. For the applicable dollar limits, please log on

to www.icmarc.org or contact Investor Services at 800-669-7400. A participant may increase, decrease, and/or start, stop and restart contributions by executing appropriate forms and will be effective, if practical, the first pay period of the calendar month commencing after the date the amendment is executed. If you defer more than allowed under IRS regulations, it is your responsibility to correct the error.

4. ALLOCATION OF CONTRIBUTIONS - You may either elect Option 1 "Managed Accounts" and have ICMA-RC manage your account for you or Option 2 and select your own investments.

Option 1 - A separate ongoing annual fee will be deducted from your account for participation in Managed Accounts. Please read the enclosed *ICMA-RC Guided Pathways™ Fund Advice and Managed Accounts Investment Advisory Agreement* for additional information. The following default values will be used if you do not provide appropriate information:

<u>Desired Retirement Age</u> - Age 65 <u>Desired Retirement Income</u> - 100% of existing annual after-tax salary <u>Estimated Social Security Income</u> - Include the Managed

Accounts Social Security estimate

Option 2 - Your contributions can be invested in one or more funds available to your plan (your employer may place restrictions on investment in certain funds). Use whole percentages for your allocations (e.g., 50 percent, NOT 33 1/3 percent). Do not use fixed dollar amounts. Please read Making Sound Investment Decisions: A Retirement Investment Guide and the appropriate prospectus for full descriptions of the funds. If no allocation instructions are provided, or the percentages do not total 100%, assets will be allocated to the default investment selected by your employer until additional instructions are received from you. Review the Notice Regarding Default Investments included in the 457 Enrollment Kit for more information.

For more information regarding the Securities Investor Protector Corporation (SIPC), including the SIPC brochure, please contact SIPC at www.sipc.org or (202) 371-8300.

5 & 6. AUTHORIZED SIGNATURES - Once you have completed this form, sign it and submit it to your employer for approval.

Note that by signing this form you acknowledge that you agree to the following:

By electing Option 1 "Managed Accounts" in Section 4, I have received and read the ICMA-RC Guided Pathways™ Fund Advice and Managed Accounts Investment Advisory Agreement and ICMA-RC's Form ADV Part II and agree to the terms and conditions stated in the Investment Advisory Agreement.

I have received and read the current VantageTrust Company's Making Sound Investment Decisions: A Retirement Investment Guide and the appropriate prospectus. I understand that ICMA-RC has established required procedures for Internet and telephone transfers that include personal identification numbers, recording of instructions, and written confirmations. In the event I choose to transfer funds by Internet or telephone, I agree that neither the VantageTrust Company, ICMA-RC, ICMA-RC Services, LLC, nor Vantagepoint Transfer Agents, LLC, will be liable for any loss, cost, or expense for acting upon any Internet or telephone instructions believed by it to be genuine and in accordance with the required procedures.

An authorizing signature does not represent an obligation to use the telephone transfer feature available on VantageLine.

Welcome to ICMA-RC!



Use this packet to:

- Transfer From an Account at Another Financial Organization (Non ICMA-RC Account) to a 457 Plan or 401 Plan Account at ICMA-RC
- Transfer From an Existing ICMA-RC Account to a 457 Plan or 401 Plan Account at ICMA-RC

Do not use this packet to:

- Transfer From an Existing ICMA-RC Account to Another Financial Organization
- Transfer To a Vantagepoint IRA
- Transfer From a 457 Plan With Your Current Employer to an ICMA-RC 457 Plan Also With Your Current Employer

This packet includes:

- Important Instructions Before You Begin
- Form Instructions
- Form #1: Direct Rollover/Transfer to ICMA-RC Form
- Form #2: Transfer From ICMA-RC to ICMA-RC Form
- Special Tax Notice Regarding Plan Payments

This packet is designed to help you with the rollover/transfer process. If you have any questions, please contact ICMA-RC's Investor Services toll-free at 800-669-7400.

Before you begin, determine which form(s) to complete

If you are transferring assets from another retirement plan provider (non-ICMA-RC account) to an account at ICMA-RC, you will need to complete Form #1, the *Direct Rollover/Transfer to ICMA-RC Form*. You should also contact the plan provider and ask if they require their own paperwork to be completed in addition to the ICMA-RC transfer forms.

If you are transferring assets from one ICMA-RC account to another ICMA-RC account, you will need to complete Form #2, the *Transfer From ICMA-RC To ICMA-RC Form*.

<u>Co-Provider Transfers</u>: If you are transferring assets from another provider's 457 plan with your current employer to an ICMA-RC 457 plan with your current employer, please contact ICMA-RC and request the 457 Co-Provider Transfer to ICMA-RC Form. Please do not submit the forms in this packet.

Request	ICMA-RC Form
Transfer to ICMA-RC from another plan provider (with a former employer)	Form #1, Direct Rollover/Transfer to ICMA-RC Form
Transfer from one employer's plan with ICMA-RC to another employer's plan also with ICMA-RC	Form #2, Transfer From ICMA-RC To ICMA-RC Form

Also remember to:

- Review the instructions for the appropriate form (contained in this packet).
- Complete the form.
- Make copies of the completed form.
- Send the originals to ICMA-RC.

Please Note: If you would like to establish a Vantagepoint IRA, please visit ICMA-RC's Web site at www. icmarc.org or call 800-669-7400 and request the IRA Account Application forms.

MAIL/WIRE INSTRUCTIONS FOR TRANSFERRING FUNDS TO ICMA-RC

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY.

Please Note: Use the enclosed return envelope for the transfer forms only. Please send any checks to the addresses listed below.

