



2025 BENEFITS GUIDE



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AIMS Benefit Trust Health Plan

Medical, Dental and Vision Benefit Options

We are pleased to offer a comprehensive benefit program through AIMS Benefit Trust Health Plan. The plan offers flexibility and choice to meet your needs.

Benefits constitute a substantial and ever-increasing part of employee compensation and we are committed to offering programs which maximize value and provide security for employees and their families.

We are pleased to offer benefits through a large group health plan consortium sponsored by the Association of Independent Maryland and DC Schools (AIMS). The plan is administered by Educators Benefit Services (EBS), a wholly owned subsidiary of AIMS.

Benefit Options Effective: January 1, 2025

Medical

Cigna Healthcare Medical

Cigna OAP \$3K 80% HSA

Cigna OAP \$2K 80% HSA

Cigna OAP 80/60 PPO

Kaiser Permanente Medical

Kaiser Signature HMO Plan

Dental

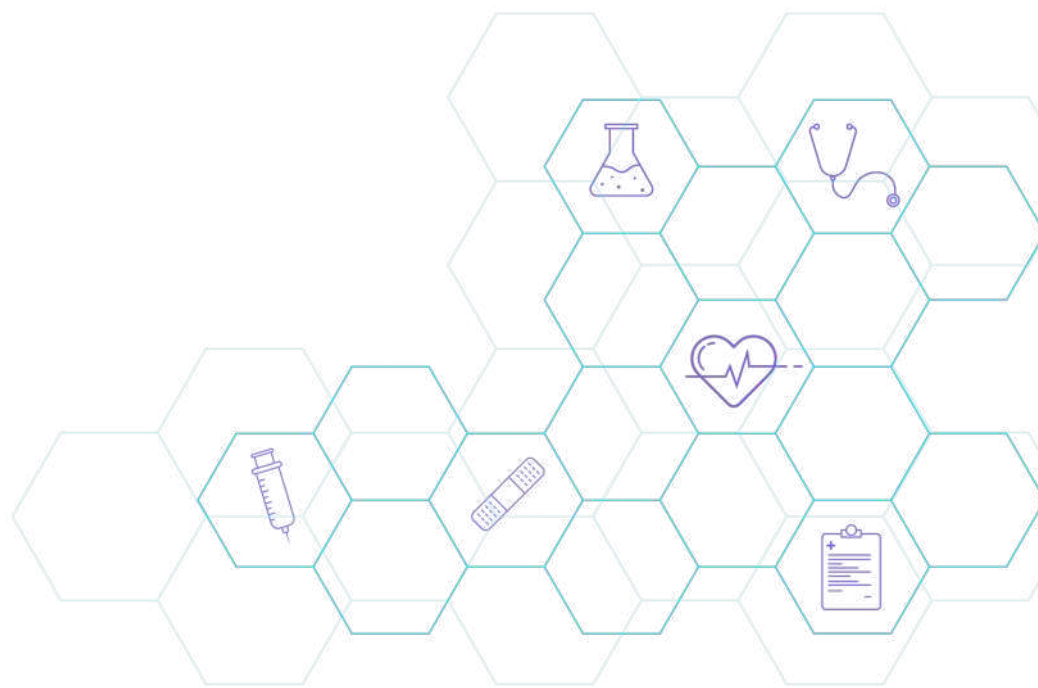
Cigna PPO 2500 MAC

Cigna PPO 5500 MAC

Dominion Elite Plus ePPO Plan

Vision

VSP Vision Plan



ELIGIBILITY

- Regular Full-time employees working 30 hours or more per week are eligible to participate in medical, dental, and vision benefits offered.
- Regular Part-time employees working 20 hours or more per week are eligible to participate in medical, dental, and vision benefits offered.
- Benefits are effective the 1st of the month coincident with or following date of hire.

Note: Variable hour, part-time and seasonal employees hours will be measured in accordance with the guidelines established by the Affordable Care Act (ACA). Eligibility and effective dates will be established based on hours worked during the applicable measurement period. Please contact HR with any questions you might have.

