Employee Benefits Guide

August 1, 2023 - July 31, 2024

GLOBAL CITIZENS
PUBLIC CHARTER SCHOOL

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Prepared by
NFP

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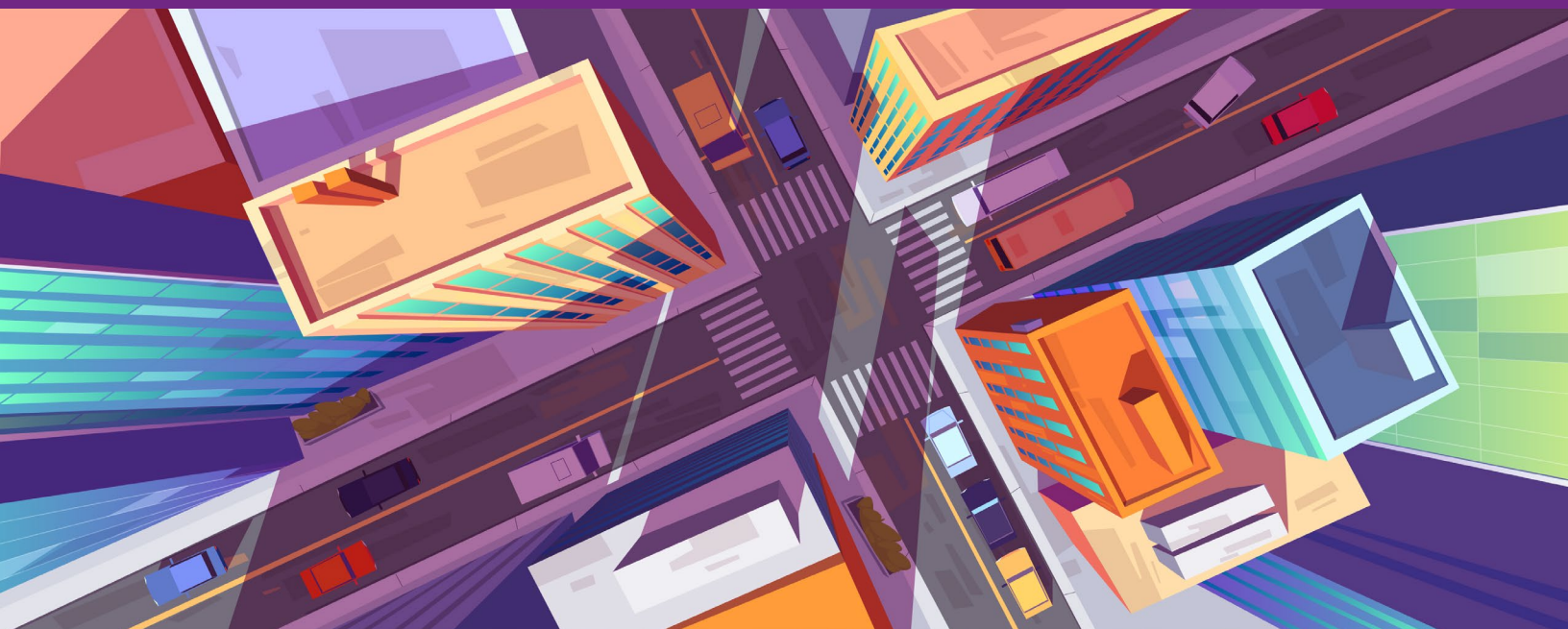
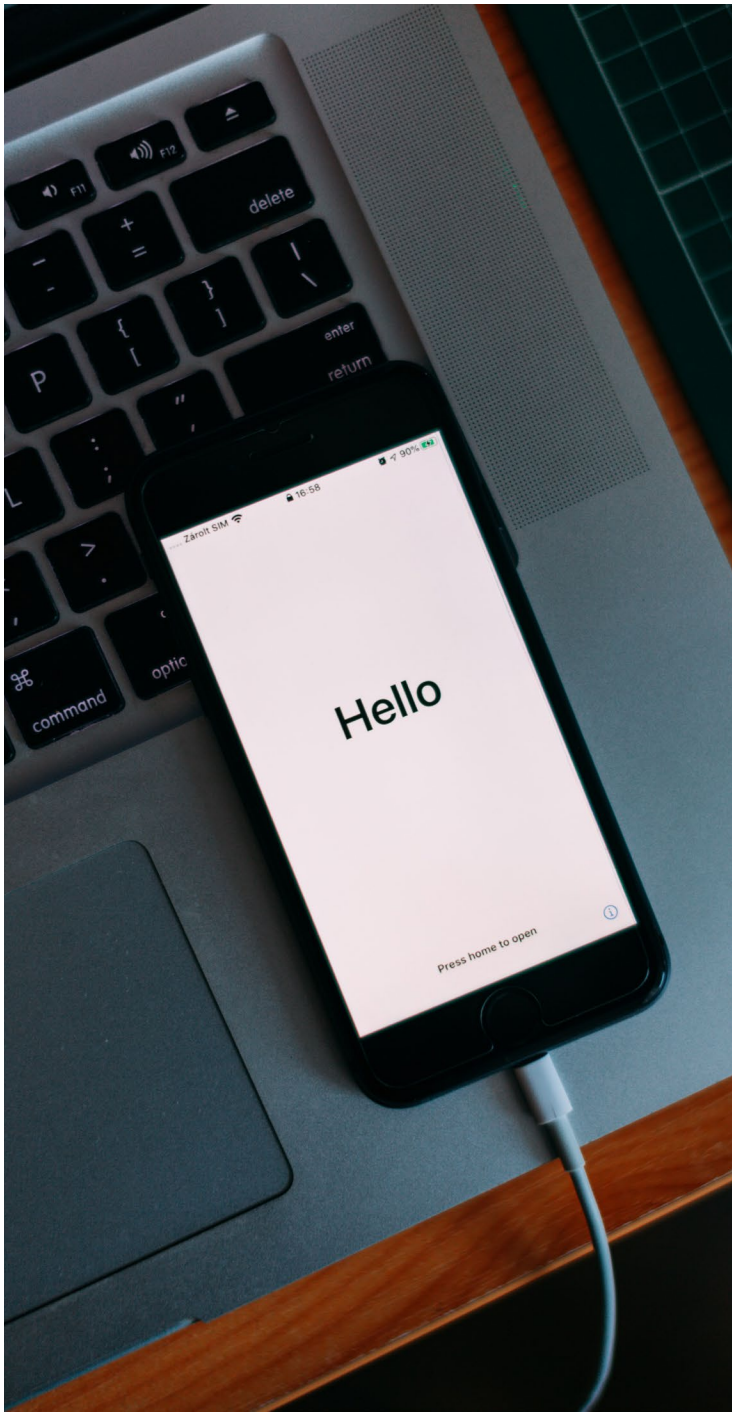


The benefits offered by Global Citizens Public Charter School are designed to provide a comprehensive package for our employees. These benefits are valuable and are provided to assist in managing the health of you and your family.