Transfers to an ICMA-RC 457 Plan:

Send checks to: Send wire transfers to:

Vantagepoint Transfer Agents/457 M & T Bank

c/o M & T Bank ABA #022000046

P.O. Box 64553 Vantagepoint Transfer Agents/457

Baltimore, MD 21264-4553 Account #42538001

Please reference the following information on the check or wire:

 30XXXX (six-digit plan # beginning with "30" specified in Section 2 of the Direct Rollover/Transfer to ICMA-RC Form)

Investor name and last four digits of SSN

Transfers to an ICMA-RC 401 Plan:

Send checks to: Send wire transfers to:

Vantagepoint Transfer Agents/401 M & T Bank

c/o M & T Bank ABA #022000046

P.O. Box 64668 Vantagepoint Transfer Agents/401

Baltimore, MD 21264-4668 Account #42537981

Please reference the following information on the check or wire:

 10XXXX (six-digit plan # beginning with "10" specified in Section 2 of the Direct Rollover/Transfer to ICMA-RC Form)

Investor name and last four digits of SSN

Direct Rollover/Transfer to ICMA-RC Form: Form #1 Instructions

Use this form if your current plan provider has agreed to accept ICMA-RC's transfer forms, or if the other provider requires ICMA-RC's paperwork in addition to their own forms.

Return the form to ICMA-RC in the envelope provided.

Section 1: Complete section 1 with your personal information.

Section 2: Complete section 2 by indicating the 457 or 401 account number and the employer's name of the account you are **transferring to.**

Section 3a: Transfer From

Please indicate the type of account you are transferring.

Note: For 457 transfers containing non-457 assets, the transferring financial organization must detail the 457 versus non-457 assets on the check. Non-457 assets rolled into 457 plans must be tracked separately since these assets may be subject to the 10% early distribution penalty upon later withdrawal. If no breakdown is provided for 457 transfers, ICMA-RC will consider the entire transfer 457 assets.

Section 3b: Transfer Amount

Please complete the transfer amount information by indicating whether you wish to transfer the total value of your account or a portion of your account. Please indicate the dollar amount and funds you wish to transfer if it is a partial transfer.

Please designate the percent of after-tax contribution (basis) that should be transferred. If no percentage is provided, 100% will be transferred. The transferring financial organization must document the after-tax contribution (basis) on the check to ICMA-RC. If you believe you have an after-tax contribution (basis), please designate the after-tax "type" and dollar amount. If there is a difference between the transferring financial organization's records and your records, ICMA-RC will use the amount provided by the transferring financial organization. If no after-tax contribution (basis) is provided, ICMA-RC will consider the entire transfer to be pre-tax.

After-tax contribution (basis) is the amount of after-tax assets you have contributed to or rolled into the account you are transferring to ICMA-RC, excluding any associated earnings or losses on those contributions.

Please Note: Only 401 plan to 401 plan transfers allow transfers of after-tax contributions (basis). In all other cases, the after-tax contributions (basis) should be sent directly to you in a check by the transferring financial organization.

Section 4: Investment Allocation

Please read this section carefully. It contains detailed information on how the assets you transfer to your ICMA-RC account will be invested.

Section 5: Participant Signature

By signing this form, you are attesting to the following: I have received and read the current VantageTrust's Making Sound Investment Decisions: A Retirement Investment Guide and the applicable prospectus for my investments.

As required by law and under penalty of perjury, I certify that the Social Security Number (taxpayer identification number) I provided for myself is correct.

I acknowledge that any outstanding loan(s) will default as outlined in my employer's plan.

I acknowledge that I received and reviewed the *Special Tax Notice Regarding Plan Payments*, and I hereby waive the "reasonable waiting period" required under IRS rules regarding payments from my retirement plan.

I hereby agree to indemnify the custodian ICMA-RC (its agents, affiliates, successors and employees) and J.P. Morgan Chase Bank, N.A., ICMA-RC Services and their affiliates from any and all liability resulting from my failure to meet any IRS requirements.

Section 6: Employer Authorization

By signing this section, your employer or former employer authorizes that you are eligible to transfer to the account in Section 2.

Section 7: Signature Guarantee

Some plan providers require a signature guarantee on the transfer request form (ICMA-RC does not). Please check with your current plan provider to see if they require a signature guarantee, as the lack of a required signature guarantee may delay the processing of your transfer request. Signature guarantees can be obtained at most local banks.

Section 7a. ICMA-RC Use Only. Representative signs when valid identification has been verified.

Section 7b. Representative Comments. For internal use only.

Section 8. ICMA-RC/ICMA-RC Services Authorization

This section verifies to the transferring trustee or custodian that ICMA-RC maintains an eligible 457 or 401 plan which is eligible to receive transfers.

Section 9. Check/Wire Instructions.

Important Note

If you are a new participant in the ICMA-RC plan into which you are transferring assets, please complete and send the appropriate enrollment form for your plan. If you do not have an enrollment form, please call ICMA-RC at 800-669-7400.

Once ICMA-RC receives the necessary forms, we will handle the rest. We will contact you if more information is needed and contact the other provider to initiate the transfer.

Please mail your completed forms to:

ICMA-RC Attn: Workflow Management Team PO Box 96220 Washington, DC 20090-6220

For additional questions, please call ICMA-RC at 800-669-7400.



Direct Rollover/Transfer To ICMA-RC Form: Form #1 - Page 1 of 3

- Do not use this form to transfer from a 457 plan with your current employer to an ICMA-RC 457 plan also with your current employer.
- Use this form to request a direct rollover/transfer of assets from your previous employer's retirement plan (401 defined contribution, 401 defined benefit, 403(b), 457), or Traditional or Conduit or SEP IRA to an ICMA-RC 457 or 401 plan. Do not use this form to request a transfer to a Vantagepoint IRA.