WHEN CAN YOU ENROLL?

You can sign up for Benefits at any of the following times:

- As a new hire, at your initial eligibility date.
- Within 30 days of a qualified family-status change.
- During the annual open enrollment period,

If you do not enroll at one of the above times, you may enroll during the next annual open enrollment period.

MAKING CHANGES

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change your benefit elections during the plan year if you have a change in status including:

- Marriage or divorce
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects your benefits
- Change in your work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child's eligibility for benefits.
- Receiving a Qualified Medical Child Support Order (QMCSO)
- Becoming ineligible for Medicaid or the Children's Health Insurance Program (CHIP).
- Becoming eligible for Premium Assistance through CHIP.
- If you or your dependents become eligible for CHIP, you will not be able to drop coverage for those dependents until Open Enrollment, unless due to another special enrollment event.

You must notify and provide the Benefits Administrator the necessary documentation within 30 days from the life event. **If you fail to do so, you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.**

WHEN DOES COVERAGE END?

Coverage will end the last day of the month in which the date of termination / resignation was given.

CONTACTS

CIGNA HEALTHCARE- MEDICAL

Website: <http://www.cigna.com>
Phone: 1-800-244-6224

KAISER PERMANENTE

Website: <http://www.kp.org>
Phone: 1-800-777-7902

CIGNA HEALTHCARE - DENTAL

Website: <http://www.cigna.com>
Phone: 1-800-244-6224

DOMINION DENTAL

Website: <http://www.dominiondental.com>
Phone: 1-888-518-5338

VSP VISION

Website: <http://www.vsp.com>
Phone: 1-800-877-7195

OPTUM BANK

Website: <http://www.optumbank.com>
Phone: 1-800-791-9361

SUMMUS

Website: <http://www.summusglobal.com/EBS>
Phone: 1-917-565-8540
Email: ebs@summusglobal.com

RELIANCE STANDARD

Website: <http://www.reliancestandard.com/aimsmembers/>
Phone: 1-800-351-7500

BHS- EMPLOYEE ASSISTANCE PROGRAM

Website: <http://portal.bhsonline.com>
Phone: 1-800-327-2251

EBS HEALTH CARE ADVOCATES

Phone: 410-590-6590
Email: clientservices@ebsonline.net

MEDICAL INSURANCE

We offer medical plan options through Cigna Healthcare and Kaiser Permanente.

The chart on the next page provides an overview and comparison of the plans. Please refer to the plan specific [Summary of Benefits and Coverage](#) (SBC) and [Summary Plan Descriptions](#) for further details.

To learn how to find a Cigna Healthcare participating provider [click here](#). To find a participating provider with Kaiser Permanente go to www.kp.org click on find Doctors and Locations and follow the next steps.

Please note: Benefit summaries and plan information for all plans offered by EBS will be included in links throughout this guide. Refer only to the options offered by the organization. If there is a discrepancy between this guide and plan document, the [plan document](#) will govern.





OAP \$3K
80% HSA Plan**

OAP \$2K
80% HSA Plan

OAP 80/60
PPO Plan**

IN-NETWORK

DEDUCTIBLE (your first dollar cost for covered in-network claims)

Deductible (Individual/Family)	Embedded \$3,300/\$6,600	\$2,000/\$4,000	Embedded \$500/\$1,000
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COINSURANCE (your responsibility on claims costs once you've met the deductible)

20%

20%

20%

OUT OF POCKET MAXIMUM (once met all in-network covered services are covered by the plan)

Maximum Out-of-Pocket (Individual/Family)	\$6,600 / \$13,200	\$4,000 / \$8,000	\$4,000 / \$8,000
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Maximum Include Deductible, Coinsurance, Prescription Costs & Copays

PREVENTIVE CARE

Wellness, Immunizations,
Mammography, Colonoscopy, etc. Covered 100%, no cost to you

OFFICE VISITS

Primary Care Physician Visit	20%, after Deductible	\$20 copay, after Deductible	\$20 Copay
Virtual Visits	20% after Deductible	20%, after Deductible	\$20 Copay
Mental Health Office Visits	20% after Deductible	20% after Deductible	\$20 Copay
Specialist Visits	20% after Deductible	20%, after Deductible	\$20 Copay