We encourage you to evaluate and select benefits that best suit the needs for you and your eligible dependents. This benefits guide highlights the many benefit options available to you and explains how to enroll in the benefits you choose. Please read this guide carefully, make your decisions, and enroll.

Welcome



ELIGIBILITY

All regular, full-time employees are eligible for benefits through Global Citizens Public Charter School. For benefits purposes only, a regular full-time employee is an employee who is scheduled to work 30 or more hours per week.

Lawful spouses, and dependent children may be covered under Global Citizens Public Charter School benefits. For a child to be considered a dependent, he or she must be less than 26 years of age regardless of student status. A child who has a physical or mental disability may be eligible for coverage at any age with proof of disability.

Coverage is effective First of the month following or coinciding with date of hire. Open enrollment takes place each year. This is the time, other than for a qualifying life event (as listed below), when you can change your benefits elections. During this period, you must determine if you want to make changes to your benefits. If you wish to do so, you must enroll and/or decline coverages for the coming year.

The effective date for CareFirst Medical, Dental, and Vision is August 1st. The effective date for Renaissance Life, AD&D, and Short Term Disability is November 1st.

QUALIFYING LIFE EVENTS

- Marriage, legal separation or divorce
- Birth or adoption of a child
- Change in employment status for you or your spouse
- Change in a dependent's benefits eligibility status (i.e. a dependent's child exceeding the maximum age for coverage)
- A significant change in the cost or coverage of your spouse's benefits
- Change in place of residence causing a loss of eligibility (i.e. moving outside of the service area)
- Change in the cost of dependent care (only for the Dependent Care Spending Account)
- Loss of a dependent (death)
- Open enrollment for your spouse

If you qualify for a change in your benefits, please notify Global Citizens Public Charter School within 30 days of the change in status. You will need to provide proof of the change.

Medical Benefits

CareFirst BlueChoice HMO Platinum 0

What is the DC Health Link?

DC Health Link is the public exchange in DC

- The shop - small business options program
- Public exchange for small group employers with 1-50 FTEs

Global Citizens School Offers all plan selections.

Metal Level	Plan Pays	Member Pays
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

There are over 50 CareFirst options. Each option has a medal level. The Platinum plans are the highest-priced options and the Bronze Plans are the lowest-priced options.

The employer contribution on the reference plan will be 100% for the employee and nothing towards dependents. If you choose a more costly option, you will also be responsible for the difference in premium between the reference plan and the plan that you elect.

BlueChoice HMO Platinum 0 Summary of Benefits

Non-Integrated Deductible

Services	In-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities
24-HOUR NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
WELLBEING PROGRAM & BLUE REWARDS	
Visit **www.carefirst.com/sharecare** for more information.	You have access to a comprehensive wellbeing program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)	
Individual/Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[2,3]	
Individual/Family	$1,900 Individual/$3,800 Family (separate)
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
PCP AND SPECIALIST SERVICES	
FACILITY CHARGE[4]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2)	$50 per visit
Office Visits for Illness—PCP[4,5]	$10 per visit
Office Visits for Illness—Specialist[4,5]	$20 per visit
Allergy Testing[4]	$20 per visit
Allergy Shots[4]	$20 per visit
Physical, Speech, and Occupational Therapy[4]	$20 per visit
Chiropractic[4]	$20 per visit
Acupuncture[4]	$20 per visit
IMMEDIATE AND EMERGENCY SERVICES	
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	$10 per visit
Urgent Care Center (such as Patient First or ExpressCare)	$50 per visit
Hospital Emergency Room Services	
■ Facility	$100 per visit (waived if admitted)
■ Physician	$20 per visit
Ambulance (if medically necessary)	$20 per service

BlueChoice HMO Platinum 0 Summary of Benefits

Services	In-Network You Pay[1]
DIAGNOSTIC SERVICES	
Labs[6,]	
■ LabCorp	$10 per visit
■ Hospital	$10 per visit
X-ray[6]	
■ Non-Hospital/Freestanding Facility	$20 per visit
■ Hospital	$20 per visit
Imaging[6]	
■ Non-Hospital/Freestanding Facility	$50 per visit
■ Hospital	$200 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)	
Outpatient Surgery (Non-Hospital)	
■ Facility	$50 per visit
■ Physician	$20 per visit
Outpatient Surgery (Hospital)	
■ Facility	$150 per visit
■ Physician	$20 per visit
Inpatient Surgery and Hospital Services	
■ Facility	$200 per admission
■ Physician	$20 per visit
HOSPITAL ALTERNATIVES	
Home Health Care (limited to 90 visits per episode of care)	No charge*
Hospice (Inpatient—limited to 60 days per hospice eligibility period; Outpatient—limited to 180 day hospice eligibility period)	No charge*
Skilled Nursing Facility (limited to 60 days/benefit period)	$20 per admission
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	$200 per admission
Artificial and Intrauterine Insemination[4,7]	Not covered
In Vitro Fertilization Procedures[4,7]	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)	
Office Visits	$10 per visit
Outpatient Services	
■ Facility	No charge*
■ Physician	No charge*
Inpatient Services	
■ Facility	$200 per admission
■ Physician	$20 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	25% of Allowed Benefit
Hearing Aids	Not covered

BlueChoice HMO Platinum 0 Summary of Benefits

Services	In-Network You Pay[1]
PRESCRIPTION DRUGS[8]	
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List
Annual Prescription Drug Deductible	$0
Preventive Drugs	No charge*
Diabetic Supplies, Oral Chemo Drugs and Medication Assisted Treatment Drugs	No charge*
Generic Drugs	30-day supply $10; 90-day supply $20 (maintenance drugs only)
Preferred Brand Drugs[9] (Preferred Insulin $0)	30-day supply $45; 90-day supply $90 (maintenance drugs only)
Non-preferred Brand Drugs[10] (Non-preferred Insulin capped at $30 for 30 days/$60 for 90 days)	30-day supply $65; 90-day supply $130 (maintenance drugs only)
Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply 50% up to $100 maximum; 90-day supply 50% up to $200 maximum (maintenance drugs only)
Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply 50% up to $150 maximum; 90-day supply 50% up to $300 maximum (maintenance drugs only)
PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)	
Routine Exam (limited to 1 visit/benefit period)	In-network-No charge*; Out-of-network-Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	In-network-No charge*; Out-of-network-Reimbursements apply
Spectacle Lenses	In-network-No charge*; Out-of-network-Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)	
Annual Dental Deductible	In-network-$25; Out-of-network-$50
Class I Preventative & Diagnostic Services—Exams (2 per year). Cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	In-network-No charge*; Out-of-network-20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	In-network-Deductible, then 20% of Allowed Benefit; Out-of-network-Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	In-network-Deductible, then 20% of Allowed Benefit; Out-of-network-Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	In-network-Deductible, then 50% of Allowed Benefit; Out-of-network-Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	In-network-50% of Allowed Benefit; Out-of-network-65% of Allowed Benefit