• If you are new to the ICMA-RC plan you are transferring into, you must also complete the appropriate enrollment form.

1	Full Name of Participant					
Personal Information	Losi		First	First		
	Social Security Number (for tax reporting purposes)	Date of Birth		Daytime Phone Numbe	r	
	Mailing Address/Street	/ . Monih Day	/ _. Year	(). Area Code	Marital Status	
	. City		State	Zip Code	Married Single	
2	I want to transfer assets to my ICMA-RC: <u>[Ch</u>	neck only one box. E	ach transfer requires a	separate form.)		
Transfer To	☐ 457 Plan Account Number: <u>3</u> <u>0</u> ☐ 401 Plan Account Number: <u>1</u> <u>0</u>	Етр	loyer Plan Name	•		
3a	I request a liquidation (see 3b) and transfer		loyer Plan Name			
Transfer From (must be completed for all transfers)	Transfer From: Trustee/Custodian Name: Employer Plan Name (if applicable): Trustee/Custodian Phone Number: Trustee/Custodian Address: Plan/IRA Account Number: Account Type: Non ICMA-RC 457 plan account Non ICMA-RC 401 plan account Non ICMA-RC Traditional or Conc Note to Transferring Financial Organ 457 breakdown on the check.		Non ICMA-RC		it the 457 versus non-	
3b Transfer Amount	I wish to liquidate and transfer:	e (Estimated Transfer ,	Amount \$)		
(must be completed)	OR Partial transfer in the amount OR	of\$	•			
	☐ The following portion of my o	account in the manne	r specified below:			
	Fund Name	Dollar Amount	Fund Name		Dollar Amount	
	1) 2) _	1 1 1 10 100 100 100 10 10 10 10 10 10 1	•			
	For 401 to 401 Transfers Only: 100% of my after-tax contribution (basis) will	% of my after-tax be transferred.				
	The transferring financial organization must o	document the after-tax	contribution (basis) or	the check to ICMA-RC. To	verify their records.	
	please designate the after-tax "type" and do		_	P. M. A. T. C. Law (MARK T. MARKAMANA)	,	
	For 401 to non-401 Transfers: Transfer directly to you.	s of after-tax contribu	tions (basis) are not all	owed. Any after-tax contrib	ution will be sent (EXTERNAL)	



Direct Rollover/Transfer To ICMA-RC Form: Form #1 - Page 2 of 3

Employer Plan Number

Social Security Number

4	Transfers to a 457 Plan with ICMA-RC	
Investment Allocation	Assets will be invested in your account according to your rollover allocation instructions. In the absence of valid rollover allocation instructions, assets will be invested according to the allocation instructions for contributions to your account (or to the default fund by your employer, if you have not yet provided allocation instructions for the investment of contributions to your account).	n selected
	New York State 457 Deferred Compensation plans: If your 457 plan account is with an employer in New York State, It transferred assets will be invested according to the same allocation instructions that are used for the investment of contributions to account (or to the default fund selected by your employer, if you have not yet provided allocation instructions for the investment of contributions to your account).	your
	Transfers to a 401 Plan with ICMA-RC	
	Assets will be invested in your account according to your rollover allocation instructions. In the absence of valid rollover allocation instructions, assets will be invested in the default fund selected by your employer. You can confirm your rollover allocation instruction contacting ICMA-RC at 800-669-7400, or by accessing your account online at www.icmarc.org and going to the "Future Allocat link."	ions by
	ICMA-RC will send you a confirmation notice when the transferred assets have been received and credited to your account. You we the ability to transfer your assets to any investments available within your plan at any time by contacting ICMA-RC at 800-669-74 by accessing your account online at www.icmarc.org.	
5 Participant Signature	I acknowledge that I have read and agree to the disclosures shown in the instructions for this section. I have also read and agree process described in Section 4 of this form relating to how the transferred assets will be invested within my account.	to the
J	1 authorize and request the custodian of my existing retirement plan specified in Section 3a to liquidate and transfer my existing at the ICMA-RC account specified in Section 2 of this form.	ccount to
	Signature Date//(mm-dd-yyyy)	
6 Employer Authorization	Please obtain signature of the employer sponsoring the plan into which you are transferring assets.	
	Date / (mm-dd-yyyy) Current Employer Authorization	
7 Signature Guarantee	Signature Guarantee Some plan providers require a signature guarantee on the transfer request form (ICMA-RC does not). Please check with your curre provider to see if they require a signature guarantee, as the lack of a required signature guarantee may delay the processing of your transfer request. Signature guarantees can be obtained at most local banks.	nt plan 'our
	Authorized Officer to Place Stamp Here Guarantor	
	Title	
:		
	LEXTERN	VAL)



Employer Plan Number

Direct Rollover/Transfer To ICMA-RC Form: Form #1 - Page 3 of 3

Social Security Number

Building Retirement S		
7a ICMA-RC Use ONLY	Representative that verified ID Type of ID	Month Day Year
7b Rep Comments - for Internal Use Only	□ No LOA needed	
8 ICMA-RC/ICMA- RC Services Authorization (Please Do Not Complete)	ICMA-RC/ICMA-RC Services hereby attests that it main will accept the above referenced transfer of assets. May Dathy Authorized Signature, ICMA-RC/ICMA-RC Services	tains an eligible 457 or 401 plan account for the above named individual and Assistant Secretary Title
Check/Wire Instructions for Former Trustee/Custo- dian	follow the appropriate instructions. 457 Plan Send checks to: Vantagepoint Transfer Agents/457 c/o M & T Bank	Seets are being transferred to a 457 plan or 401 plan account and Send wire transfers to: M & T Bank ABA #022000046
-	to discontinuo del control del	Vantagepoint Transfer Agent/457 Account # 42538001 g with "30" specified in Section 2), investor name and SSN on check/wire.
	401 Plan	
	<u>Send checks to:</u> Vantagepoint Transfer Agents/401	<u>Send wire transfers to:</u> M & T Bank
	c/o M & T Bank	ABA #022000046
	P.O. Box 64668	Vantagepoint Transfer Agent/401
	Baltimore, MD 21264-4668	Account # 42537981
	Please reference: 10XXXX (six-digit plan # beginnin	g with "10" specified in Section 2], investor name and SSN on check/wire.