HOSPITAL SERVICES

Inpatient Hospital	20% after Deductible	20%, after Deductible	20%, after Deductible
Outpatient Surgery	20% after Deductible	20%, after Deductible	20%, after Deductible
Emergency Room	20% after Deductible	20%, after Deductible	20%, no Deductible
Urgent Care	20% after Deductible	20%, after Deductible	20%, no Deductible

DIAGNOSTIC TESTING

X-ray & Diagnostic- Outpatient	20% after Deductible	20%, after Deductible	20%, after Deductible
Laboratory Services	20% after Deductible	20%, after Deductible	20%, after Deductible

PRESCRIPTIONS

Retail Tier 1 / 2 / 3	\$10 / \$30 / \$50	\$10 / \$30 / \$50	\$10 / \$30 / \$50
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**Embedded Deductible - No single individual on a parent/children, employee/spouse or family plan will have to pay a deductible higher than the individual deductible amount.

DEDUCTIBLE (your first dollar cost for covered in-network claims)

Deductible

(Individual/Family)

\$0/\$0

COINSURANCE (your responsibility on claims costs once you've met the deductible)

OUT OF POCKET MAXIMUM (once met all in-network covered services are covered by the plan)

Maximum Out-of-Pocket
(Individual/Family)

\$1,300 / \$2,600

Maximum Include

Deductible, Coinsurance, Prescription Costs & Copays

PREVENTIVE CARE

Wellness, Immunizations,
Mammography, Colonoscopy, etc.

Covered 100%, no cost to you

OFFICE VISITS

PCP required / Referrals

YES / YES

Virtual Visits

\$20 copay

Office Visits
(Illness/Injury)

\$20 copay

Specialist Visits

\$30 copay

HOSPITAL SERVICES

Inpatient Hospital

\$0 Copay

Outpatient Surgery

\$0 Copay

Emergency Room

\$100 Copay

Urgent Care

\$30 Copay

DIAGNOSTIC TESTING

Lab & X-Ray

\$0 Copay

Advanced Imaging
(MRI, CAT, PET, etc.)

\$0 Copay

PRESCRIPTIONS

Retail
Tier 1 / 2 / 3

\$10 / \$30 / \$50

	Employee Only	Employee/Spouse	Employee/Children	Employee/Family
Per Paycheck Cost for Coverage:				
Cigna OAP \$3K 80% HSA	\$28.32	\$325.64	\$269.01	\$424.74
Cigna OAP \$2K 80% HSA	\$29.26	\$336.48	\$277.97	\$438.89
Cigna OAP 80/60 PPO	\$44.22	\$508.54	\$420.10	\$663.31
Kaiser Signature HMO	\$35.30	\$405.88	\$335.29	\$529.41

This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the [Summary Plan Description \(SPD\)](#), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PRESCRIPTION & WAYS TO SAVE

Ask your doctor or pharmacist if your brand medication has a generic or lower cost alternative. You can also use [Cigna's Drug Pricing Tool](#) to find the best pricing for your prescription.