BlueChoice HMO Platinum 0 Summary of Benefits

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 Separate - For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.
3 All drug costs are subject to the in-network out-of-pocket maximum.
4 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
5 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.
6 Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/freestanding facility for X-rays and specialty Imaging.
7 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.
8 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
9 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
10 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

Reminder: To enroll in HMO, HMO Referral and Plus plans, members must live or work within the CareFirst service area of Maryland, Washington, D.C. or Northern Virginia.
Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (PCP). To select a PCP, go to www.carefirst.com/findadoc for the most current listing of PCPs from our online provider directory. You may also call the Member Services number on the back of your CareFirst ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: DC/CFBC/SHOP/GC (R. 1/19); DC/CFBC/SHOP/HMO POS/EOC (R. 1/20); DC/CFBC/DOL APPEAL (R. 1/22); DC/CFBC/SHOP/HMO DOCS (R. 1/20); DC/CFBC/SHOP/2021 AMEND (1/21); DC/CFBC/SHOP/2022 AMEND (1/22); DC/CFBC/SG/HMO/V BRZ 6000 (1/22); DC/CFBC/SG/HMO OA CDH/BRZ 6100 (1/22); DC/CFBC/SG/HMO OA CDH/BRZ 6500 90 (1/22); DC/CFBC/SG/HMO OA CDH/GOLD 1500 (1/22); DC/CFBC/SG/HMO OA CDH/GOLD 1500 90 (1/22); DC/CFBC/SG/HMO OA CDH/SIL 1500 (1/22); DC/CFBC/SG/HMO OA CDH/SIL 2000 (1/22); DC/CFBC/SG/HMO OA CDH/SIL 2100 70 (1/22); DC/CFBC/SG/HMO OA CDH/SIL 3000 (1/22); DC/CFBC/SG/HMO OA CDH/SIL 3000 70 (1/22); DC/CFBC/SG/HMO OA/GOLD 500 (1/22); DC/CFBC/SG/HMO OA/GOLD 1500 (1/22); DC/CFBC/SG/HMO OA/GOLD 3000 (1/22); DC/CFBC/SG/HMO

CareFirst

BlueDental Plus

BlueDental Plus

Includes access to a national provider network

CareFirst BlueCross BlueShield (CareFirst) offers BlueDental Plus coverage, which allows you the freedom to see any dentist you choose.

Advantages of the plan

- **Freedom of choice, freedom to save**—With BlueDental Plus, you can see any dentist you choose. However, this plan also gives you the option to reduce your out-of-pocket expenses by visiting a dentist who participates in our Preferred Provider Network. It's your choice!
- **Comprehensive coverage**—Benefits include regular preventive care, X-rays, dental surgery and more. Your plan even covers orthodontia for members of all ages! A summary of your benefits is available on the following page.
- **Nationwide access to participating dentists**—You have access to one of the nation's largest dental networks, with participating dentists throughout the United States. BlueDental Plus gives you coverage for the dental services you need, whenever and wherever you need them.

Three options for care

- **Option 1**—By choosing a dentist in the Preferred Provider Network, you incur the lowest out-of-pocket costs. These dentists accept CareFirst's allowed benefit as payment in full, which means no balance billing for you. You are responsible for deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- **Option 2**—By choosing a dentist who participates with CareFirst, but not through the Preferred Provider Network, you incur slightly higher out-of-pocket costs. Similar to Option 1, there is no balance billing. You are responsible for deductibles and coinsurance, and also have the convenience of your provider being reimbursed directly.
- **Option 3**—You can receive out-of-network coverage from a dentist who has no relationship with CareFirst. With this option, you may experience higher out-of-pocket costs since you pay your provider directly. You can be balance billed and must pay your deductible and coinsurance as well.

Using your plan

How do I find a preferred dentist?

Visit **carefirst.com/doctor** to access our online directory 24 hours a day. Click on *Dental* and then select *BlueDental Plus*.

Can I start using my benefits immediately?

Benefits for Preventive & Diagnostic Services and Basic Services begin on your Effective Date. Other benefits may not be available until 12 months after your Effective Date. If your employer offered a dental plan immediately prior to selecting this CareFirst dental plan, the waiting period may be waived. Ask your benefits manager for details.

Is there a lot of paperwork?

There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a non-participating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at: 866-891-2802 between 8:30 am and 5:00 pm ET, Monday–Friday.

BlueDental Plus

Summary of Benefits

	In-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$25 Individual/$75 Family—in-network $50 Individual/$150 Family—out-of-network
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $1,500 maximum
PREVENTIVE & DIAGNOSTIC SERVICES	
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays ▪ Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) ▪ Fluoride treatments (two per benefit period per member, until the end of the year the member reaches the age 19) ▪ Sealants on permanent molars (once per tooth per 36 months per member, until the end of the year the member reaches the age 19) ▪ Space maintainers (once per 60 months) ▪ Palliative emergency treatment	No charge from participating dentist[1]
BASIC SERVICES AND MAJOR SERVICES—SURGICAL[2]	
▪ Direct placement fillings using approved materials (one filling per surface per 12 months) ▪ Periodontal scaling and root planing (once per 24 months, one full mouth treatment) ▪ Simple extractions ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) ▪ Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) ▪ General anesthesia rendered for a covered dental service	20% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE[2]	
▪ Full and/or partial dentures (once per 60 months) ▪ Fixed bridges, crowns, inlays and onlays (once per 60 months) ▪ Denture adjustments and relining (limits apply for regular and immediate dentures) ▪ Recementation of crowns, inlays and/or bridges (once per 12 months) ▪ Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance) ▪ Dental implants, subject to medical necessity review (once per 60 months)	50% of Allowed Benefit after deductible[1]
ORTHODONTIC SERVICES[2]	
▪ Benefits for orthodontic services are available for covered members who meet treatment criteria.	50% of Allowed Benefit[1]
ORTHODONTIC LIFETIME MAXIMUM	Plan pays $1,500 maximum

[1] CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

[2] Benefits for Major Services and Orthodontic Services may not be available until 12 months after your Effective Date.