(EXTERNAL)

Transfer From ICMA-RC To ICMA-RC Form: Form #2 Instructions

Use this form to consolidate your ICMA-RC accounts. You can use this form to request a transfer of assets from one ICMA-RC plan to another ICMA-RC plan.

Section 1: Personal Information

Provide all of the requested personal information.

Section 2: Transfer To

Indicate the ICMA-RC account that you are transferring the assets to, and provide the employer plan name.

Section 3: Transfer From

Indicate the ICMA-RC account that you are transferring the assets from, and provide the employer plan name.

Section 4: Transfer Amount

Indicate whether you wish to transfer the total value (100%) of your account or a portion of your account. If you are requesting a partial transfer, specify the dollar amounts and funds you wish to transfer.

Section 5: Investment Allocation

Please read this section carefully. It contains detailed information on how the assets you transfer to your ICMA-RC account will be invested.

Note to participants in 457 plans residing in New York State: Your assets will be invested according to the allocation instructions on file for your current contributions.

Section 6: Participant and Employer Signatures

Please sign the form in this section and obtain authorized signatures from both your current and previous employers. The employer signatures are required in order to process your transfer request.

Please return the completed forms to ICMA-RC

Fax to: 202-682-6439

Attn: Workflow Management Team

OR

Mail to: ICMA-RC

Attn: Workflow Management Team

P.O. Box 96220

Washington, DC 20090-6220

Qualified Joint and Survivor Annuity (applies to married participants in some 401 plans only)

If you are married and transferring assets from an ICMA-RC 401 plan, **and** the employer sponsoring the plan has elected the Qualified Joint and Survivor Annuity Option, your spouse must consent to the transfer of assets to another retirement plan. You and your spouse will need to complete the *Waiver of Qualified Joint and Survivor Annuity Form* (available online at www.icmarc.org/forms or by calling ICMA-RC at 800-669-7400).



Transfer From ICMA-RC To ICMA-RC Form: Form #2

- Use this form to request a direct rollover/transfer of assets from one ICMA-RC plan to another ICMA-RC plan. Do not use this form to request a transfer to a Vantagepoint IRA.
- If you are new to the ICMA-RC plan you are transferring into, you must also complete the appropriate enrollment form.

1_	Full Name of Participant						
[]			.				
Personal Information	Last Social Security Number (for tax reporting purposes)	Date of Birth	First	Daytime Ph	one Number		M.i.
		1. 1.		()		
	Mailing Address/Street	Month Day	Year	Area Code		Marital :	Status
	City		State	Zip Code		Married	Single
2	I want to transfer assets to my ICMA-RC: <u>[Cf</u>	heck only one box. Each	ransfer requires a se	parate form.	1		
Transfer To	457 Plan Account Number: 3 0	Employe	Plan Name				
	401 Plan Account Number: 1 0		Plan Name				
2	I want to transfer assets from my ICMA-RC: [
3 Transfer		·	·	·	•		
From	457 Plan Account Number: 3 0	Employer	Plan Name				
	401 Plan Account Number: 1 0		Plan Name				
	Existing Vantagepoint IRA Account Nur	mber: <u>7</u> <u>0</u>					
4	I wish to liquidate and transfer:						
Transfer	My entire account OR	The following po	rtion of my account	in the manne	r specified below	<i>r</i> :	
Amount	Fund Name	Dollar Amount	Fund Name			Dollar	Amount
	1}		3)				
	2)		4)				
	For 401 to 401 Transfers:% my after-tax contribution (basis) will be transfor 401 to non-401 Transfers: Transfe	ferred.					
	to you.			,,			,
5 Investment Allocation	Transfers to a 457 Plan with ICMA-R Assets will be invested in your account acco- tions, assets will be invested according to the employer, if you have not yet provided alloc	rding to your rollover allow e allocation instructions fo	r contributions to yo	ur account (o	r to the default fu	allocation i nd selected	instruc- l by your
	New York State 457 Deferred Competerred assets will be invested according to the forto the default fund selected by your emplyour account).	ne same allocation instruct	ons that are used fo	r the investm	ent of contribution	ns to your a	iccount
	Transfers to a 401 Plan with ICMA-Re. Assets will be invested in your account accordions, assets will be invested in the default full ICMA-RC at 800-669-7400, or by accessing	rding to your rollover allow and selected by your emplo	yer. You can confirr	n your rollove	er allocation instr	uctions by o	instruc- contacting
	ICMA-RC will send you a confirmation notice the ability to transfer your assets to any inve- accessing your account online at www.icma	stments available within ye	ets have been receiv our plan at any time	red and cred by contacting	ited to your acco g ICMA-RC at 80	unt. You wii 10-669-740	ll have O or by
6	I acknowledge that I have read and agree to process described in Section 5 of this form re	the disclosures shown in elating to how the transfer	the instructions for the ed assets will be inv	is section. I h ested within	iave also read ar my account.	nd agree to	the
Participant and Employer Signatures	I authorize and request ICMA-RC to liquidate retirement plan account specified in Section 2	the retirement plan accor 2 (above).	int specified in Secti	on 3 (above)			RC
	Employee Signature				Dafe		
	Current Employer Authorization				Date		
	Previous Employer Authorization (Required for t	ransfer from one employ	rer to another)		Dale		
	Participant's Termination Date/	/(mm/	dd/yyyy)	Vesting		%	