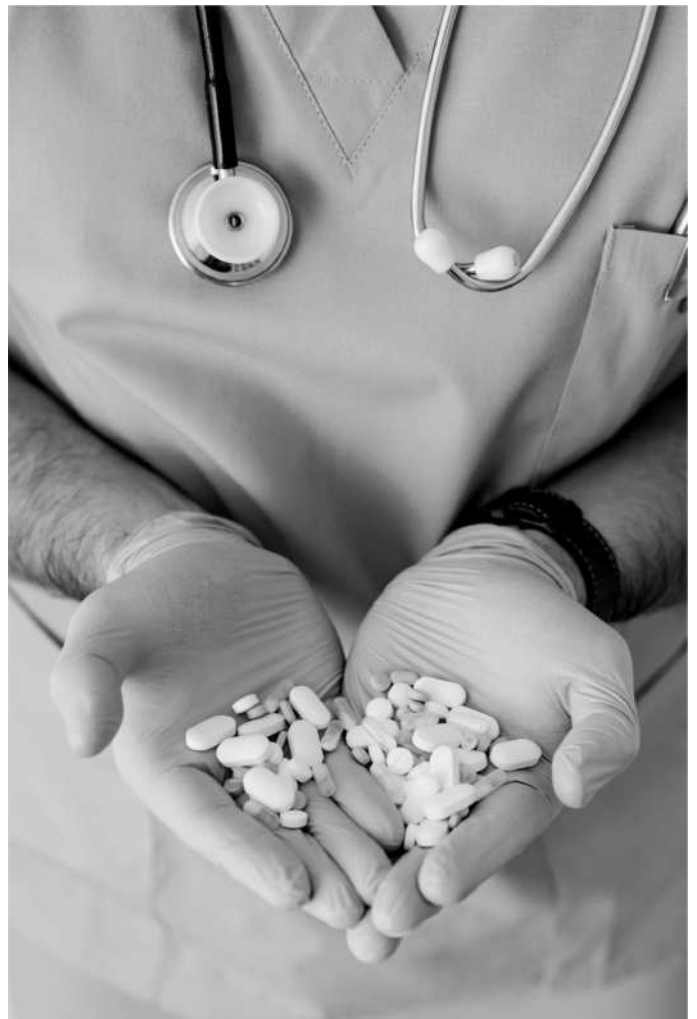
Saving on prescriptions

Mail order prescriptions may be available through Cigna's [Express Scripts](#) program. You may be able to get a 90-day supply for only a 60-day co-pay.

Visit [myCigna.com](#) or [KPorg](#) for more information on mail order prescription drug coverage.

Not all pharmacies charge the same amount for medications. When you and your doctor are considering the right medication treatment, knowing how much medication costs and which pharmacies offer the best price can help you avoid surprises.

Prescription drug lists can be viewed [here](#).





You're not alone

The Cigna Total Behavioral Health Program can help you move forward.

Our whole-person approach

If you or a loved one has been diagnosed with a behavioral health condition, Cigna is here for you. Our comprehensive program provides help with life events, dedicated support, lifestyle coaching, and online tools. You can call anytime, any day. Cigna is here 24/7 to assist you with your routine or urgent needs. We can also help you find a provider with confirmed appointment availability.

Virtual behavioral care

You can talk to a licensed psychiatrist or counselor by phone or video with MDLIVE, or our Behavioral Health network. With MDLIVE you can schedule phone and video appointments online. With our Behavioral Health network, you can find a provider and start video counseling by going to mycigna.com. Find Care & Costs.

On Demand coaching and personalized learning with iPrevail offered through Cigna

Learn how to boost your mood and improve mental health with on-demand coaching 24/7. After completing a brief assessment, you receive a program tailored to your needs that includes interactive lessons and tools. You get access to a peer coach who is matched based on your symptoms. You can also join support communities focused on stress, anxiety, depression and more.

Unlimited in-the-moment consultations

Our team will take time to talk through your issue and get you to the right resources or licensed clinician based on your needs.

Behavioral Specialty Coaching & Support Services

Our coaches provide dedicated support for a broad range of conditions including:

- Autism spectrum disorder
- Eating Disorders
- Intensive behavioral case management
- Opioid and pain management
- Substance use

We also provide coaching and support for parents and families, which allows individuals to be effective advocates for their family member or their own mental health needs.

Services to help manage life events:

At no additional charge to you, you can receive face to face sessions with a licensed mental health professional in our EAP network. You also get online, on-demand seminars as well as community resources and referrals on a range of topics including:

- Child care
- Adoption
- Senior care
- Pet care
- Legal and financial consultation services
- Identity theft support
- Summer camps
- Parenting
- Convenience services

To learn more or access services:

To access services to help manage life events, visit myCigna.com.

You can call 877.231.1492 for referrals or go online, search the provider directory and obtain an authorization.

For links to iPrevail and Happify, visit the Wellness page. You can also call the toll-free number on your ID card.