* Deductible and Annual Maximum Combined In-network/Out-of-network.

Summary of Exclusions: Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

MD Benefits issued under policy form numbers: CareFirst of Maryland, Inc.: CFMI/BLUEDENTAL EOC (1/15); CFMI/BLUEDENTAL DOCS (1/15); CFMI/BLUEDENTAL SOB (1/15); CFMI/51+/GC (R. 1/13); CFMI/ELIG/D-V (7/09) and any amendments; Group Hospitalization and Medical Services, Inc.: MD/GHMSI/BLUEDENTAL EOC (1/15); MD/GHMSI/BLUEDENTAL DOCS (1/15); MD/GHMSI/BLUEDENTAL SOB (1/15); MD/CF/GC (R.1/13); MD/CF/ELIG (R. 1/08) and any amendments;

DC Benefits issued under policy form numbers: DC/GHMSI/BLUEDENTAL EOC (1/15); DC/GHMSI/BLUEDENTAL DOCS (1/15); DC/GHMSI/BLUEDENTAL SOB (1/15); DC/CF/GC (1/14); DC/CF/ELIG (1/14) and any amendments.

CareFirst

BlueVision Plus

CareFirst Family of health care plans

BlueVision Plus Summary of Benefits

We're not an eyewear plan. We're an eye care plan.

12-month benefit period

Benefit	In-Network You Pay	Out-of-Network You Pay
EYE EXAMINATIONS (once per 12-month benefit period)		
Routine Eye Examination with dilation (per benefit period)	No copay	Plan pays $45, you pay balance
FRAMES (once per 12-month benefit period)		
Davis Vision Frame Collection[1]	No copay for over 200 frames	Not applicable
Non-Collection Frame	Plan pays up to $100, you pay balance	Plan pays $45, you pay balance
SPECTACLE LENSES (once per 12-month benefit period)		
Basic Single Vision (including lenticular lenses)	No copay	Plan pays $52, you pay balance
Basic Bifocal	No copay	Plan pays $82, you pay balance
Basic Trifocal	No copay	Plan pays $101, you pay balance
CONTACT LENSES (initial supply; once per 12-month benefit period)		
Medically Necessary Contacts	No copay with prior approval	Plan pays $285, you pay balance
Davis Vision Contact Lens Collection[1]	No copay with evaluation if Collection Lenses are dispensed	Not applicable
Other (Non-Collection) Contact Lenses	Plan pays up to $127, you pay balance	Plan pays up to $127, you pay balance

Value Add and Discounts[3,4] (fixed fee)			
LENS OPTIONS[3,4] (add to spectacle prices above)			
Digital Single Vision	$30	Anti-Reflective (AR) Coating (Standard/Premium/Ultra/Ultimate)	$35/$48/$60/$85
Tinting of Plastic Lenses (Solid/Gradient)	$0	Progressive Lenses (Standard/Premium/ Ultra/Ultimate)	$50/$90/$140/$175
Scratch-Resistant Coating	$0	High-Index Lenses (1.67/1.74)	$55/$120
Polycarbonate Lenses (Children/Adults)[2]	$0/$30	Polarized Lenses	$75
Ultraviolet Coating	$12	Plastic Photochromic Lenses	$65
Blue Light Coating	$15	Scratch Protection Plan: Single Vision/ Multifocal Lenses	$20/$40
ADDITIONAL DISCOUNTED SERVICES[3,4]			
Retinal Imaging—Member Charge	$39		
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices[3]		
Laser Vision Correction[3]	Up to 25% off allowed amount or 5% off any advertised special[3]		

[1] Collection is available at most participating independent provider offices. Collection is subject to change.

[2] Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

[3] These discounts are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. Additional plan discounts may not be available at all provider locations in all states. Please confirm that discounts are accepted when making your appointment. Discounts are not insurance and subject to change without notice.

[4] Available additional discounts not applicable at Glasses.com, 1-800 Contacts, Walmart locations, Sam's Club locations, or Costco locations or where limited by law or manufacturer restrictions.

[5] Reena Mukamal, "20 Surprising Health Problems an Eye Exam Can Catch," American Academy of Ophthalmology, aao.org.

Benefits issued under policy form numbers: Non-rider/Freestanding:
MD: CFMI/51+/GC (R. 1/13) • CFMI/LG/2021 GC AMEND (1/21) • CFMI/EOC/D-V (R. 10/11) • CFMI/VISION DOCS (R. 7/21) CFMI/VISION SOB (R. 7/21) • CFMI/DOL APPEAL (R. 9/11) • CFMI/DB/SPOUSE (10/12) • CFMI/DOM PARTNER (R. 9/11) • CFMI/ELIG/D-V (7/09) • CFMI HEALTH GUARANTY 1/22 • CFMI–DISCLOSURE 10/15 MD/CF/GC (R. 1/13) • MD/CF/LG/2021 GC AMEND (1/21) • MD/CF/EOC/D-V (R. 10/11) • MD/CF/DOCS-V (R. 7/21) • MD/CF/SOB-V (R. 7/21) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/SPOUSE (10/12) • MD/CF/PARTNER (R. 9/11) • MD/CF/ELIG (R. 1/08) • MD NCA–HEALTH GUARANTY 1/22• GHMSI-DISCLOSURE 10/15

DC: DC/CF/GC (R. 1/13) • DC/CF/LG/2021 GC AMEND (1/21) • DC/CF/EOC/D-V (1/12) • DC/CF/DOCS-V (R. 7/21) • DC/CF/SOB-V (R. 7/21) • DC/CF/ELIG (9/04) • DC/GHMSI/DOL APPEAL (R. 1/22) • DC/CF/PARTNER (R. 7/09) • DC GHMSI – HEALTH GUARANTY 5/21

VA: VA/CF/GC (R. 1/13) • VA/CF/LG/2021 GC AMEND (1/21) • VA/CF/EOC/D-V (1/12) • VA/CF/DOCS-V (R. 7/21) • VA/CF/SOB-V (R. 7/21) • VA/CF/ELIG (R. 1/12) • VA/GHMSI/DOL APPEAL (R. 1/20) • VA/CF/PARTNER (R. 10/11) • VA/GHMSI/HEALTH GUARANTY 7/18 Ridered: CFMI/BLUEVISION PLUS RIDER (7/21) • MD/CF/BLUEVISION PLUS RIDER (7/21) • MD/CFBC/BLUEVISION PLUS RIDER (7/21) • DC/CF/BLUEVISION PLUS RIDER (7/21) • DC/CFBC/BLUEVISION PLUS RIDER (7/21) • VA/CF/BLUEVISION PLUS RIDER (7/21) • VA/CFBC/BLUEVISION PLUS RIDER (7/21)

CareFirst BlueVision Plus

Did you know that eye exams allow eye care professionals to take a non-invasive look inside the body? An eye care professional can detect up to 20 chronic medical conditions during an eye exam, from diabetes and heart disease to hypertension and cognitive dysfunction, even before symptoms occur[5].