ICMA RETIREMENT CORPORATION
P.O. BOX 96220
WASHINGTON, DC 20090-6220
1-800-669-7400
EN ESPAÑOL LLAME AL 1-800-669-8216
WWW.ICMARC.ORG



457 DEFERRED COMPENSATION PLANS

CONTRIBUTION FORM

- 1. Use this form to change the amount you contribute to your 457 deferred compensation plan account with ICMA-RC. **Note:** You should only use this form if you have previously established an account in your employer's plan.
- 2. Return the completed form to your employer.

Year	Maximum Contribution	Age-50 Catch-Up	Pre-Retirement Catch-Up
2019	\$19,000 (Approximately \$731 every two weeks)* * If you are paid semi-monthly (24 pay periods per year), contribute \$792 per pay period.	\$6,000 (\$25,000 total)	\$19,000 (\$38,000 total)

1 PARTICIPANT INFORMATION
Employer Plan Number: Employer Plan Name:
Identification (Please provide your Social Security Number or Employee ID)
Social Security Number: OR Employee ID:
Full Name of Participant:
2 CONTRIBUTION AMOUNT & EFFECTIVE DATE
Contribution Amount (per pay period)
I authorize my employer to contribute the amount specified below from my pay each pay period, to be contributed to my 457 deferred compensation plan account with ICMA-RC. (Specify a percentage or dollar amount for pre-tax contributions.)
Pre-Tax Contributions: Percentage: % or Dollar Amount: S (per pay period)
Normal Contribution Limit (2019): 100% of compensation or \$19,000, whichever is less.
Catch-up Contributions: If you are taking advantage of either of the catch-up contribution provisions available to 457 plan participants, please check the applicable box below.
Age 50 catch-up contributions (up to \$6,000 more than the normal limit. \$25,000 maximum.)
Special pre-retirement catch-up (up to \$19,000 more than the normal limit. \$38,000 maximum.)
Please read ICMA-RC's Pre-Retirement Catch-Up Form for more information.
Effective Date
All contribution changes will be effective as of the first pay period of the calendar month following the date you submit this form to your employer, or as soon as administratively possible thereafter, unless a later date is specified below.
Future Effective Date (cannot be earlier than the beginning of the following month):/
3 SIGNATURES
Participant Signature Date://
Employer Signature Date://

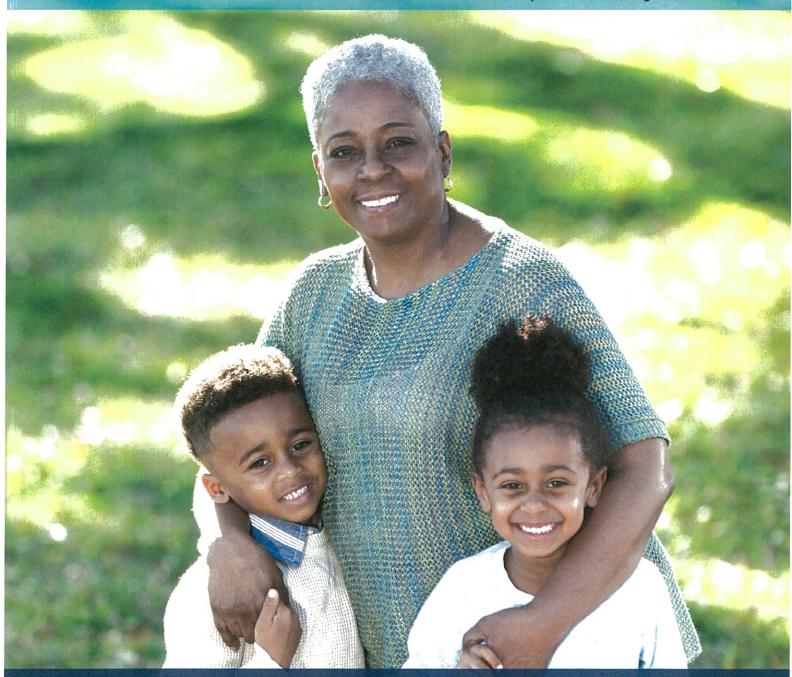


ONCE I'M RETIRED, THEN WHAT? INCOME SOLUTIONS



Income Challenges

- How do I turn my savings into income?
- ► What if I withdraw too much and run out?
- Or too little and sacrifice my standard of living?



Whether you're nearing or in retirement, how you turn your savings into reliable income matters. This guide is designed to help you understand the options that may be available to you through your ICMA-RC accounts, and personalize them to you so you can realize the retirement you want.

HOW LONG WILL I LIVE?

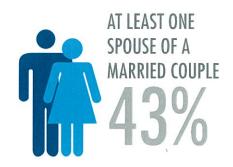
Many retirees should plan for the realistic possibility of living into their 90s.