Now Available: Teletherapy through myStrength Complete



We're excited to introduce a new wellness resource for members: myStrength Complete for behavioral health services. myStrength Complete is a comprehensive, flexible digital program with proven tools and support for stress, sleep management, depression, anxiety, and more.

myStrength Complete is the latest in the suite of behavioral health resources. Explore your options at kp.org/mentalhealthservices.



myStrength Complete offers many services and resources

- **Teletherapy.** Phone and video appointments with a licensed therapist from the comfort of home, seven days a week.
- **Telecoaching.** Live video sessions with a certified coach.
- **Structured digital courses.** Based on gold-standard, evidence-based clinical protocols.
- **Recommended digital content.** Personalized for your interests and goals.
- **In-the-moment-tools.** Short, actionable digital activities to help you cope with periods of high stress.

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care



It's not always easy to find time for the health care you need. After all, doctor's appointments traditionally involve time and travel. That can leave to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE and MyChart to offer a comprehensive suite of convenient virtual care options-available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs. MDLIVE is available 24/7/365. MyChart will connect you with a dedicated nurse practitioner from EVERNORTH, Monday-Friday during normal business hours. The nurse is able to treat and prescribe medication for acute care needs. Virtual visits through MyChart may be at little to no cost compared to virtual visits with MDLIVE.

Primary Care through MDLIVE

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no cost to identify conditions
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities

Urgent Care through MDLIVE and MyChart

On-demand care for minor medical conditions

- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

3 easy steps to connect to care

Virtual care visits are convenient and easy. To schedule an appointment:



Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. To get started with MyChart, first create a MyChart Account. More information can be found [here](#).



Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE



For MDLIVE follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Behavioral Care through MDLIVE

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

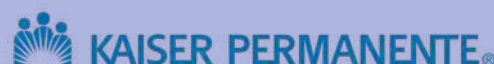
Dermatology through MDLIVE

Fast, customized care for skin, hair, and nail conditions - no appointment required

- Board certified dermatologist review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours.

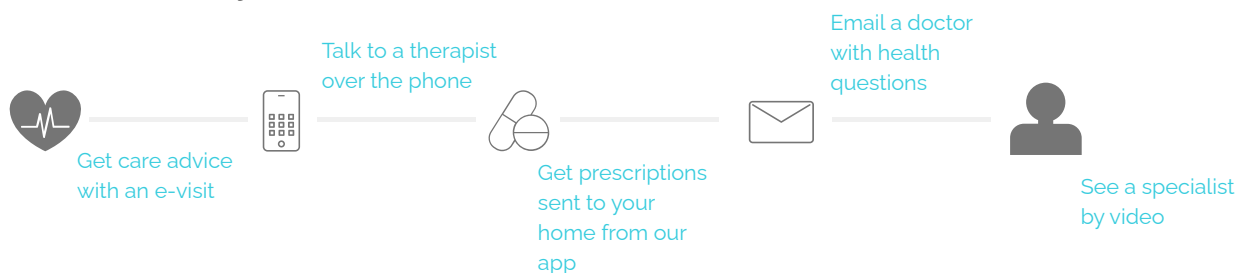
Kaiser Permanente virtual care

Convenient care from connected teams



Health happens everywhere. Getting quality health care should, too. That's why our health care team can meet employees when and where they need care most. Since our care team can see and update electronic health records, employees can connect with someone who knows their health history.

Save time and money with \$0 virtual care



There are many ways to get high-quality care over the phone, by video, and online. Even better, most are available at no additional cost from day one.

- **Video or phone appointment** - Schedule a face-to-face video visit or phone appointment with Kaiser Permanente doctors and specialists.
- **E-visit** - Use our online symptom checker for certain conditions and get personalized care advice within a few hours.
- **24/7 advice** - Get on-demand support with 24/7 advice by phone.
- **Email** - Message our care team with non-urgent health questions and get a reply usually within 2 business days.

Manage your health online

Once enrolled on kp.org, you can use the Kaiser Permanente app to schedule routine appointments, refill most prescriptions, see most test results, and more - 24/7, all in one place.