How the plan works

Our Plusses

Davis Vision® administers BlueVision Plus. Our vision plans provide an affordable way for members to receive their annual eye exams. And if you need corrective lenses, we have you covered there too.

National Network

More than 121,000 access points across the U.S. accept BlueVision Plus. This includes private practices, retailers, and online retailers such as Visionworks, Walmart, Costco and Glasses.com.

How do I find a provider?

To find a provider, go to **carefirst.com** and use the Find a Provider feature or call Davis Vision for a list of network providers closest to you at 800-783-5602, available seven days a week. Service is available 8 a.m.–11 p.m., Monday through Friday; 9 a.m.–4 p.m., Saturday; and noon–4 p.m. on Sunday.

Be sure to ask your provider if they participate with the Davis Vision network before receiving care.

How do I receive care from a network provider?

Call your provider and schedule an appointment. Identify yourself as a CareFirst BlueVision Plus member and provide the doctor with your identification number, as well as your date of birth. Then go to your appointment and receive care. There are no claim forms to file.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer some out-of-network coverage. However, you will be responsible for all payments upfront and need to file a claim with Davis Vision for reimbursement. You must also pay any balances over the allowed benefit to the non-participating provider. Find the claim form at **carefirst.com:** locate *For Members*, then click on *Forms, Vision, Davis Vision.*

Can I get contacts and eyeglasses in the same benefit period?

No. BlueVision Plus covers one pair of eyeglasses OR a supply of contact lenses per benefit period.

When do I get my ID card?

Member ID cards are mailed to your home after enrollment. You can also access your member ID card—along with other claims and benefit information—at *My Account* or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

BlueVision Core vs BlueVision Plus

Some CareFirst members have an embedded vision product called BlueVision Core (exam only with discounts) plan AND a BlueVision Plus plan. To ensure you are receiving your BlueVision Plus benefits look for the **VU indicator on your member ID card**.

Other benefits

- **Access to in-network online retail partners:** Glasses.com, Warby Parker and Befitting
- **Mail order replacement contact lenses:** Davis Vision's mail order contact lens replacement service is powered by ABB Optical Group, the nation's #1 optical distributor and second largest contact lens provider. By accessing **davisvisioncontacts.com**, members can easily order replacement contact lenses at significant savings and have them shipped directly to their doorstep.
- **Hearing aid discounts** through YourHearing Network
- **Free LASIK consultation**
  - **Under $1,000/eye for conventional LASIK** (usually $1,677/eye)
  - **40-50% off** the national average price
  - **1,000 locations nationwide**

Renaissance

Life, AD&D, and Short Term Disability

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Global Citizen School

Basic Employee Life - Benefit Summary

Class: A - All full-time active eligible employees who are regularly scheduled to work 40+ hours per week.

Benefit	$50,000
Minimum	n/a
Maximum	n/a
Guaranteed Issue Amount	$30,000
Age Reductions	Age 65 Reduces to 65% / Age 70 Reduces to 50% Maximum $5,000
Waiver of Premium Provision	Total disability must occur prior to age 60; insurance ends when the employee ceases to be totally disabled; fails to provide proof of disability; attains age 65; or attains his or her retirement date. Elimination period: 9 months.
Accelerated Death Benefit	Maximum benefit 75%; Included for Life insurance amounts of at least $10,000
Continuation	After total disability
Conversion	Included
Portability	Not Included
Employee Contribution	0% (non-contributory)
Minimum Participation Requirement	See Assumptions & Qualifications
Spouse Life Benefit	n/a
Domestic Partner	n/a
Child Life Benefit	n/a
	n/a
	n/a

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Accidental Death and Dismemberment (AD&D) - Benefit Summary

Class: A - All full-time active eligible employees who are regularly scheduled to work 40+ hours per week.

Benefit	$50,000
Minimum	n/a
Maximum	n/a
Guaranteed Issue Amount	$30,000
Age Reductions	Age 65 Reduces to 65% / Age 70 Reduces to 50% Maximum $5,000
Coverage Type	24 hour
Loss of Life	100%
Seatbelt/Airbag	10% / $10,000

Enhanced Benefits	
Quadriplegia	100%
Loss of both hands or both feet; loss of sight in both eyes; loss of one hand and sight in one eye; loss of one foot and sight in one eye	100%
Loss of one of the following: arm, hand, leg, foot or sight in one eye	50%
Paraplegia/Hemiplegia/Triplegia	50%
Uniplegia	50%
Loss of Speech/Hearing	50%
Loss of Thumb & Index Finger Same Hand	25%
Coma	5% / $5,000 (lesser of)
Common Carrier Hazard	10%
Repatriation	10% / $10,000 Covered Expenses (lesser of)
Spouse Training	10% / $2,500 (lesser of)
Qualified Child Education	5% / $2,500 (lesser of)
Childcare Expense	3% / $2,500 (lesser of)

- All benefits combined will be limited to no more than 150% of the benefit amount shown above.

Renaissance Short Term Disability Insurance

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Short Term Disability (STD) - Benefit Summary

Class: A - All full-time active eligible employees who are regularly scheduled to work 40+ hours per week.

Benefit Percentage	60% of Basic Weekly Earnings rounded to the next higher $1
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$25
Accident Elimination Period	0 days (benefits begin the day following completion of the elimination period)
Sickness Elimination Period	7 days (benefits begin the day following completion of the elimination period)
First Day Hospital	Not Included
Maximum Payment Duration	13 weeks
Definition of Disability	Residual with loss of duties and loss of earnings: Claimant is unable to perform the material and substantial duties of his/her own job and has a 20% or more loss of weekly earnings. Total disability is not required during the elimination period.
Work Incentive Benefit	Included
Pre-Existing Conditions	3/12
Other Income Amount offsets, including State Disability Plan, Social Security, work earnings, and other benefits	Direct
Social Security Integration	Primary and Family
Employee Contribution	0% (non-contributory)
Minimum Participation Requirement	See Assumptions & Qualifications
Coverage Type	Non-Occupational
Guaranteed Issue Amount	$1,000
Recurrent Disability Period	14 days
Waiver of Premium	Not Included

Glossary of Insurance Terms

BALANCE BILLING
An out-of-network healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

CO-INSURANCE
The percentage of costs of a covered health care service you pay after you've paid your deductible.