CURRENT PROBABILITY OF A HEALTHY 65 YEAR OLD AMERICAN LIVING TO 95:

Source: Social Security Administration, Society of Actuaries (2014)





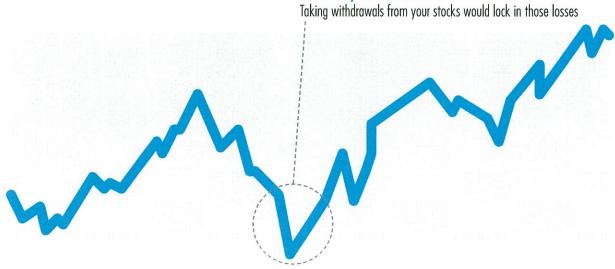


WHAT IF I RETIRE AT THE "WRONG"TIME?

Owning stocks, even in retirement, can make good sense to keep pace with inflation, but . . .

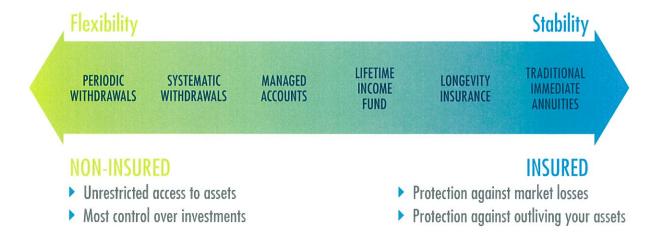
Stock market losses can affect you soon before or after retirement

What if you retire here?



SO, HOW DO YOU DEAL WITH ALL THESE UNKNOWNS?

You need a plan that includes some combination of diversification, flexibility, and certainty. We make available a suite of income and investment solutions to help you regardless of your needs.



THINK ABOUT YOUR FINANCIAL RESOURCES AND PERSONALITY.

You should consider NON-INSURED SOLUTIONS if you:

- Are unlikely to be dependent on your retirement assets for essential expenses

 OR . . .
- Want maximum control and flexibility over your assets

You should consider INSURED solutions if you:

- Will receive little guaranteed lifetime income from a defined benefit pension and Social Security
 OR . . .
- Want extra assurance

Advice solutions are available for those who want extra assistance.

DESCRIBE YOURSELF

Consider the following three approaches — which most closely matches you?



I JUST WANT IT MANAGED FOR ME

Consider if:

- You want the investment decisions made for you and you want specific advice on taking withdrawals
- You don't have the time, knowledge, or interest
- You find that your emotions get in the way





I WANT SOME CERTAINTY ABOUT HOW MUCH I RECEIVE AND FOR HOW LONG

Consider if:

- You will not receive a pension or only receive a small one
- You want added protection for you, and your spouse if applicable, in case you live longer than your life expectancy
- You want added protection against investment losses





I WANT TO DO IT MYSELF WITH LOTS OF FLEXIBILITY AND CONTROL

Consider if:

- You have the experience and discipline to navigate a variety of market conditions
- You want more control over how all your assets are invested and the fees you pay
- You want more flexibility to make adjustments along the way

Next, read on to learn more about the solutions designed for each approach.





Some retirees will just not have the time, interest, or knowledge to play an active role with their investment and withdrawal decisions.

That's who Managed Accounts* is designed to assist.

ICMA-RC's MANAGED ACCOUNTS

- Invests your savings for you
- Provides automatic advice on how to withdraw your savings
- Additional fees apply

LEARN MORE — www.icmarc.org/maretire

Or, log in to your account at www.icmarc.org/login and select the "Investments" tab.

^{*}Investment advice and analysis tools are offered to participants through ICMA-RC, a federally registered investment adviser. Investment advice is the result of methodologies developed, maintained and overseen by the Independent Financial Expert, Morningstar Investment Management LLC. Morningstar Investment Management LLC is a registered investment advisor and subsidiary of Morningstar, Inc. Morningstar, Inc. and Morningstar Investment Management LLC are not affiliated with ICMA-RC. All rights reserved. The Morningstar name and logo are registered marks of Morningstar, Inc.



Some retirees are more focused on adding protection against the risks of investment losses and outliving their savings and should consider boosting their sources of lifetime income.

INSURANCE OPTIONS THROUGH ICMA-RC

- Lifetime income no matter how long you live
- Can provide for spouse
- Help address the market risk of "retiring at the wrong time"
- Added fees and/or restrictions
- Less flexibility and control
- Guarantees: depend on insurer's claims-paying ability

Through your ICMA-RC retirement account, you may have up to three different lifetime income solutions to choose from.



ICMA-RC's LIFETIME INCOME FUND*

VT Retirement IncomeAdvantage Fund

- Income you receive has upside potential and downside protection
- Flexibility you have access to the market value at all times
- Additional 1% guarantee fee
- Excess withdrawals may reduce or terminate guarantees

HOW IT WORKS

Contributions are invested in a balanced portfolio of stocks and bonds in a separate account under a group variable annuity contract.

Retire and begin receiving lifetime income payments, as early as age 55. The payments have the potential to increase but won't decline due to market conditions.

^{*}The VT Retirement IncomeAdvantage Fund is offered through VantageTrust. The Fund invests in a group variable annuity issued by Prudential Retirement Insurance and Annuity Company (Prudential) CA COA #08003, Hartford, CT. Guarantees are based on Prudential's claims-paying ability and are subject to certain limitations, terms and conditions. This annuity is issued under Contract form #GA-2020-TGWB4-0805-RC. Variable annuities are suitable for long-term investing, particularly retirement savings. Prudential and the Rock logo are registered service marks of The Prudential Insurance Company of America, Newark, NJ and its affiliates. Note: This material must be accompanied or preceded by the VT Retirement IncomeAdvantage Fund Important Considerations document.