CO-PAYMENT
A fixed amount you pay for a covered health care service.

DEDUCTIBLE
The amount you pay for covered health care services before your insurance plan starts to pay.

EMERGENCY SERVICES
A medical emergency is an acute injury or illness that poses an immediate risk to a person's life or long-term health.

FORMULARY
A list of prescription drugs that are covered by your health insurance plan. The formulary is separated into cost levels called tiers, which affects how much you pay for each drug. Also known as a Prescription Drug List (PDL).

NON-PREFERRED PROVIDER
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

OUT-OF-POCKET MAXIMUM
The most you could pay during a plan year for your share of the costs of covered services. After you meet this limit the plan will pay 100% of the allowed amount.

PRE-AUTHORIZATION
Prior review of a procedure and authorization by the insurance company to pay for scheduled services.

PREFERRED PROVIDER
A provider who has a contract with your health insurer or plan to provide services to you at a redetermined rate. Costs will be less when receiving services from Preferred Providers.

PREMIUM
The amount that must be paid for your health insurance or plan each month. This amount is shared by you and your employer.

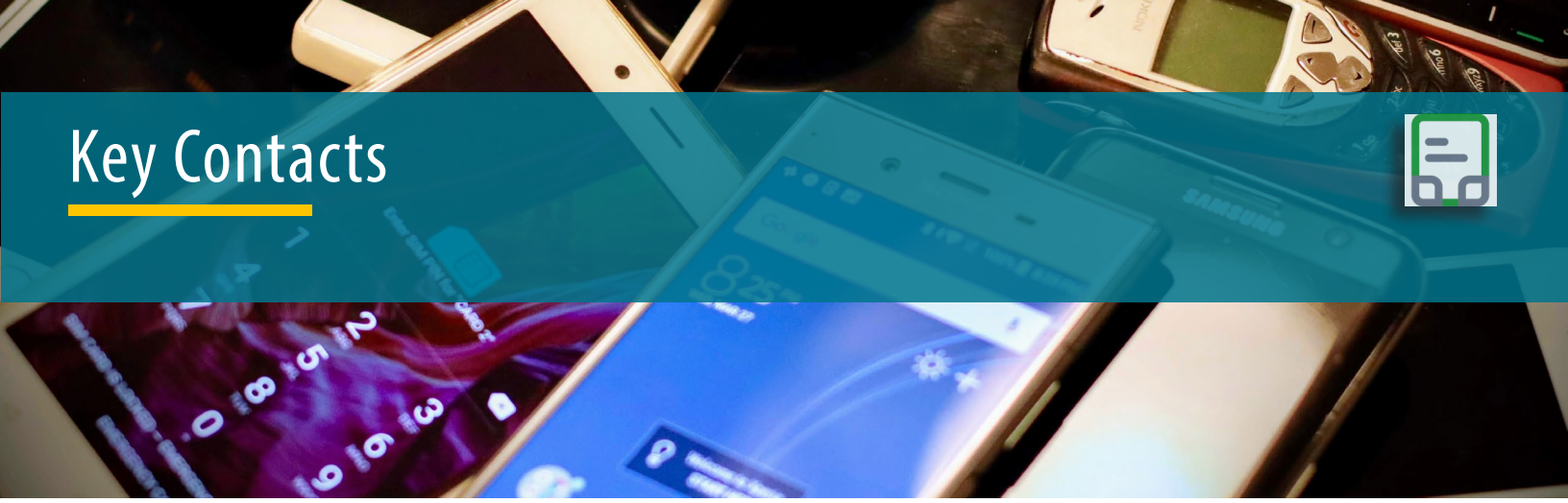
PRIMARY CARE PHYSICIAN
A physician who directly provides or coordinates a range of health care services for a patient.

PRIMARY CARE PROVIDER
A physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

SPECIALIST
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

UCR (USUAL, CUSTOMARY AND REASONABLE)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical services. The UCR amount sometimes is used to determine the allowed 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 emergency room care.



Key Contacts

HAVE QUESTIONS, PROBLEMS OR CONCERNS?

Should you need any personal assistance understanding your benefits, claims or other insurance related information, the following are your carrier contact numbers and websites. There is a wealth of information regarding your plans, claims and other online resources. We recommend that your first step be to call the insurance carrier. You will need your ID number or Social Security Number along with the date of service and provider name (when applicable). If you require further assistance, please contact your Client Advocate at NFP or Human Resources. Please have the same information available when contacting NFP or Human Resources.

BENEFIT	CARRIER	CONTACT INFORMATION
Medical & Rx	**CareFirst**	855-444-3122 www.carefirst.com
Dental	**CareFirst**	866-891-2802 www.carefirst.com
Vision	**CareFirst**	800-783-5602 www.carefirst.com
Life, AD&D, and Short Term Disability	**Renaissance**	888-791-5995 www.enaissancebenefits.com

COMPANY	CONTACT	CONTACT INFORMATION
Global Citizens Public Charter School	**Camerra Taliaferro** Director of Operations	202-221-6400 CTaliaferro@globalcitizensschool.org
NFP	**Jaret Gutwald** Employee Advocate	240-845-7322 jaret.gutwald@nfp.com
NFP	**Lori Leisher** Sr. Account Executive	240-387-2183 lori.leisher@nfp.com

This benefit brochure is only intended as a brief summary of your benefits. Please note that all Benefits are subject to the contractual terms, limitations and exclusions as set forth in the master contracts of the carriers. If this summary conflicts in any way with the carrier Certificate of Coverage (COC), Riders and/or Amendments, those documents shall prevail. It is highly recommended that you review the carrier COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Enrollment Forms

CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

Enrollment Form

Dental and Vision Plans

(District of Columbia Small Groups)

HOW TO COMPLETE THIS FORM:

1. Please type or print clearly with pen.
2. Complete all appropriate items, sign and date.
3. Please return this form to your employer.
4. **Employer must complete if Section VII is answered** – Number of employees in group: _____.