Flexibility Stability LIFETIME TRADITIONAL LONGEVITY PERIODIC SYSTEMATIC MANAGED INCOME **IMMEDIATE** WITHDRAWALS WITHDRAWALS ACCOUNTS **INSURANCE** FUND **ANNUITIES**

LONGEVITY INSURANCE

- You get a higher payout later for a relatively small purchase amount, compared to other annuity products
- Not subject to IRS Required Minimum Distributions (RMD)
- You have to wait to receive payments

payments you received

Risk that your payments have less purchasing power than anticipated due to increased inflation after your purchase

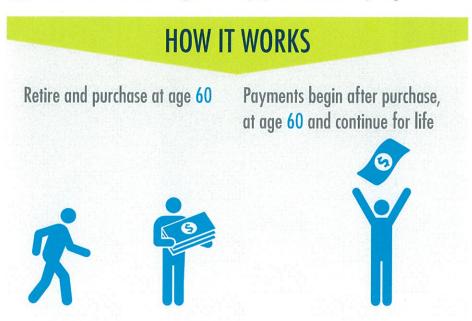
You just need your assets to last 20 years, which allows for easier planning and more flexibility in how you invest. Retire and purchase at age 60 Payments begin at age 80 and continue for life The payments begin at age 80 and continue for life Payments begin at age 80 and continue for life The payments begin at age 80 and continue for life The payments begin at age 80 and continue for life The payments begin at age 80 and continue for life

For illustrative purposes. As long as you are eligible to take distributions under your plan's rules, you may purchase and then begin payouts (up to age 85) at different ages.



TRADITIONAL, IMMEDIATE ANNUITY

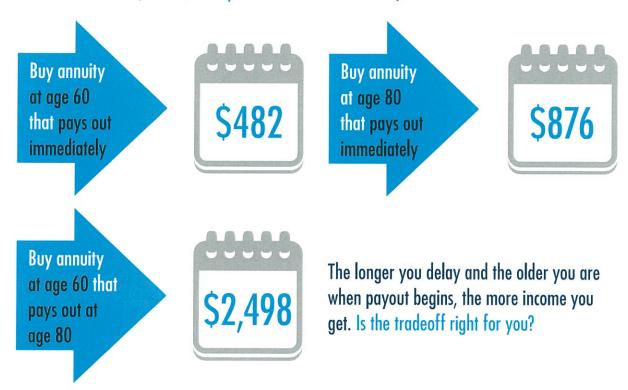
- Generally higher initial payouts than other annuity products
- Choose from different payout options, including inflation-protected payouts
- You no longer retain ownership or access to assets
- You cannot make changes to the payments once they begin



For illustrative purposes. As long as you are eligible to take distributions under your plan's rules, you may purchase at different ages.

COMPARING LONGEVITY AND IMMEDIATE ANNUITIES

Purchase an annuity with \$100,000 and receive monthly income of:



INSURANCE SOLUTIONS THROUGH ICMA-RC — AT-A-GLANCE

SOLUTION	LIFETIME INCOME AND	BUT REMEMBER
LIFETIME INCOME FUND IncomeAdvantage Fund	Most flexible — retain access to market value for you and your beneficiaries	You pay extra guarantee fee and excess withdrawals can reduce or terminate the guarantees
LONGEVITY INSURANCE	Higher payment later in exchange for relatively small purchase amount — eases planning for other assets	You cannot undo the purchase and you have to wait to receive payments
IMMEDIATE ANNUITY Income for Life Program	Highest up-front payment amount	You cannot undo the purchase

Each option provides guaranteed lifetime income once the payout period begins. Those guarantees are subject to the underlying insurer's claims-paying ability.





The third approach to consider is for those who want the most control over their ongoing options and how much they pay.

PERIODIC AND SYSTEMATIC WITHDRAWALS

You can take periodic withdrawals of varying amounts and at varying times, based on your needs. Or, you can get systematic payments each month, quarter, or year — and you can stop, change, or restart these payments at any time.

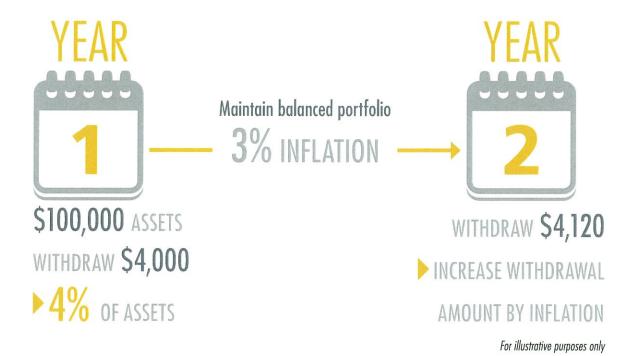
To help guide your withdrawal and investment decisions, you have access to Guided Pathways® Asset Class Guidance and Fund Advice.

LEARN MORE — www.icmarc.org/guidedpathways

If you prefer an even more "do-it-yourself" approach, there are two strategies that you should know about, to help make your money last.

WITHDRAWAL STRATEGY — 4% RULE OF THUMB

The 4% rule involves withdrawing about 4% of your assets from a balanced portfolio of stocks and bonds in your initial distribution year, and then adjusting those withdrawals by inflation in later years.





- Useful reference point to answer:
 "About how much can I withdraw and likely not run out of money?"
- No guarantees, and may not be reliable given today's low interest rates

THE KEY IS TO BE FLEXIBLE

If investments lose value

- Withdraw at lower rate
- Don't adjust for inflation
- Cut back spending

If your investments do well, you may be able to boost your withdrawals.

Review investment and withdrawal strategy yearly and when your situation changes

WITHDRAWAL STRATEGY — BUCKET APPROACH

Divide investments based on when you'll withdraw, then withdraw, replenish and rebalance yearly.

Start each year with...



LOWER-RISK BUCKET — about 5 years' expenses in stable value fund or cash

HIGHER-RISK BUCKET — longer-term expenses in target mix of stocks/bonds

May help you stick to your plan during rough stretches

No guarantees

WHICH STRATEGY IS RIGHT FOR YOU?



You have high savings or sufficient sources of lifetime income — 4% Rule of Thumb

- Could play it safe, target 3% withdrawal rate just don't underspend unnecessarily
- ▶ Or, target higher 5—6% withdrawal rate adjust if you experience investment losses



You tend to get nervous about investment losses — Bucket Strategy

- Can provide the confidence to stick with your strategy during tough times knowing you have assets set aside in lower-risk buckets
- Could add a third bucket for extra assurance one for cash and/or stable value funds, one for bond funds, one for stock funds

Whichever approach is chosen, you have significant control over when and how you receive withdrawals. And do-it-yourself retirees can still benefit from investment and withdrawal advice.

MORE ICMA-RC RESOURCES

FINANCIAL PLANS	Get written guidance for your retirement as well as your insurance, major purchase, college funding, and estate planning needs	www.icmarc.org/financialplans
HEALTH CARE COSTS	Tips, tools, and savings vehicles to help you manage health care costs	www.icmarc.org/rhs www.icmarc.org/medicare
INCOME BENEFITS	What you need to consider in evaluating Social Security and pension benefits	www.icmarc.org/socialsecurity www.icmarc.org/servicecredits
LONG-TERM CARE	Evaluate long-term care insurance options	www.icmarc.org/longtermcare
RMD	We calculate and distribute your RMD automatically while providing you the flexibility to customize your payments	www.icmarc.org/rmd www.icmarc.org/rmdcalc
ROTH CONVERSIONS	Building Roth assets can help you manage your tax bills in retirement	www.icmarc.org/rothconversion
TAXES	We help you with IRS withholding and tax forms	www.icmarc.org/taxplanning
WITHDRAWAL STRATEGIES	Investment options to help you meet your goals, whichever approach you choose	www.icmarc.org/incomegap

For more retirement planning tips and tools — www.icmarc.org/retiree.

As you weigh your retirement income options, follow a strategy that is right for you — there is no "one" correct way. It may even be appropriate for you to use a combination of solutions.

ICMA-RC can help:



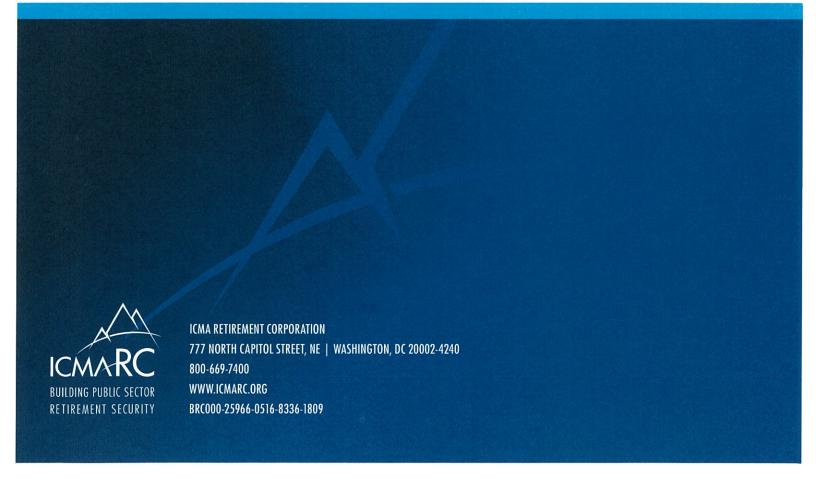
Coordinate your income strategy with your overall financial situation. Consult your ICMA-RC CERTIFIED FINANCIAL PLANNERTM.

Your ICMA-RC Retirement Plans Specialist can help you understand all the investment and income options available to you.



ICMA-RC can also help you manage key expenses in retirement, such as long-term care. Our Long-Term Care Insurance Quote service allows you to evalute policies from different insurers.

LEARN MORE — www.icmarc.org/longtermcare





The path to your financial freedom starts with a SECU Visa credit card.

Open one today or transfer your high rate, non-SECU credit card balances to your existing SECU Visa credit card, and take advantage of our 6.99% balance transfer rate that never expires. Pay off your high rate balances faster and save money for what matters.



No balance transfer fees



Low 6.99% fixed rate until the transferred balance is paid off



Transfer balances now through July 31, 2019

Transfer your balances today at secumd.org/6.99%



Balance transfer offer expires July 31, 2019. Total value of transfers cannot exceed your credit limit. SECU sends either full or partial payment to your creditors in the order you list them. Allow at least two weeks from submitting the balance transfer request for processing. Continue paying each creditor until the transfer appears as a credit. It will take at least 17 days from account opening to initiate your balance transfer request. Within this 17 day time period, you may cancel your balance transfer by calling us at 800-879-7328. Do not transfer any disputed purchase or charge because you may lose dispute rights. Promotion rate of 6.99% is only available for balances transferred from non-SECU accounts.



As New Carrollton Employees You are entitled to join Retro Fitness for ZERO ENROLLEMENT And enjoy an upgraded membership \$19.99 a month includes Unlimited Classes

All City of New Carrollton Employees will receive 50% off your Registration Fee when you register your child/children at New Carrollton Early Learning Center 7823 Riverdale Road New Carrollton, MD 20784 301-577-1868 newcarrolltonelc@aol.com Visit our Website newcarrollton-elc.com