I. EMPLOYER INFORMATION – To be completed by the employer		
Employer / Group Administrator	Effective Date Requested / /	Group Number
II. ENROLLEE		
Social Security Number	Date of Birth / /	Sex ☐ Male ☐ Female
Last Name	First Name	Middle Initial
Date of Hire / /	Occupation	Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired
Residence Address *(Number and Street)*	*(City and State)*	*(Zip Code – 9-digit, if known)*
Home Phone ( )	Work Phone ( )	Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Other ☐ Separated ☐ Divorced

III. TYPE OF ENROLLMENT

CHECK ONE: ☐ New ☐ Coverage Change

IV. TYPE OF COVERAGE

To avoid delays in processing this form, please confirm with your employer the details of the coverage levels offered by your employer prior to completing this section.

CHECK ONE:

☐ Individual
☐ Individual and Adult
☐ Individual and Child
☐ Individual and Children
☐ Family

V. PLAN SELECTION

To avoid delays in processing this form, please confirm with your employer the details of the dental and/or vision plans offered by your employer prior to completing this section.

CHECK ALL APPLICABLE:

☐ Preferred Dental ☐ Traditional Dental

☐ BlueDental Preferred ☐ Blue Dental Traditional ☐ BlueVision *Plus*

VI. CHANGE TO EXISTING ENROLLMENT

Dependents affected by additions or deletions must be listed in Section VII - Dependent Information.

Identification Number, if different from Social Security Number: _____

- ☐ ADD dependent(s) listed in Section VII
- ☐ ADD spouse due to marriage on _____ (Date)
- ☐ ADD domestic partner on _____ (Date)
- ☐ ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____

  (Note: Documentation of adoption or court-appointed legal guardianship must be provided)
- ☐ REMOVE dependent(s) listed in Section VII due to _____ (Reason) on _____ (Date)
- ☐ CHANGE address to that shown in Section II
- ☐ CHANGE my name from _____ to that shown in Section II

VII. DEPENDENT INFORMATION

1	**Spouse**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	☐BlueDental Preferred ☐Preferred Dental ☐BlueDental Traditional ☐Traditional Dental ☐BlueVision *Plus*
2	**Domestic Partner**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	☐BlueDental Preferred ☐Preferred Dental ☐BlueDental Traditional ☐Traditional Dental ☐BlueVision *Plus*
3	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	☐BlueDental Preferred ☐Preferred Dental ☐BlueDental Traditional ☐Traditional Dental ☐BlueVision *Plus*
4	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	☐BlueDental Preferred ☐Preferred Dental ☐BlueDental Traditional ☐Traditional Dental ☐BlueVision *Plus*
5	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	☐BlueDental Preferred ☐Preferred Dental ☐BlueDental Traditional ☐Traditional Dental ☐BlueVision *Plus*
6	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	☐BlueDental Preferred ☐Preferred Dental ☐BlueDental Traditional ☐Traditional Dental ☐BlueVision *Plus*

COMPLETE ONLY IF CHILD IS A STUDENT OR DISABLED (AGE 26 OR OLDER)

If child is a student age 26 or older, please confirm coverage with your employer prior to completing this section.

Child Name – (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No	**If Yes, Attach Student Certification Form**	Disabled? ☐ Yes ☐ No	**If Yes, Attach Disability Certification Form and Supporting Documentation**
Child Name – (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No		Disabled? ☐ Yes ☐ No	

VIII. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this box if any person listed on this form is eligible for or receiving benefits under Medicare.

If you checked the box, please give:

Name _____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ___ /___ /___ ☐ Part B Eff. Date ___ /___ /___

EMPLOYMENT STATUS (CHECK ONLY ONE BOX): ☐ Actively Employed ☐ Retired

Name _____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ___ /___ /___ ☐ Part B Eff. Date ___ /___ /___

EMPLOYMENT STATUS (CHECK ONLY ONE BOX): ☐ Actively Employed ☐ Retired

IX. PRIOR COVERAGE / OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this box if any person listed on this form is now or has been enrolled within the last 31 days in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, another insurance carrier, or Medicaid. Is this coverage currently in effect? ☐ Yes ☐ No

If Yes, will this coverage be continued? ☐ Yes ☐ No If No, please provide cancellation date _____ /_____ /_____

1. Policy Holder's Name and Social Security Number _____
   Sex ☐ M ☐ F Date of Birth _____ /_____ /_____
2. Name and Location of Insurance Company _____
3. Policy Number _____ Policy Covers: ☐ Policy Holder Only ☐ Two Persons ☐ Family
4. Effective Date of Policy _____ /_____ /_____
   month day year
5. Service(s) Covered:

A. Hospital Services	☐ Yes ☐ No	E. Dental	☐ Yes ☐ No
B. Physician Services	☐ Yes ☐ No	F. Eye / Vision Care Services	☐ Yes ☐ No
C. Major Medical (out-of-pocket expenses)	☐ Yes ☐ No	G. Mental Illness Services	☐ Yes ☐ No
D. Separate Drug Program	☐ Yes ☐ No	H. HMO	☐ Yes ☐ No

6. Is coverage through an employer or other group? ☐ Yes ☐ No
   If Yes, name of employer or other group _____
7. Is this coverage under COBRA? ☐ Yes ☐ No
8. To be completed if the parents live apart and provide medical coverage for their child(ren):
   Please indicate relationship to child(ren).

PARENT WITH COURT-ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES	_____ *Parent's Name / Relationship*	PARENT WITH CUSTODY OF CHILD(REN)	_____ *Parent's Name / Relationship*
	_____ *Child's Name / Date of Birth*		_____ *Child's Name / Date of Birth*

X. PLEASE READ CAREFULLY – THIS SECTION MUST BE DATED AND SIGNED

I hereby enroll, on behalf of myself and each dependent listed above, for the coverage indicated. Coverage will be provided according to the terms and conditions of the contract between CareFirst BlueCross BlueShield and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future charges to my employer.

CareFirst BlueCross BlueShield may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. CareFirst BlueCross BlueShield will provide 30-days advance written notice of any rescission of coverage.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, CareFirst BlueCross BlueShield may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

_____

Enrollee Signature Date

XI. CONSENT TO RECEIVE ELECTRONIC NOTICES

CareFirst BlueCross BlueShield wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst BlueCross BlueShield health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst BlueCross BlueShield health care coverage include, but are not limited to:

- Explanation of Benefits alerts
- Reminders
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note, you may change your email, cell phone and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging:

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery, by:

☐ Email only
☐ Cell phone text messaging only
☐ Email and cell phone text messaging

By signing below, I hereby agree to electronic delivery of notices.

Member Name	**Signature**	**Email Address**	**Cell Phone Number**

By signing below, my spouse/partner and any other dependents covered by CareFirst BlueCross BlueShield individually agree to electronic delivery of notices.

Spouse/Partner/ Dependent Name	**Signature**	**Email Address**	**Cell Phone Number**

CareFirst BlueCross BlueShield will not sell your email address or cell phone number to any third party and we do not share them with third parties except for CareFirst BlueCross BlueShield vendors that perform functions on our behalf or to comply with the law.

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Renaissance Life & Health
Insurance Company of America
P.O. Box 1596, Indianapolis, IN 46206

RENAISSANCE EMPLOYEE ENROLLMENT FORM

—Please Type Or Print Clearly In Dark Ink—

SECTION I | EMPLOYER INFORMATION (Policyholder Use Only)

Name of Employer:		**Group ID Number:**	**Billing Class:**
Unit Name and Number:		**Policy Number(s):**	
Date of Hire or Rehire:	**Hours Worked Per Week:**	**Earnings:** $ _____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other If Other Specify: _____	

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Re-enrollment ☐ Change in Status ☐ Other
If Other Specify: _____

SECTION II | EMPLOYEE INFORMATION (Completed By Applicant)

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	**Email:** **Phone:** ( ) -	
Street Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**
Social Security Number:	**Date of Birth** *(mm/dd/yyyy)*:	**Job Title/Occupation:**	

SECTION II.A | SPOUSE INFORMATION (If Applying For Benefits For Your Spouse*, Complete Information Below)

Your ☐ Spouse ***OR*** ☐ Domestic Partner* *(Check One Box Only)*	**Full Name** *(Last, First, MI)*:	☐ Male ☐ Female	**Date of Birth** *(mm/dd/yyyy)*:	**Social Security Number:**
Street Address *(Include Apt#/Suite)*: ☐ ***Check if same as above***		**City:**	**State:**	**ZIP Code:**

SECTION II.B | CHILD(REN) INFORMATION (If Applying For Benefits For Your Dependent Child(Ren), Complete Information Below)

Dependent's Name (Last, First, MI)	Male (M) Female (F)	Full-Time Student	Date of Birth (mm/dd/yyyy)	Social Security Number
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		
	☐ M ☐ F	☐ Yes ☐ No		

If more than three children are to be enrolled, include a separate list including the above information with this form

**This Employee Enrollment Form uses the term "Spouse" to refer to the person, either Spouse or Domestic Partner, for whom you are applying for benefits. If your Employer does not extend benefits to Domestic Partners and you are not enrolling a Spouse, leave this section blank.*

SECTION III | COVERAGE ELECTIONS

IF YOU SELECT "NO COVERAGE" BELOW, YOU ACKNOWLEDGE THAT YOU UNDERSTAND THAT IF YOU APPLY FOR COVERAGE AT A LATER DATE, YOU WILL BE CONSIDERED A LATE APPLICANT, YOU MAY BE SUBJECT TO WAITING PERIODS AND/OR REQUIRED TO FURNISH EVIDENCE OF INSURABILITY AT YOUR OWN EXPENSE, AND THAT RENAISSANCE WILL HAVE THE RIGHT TO REFUSE YOUR REQUEST.

If applying for Life or Disability insurance, please check with your Human Resources Department on coverage options and health information requirements.

A. TERM LIFE INSURANCE	**EMPLOYEE**	☐ Basic Life ☐ Basic Accidental Death & Dismemberment (AD&D) ☐ No Coverage ☐ Supplemental Life: Amount Electing: $ _____ OR _____x Base Annual Compensation ☐ Supplemental AD&D: Amount Electing: $ _____ OR _____x Base Annual Compensation	
	SPOUSE	☐ Supplemental Life Amount Electing: $ _____	☐ Supplemental AD&D Amount Electing: $ _____
	CHILD	☐ Supplemental Life Amount Electing: $ _____	☐ Supplemental AD&D Amount Electing: $ _____
B. SHORT TERM DISABILITY (STD) INSURANCE	**EMPLOYEE ONLY**	☐ STD ☐ No Coverage ☐ Voluntary STD: Flat Amount Per Week: $_____ . ☐ Voluntary STD: % of Weekly Earnings: _____%	
C. LONG TERM DISABILITY (LTD) INSURANCE	**EMPLOYEE ONLY**	☐ LTD ☐ No Coverage ☐ Voluntary LTD: Flat Amount Per Week: $_____ . ☐ Voluntary LTD: % of Weekly Earnings: _____%	

SECTION IV | BENEFICIARY (Completed Only If Life/AD&D Coverages Are Elected)

Full Name (First, Last, MI)	Relationship To You	Social Security Number	Percentage
			0.00%
			0.00%
			0.00%
			0.00%
			0.00%
			0.00%
			0.00%
			0.00%

If you need more room, please request our Beneficiary form

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

SECTION V | ELECTRONIC DELIVERY OF DOCUMENTS

Electronic Delivery of Policy Document

☐ Yes, send the following information electronically: Certificate of Coverage, Summary of Benefits, ID Cards, Explanation of Benefits, Renewal Letters and related coverage and claim documents.

By checking the box above, you are agreeing to receive such materials electronically pursuant to the Terms for Paperless Delivery attached to this Employee Enrollment Form. **You must provide a current email address on the first page of this Employee Enrollment Form.** If the box is not checked, all materials will be sent by hard copy.

SECTION VI | SIGNATURES

My signature on this Employee Enrollment Form further represents that:

I authorize my Employer's Payroll Department to deduct the required premium, if any, from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my Employer and Renaissance, and are to be paid to Renaissance when due.

I am applying for the coverages designated for which I am eligible under my Employer's plan with Renaissance and I understand that my dependents are not eligible for coverage if I am not enrolled. No coverages above the Guaranteed Issue Limit are effective until my completed Evidence of Insurability is approved by Renaissance. If I am applying as a Late Applicant, I understand that no coverage is effective until my completed Evidence of Insurability is approved by Renaissance and certain limitations and waiting periods may apply.

I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work.I also understand that dependent coverage will not become effective while the dependent is confined to the Hospital or otherwise unable to perform the duties of a person of like sex and age.

For any Life or AD&D coverage for which I am applying, I designate the beneficiary(ies) named in the beneficiary section of this Employee Enrollment Form to receive any benefits payable in the event of my death.

The Employee Enrollment Form is subject to approval, refusal or modification in accordance with Renaissance guidelines. Misrepresentation or fraud will cause this form and subsequent coverage to be null and void from the start. WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Applicant Signature *(Required)*: _____ Date: _____

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