Tap into wellness resources

Live well and thrive with many digital resources - many available at no cost.



Get special rates on thousands of on-demand fitness videos from fitness industry leader **ClassPass**.



Get daily support for improving and maintaining well-being with **myStength** app.



Ease of mind with **Calm**, the #1 app for sleep, meditation, and relaxation.

Nurse Advocates

*Through Cigna and Kaiser
Permanente*

A no-cost Health Information Line puts you in touch with a personal nurse advocate via chat or phone. They're here to answer your health questions and help you make the best choice for your needs.

Nurse advocates are available for questions like:

- I've had a fever for 2 days. Should I go to the emergency room?
- Is virtual care a good option for my needs?
- Is there a good orthopedic doctor in my area?
- I take maintenance medication, how can I save on my prescription and get it delivered?

The no-cost Health Information line is always confidential.

- Chat - 24/7/365 - at www.my.cigna.com or www.kp.org/getcare or on the myCigna or KP App.
- Call 24/7/365 - Just dial the number on the back of your ID card.

Health Engagement Nurse

A dedicated health engagement nurse is available to meet with all employees to discuss lifestyle behaviors they may want to address such as weight loss, physical activity, nutrition counseling, chronic condition management and disease prevention. The Health Engagement Nurse will help employees create and work toward your personal health goals. The nurse is available M-F during normal business hours.

**The Health Engagement Nurse
Assists with:**

- Health Education
- One-on-One Planning
- Finding Providers
- Reviewing Medical Benefits
- Condition Management
- Support / Outreach
- Wellness Education
- Preventive Care
- Blood Pressure Screenings
- Cigna Programs

Personal information will not be shared with your employer. All your personal health information is protected in accordance with HIPAA.

Lifestyle Management

Through Cigna

Whether your goal is to lose weight, quit tobacco or lower your stress levels, you have the power to make it happen. Cigna Lifestyle Management Programs can help- and all at no additional cost to you. Each program is easy to use and available where and when you need it. And, you can use each program online or over the phone - or both.

Weight Management

Reach your goal of maintaining a healthy weight- all without fad diets. Create a personal healthy-living plan that will help you build your confidence, be more active and eat healthier.

Tobacco Cessation

Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. You'll get free over-the-counter nicotine replacement therapy.

Stress Management

Get help lowering your stress levels and raising your happiness levels. Develop a personal stress management plan and get the support you need.

Get support over the phone with one-on-one wellness coaching or online with a self-paced program.

Take the first step.

Call 800-244-6224 or visit myCigna.com

SUMMUS

Get fast access to world-class medical expertise. The Summus specialist network and medical advisory team is available to you and your dependents by phone or video from anywhere in the world-across all health concerns.

Member Benefits Include:

- Fast, Virtual access to Summus MDs and expert physician network.
- Personalized concierge service, including medical records collection and prep for every consult.
- Verified referrals to specialist.
- Individual condition-specific plans and coaching.

Support for any health questions, anytime, any plan

Health Navigation - caregiver support, elder care navigation, finding a specialist, men's & women's health

Preventive & Chronic Health- arthritis, diabetes, migraines, blood pressure, pain management, thyroid.

Complex & Serious - Alzheimer's, dementia, cancer, heart disease, high-risk pregnancy

This benefit is available to all medical plan participants.

Contact Summus:

Phone: 1-917-565-8540

Email: ebs@summusglobal.com.

KNOW WHERE TO GO

Virtual Visits	Convenience Care	Doctor's Office	Urgent care	ER
Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when where and how it works best for you.	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room.
• Colds and flu • Rashes • Sore throats • Headaches • Stomachaches • Fever • Allergies • UTIs and more	• Colds and flu • Rashes or skin conditions • Sore throats, earaches, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccines	• General health issues • Preventive care • Routine checkups • Immunizations and screenings	• Colds and flu • Rashes or skin conditions • Sore throats, earaches, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccines	• Major health issues that cannot wait • Broken Bones • Major cuts and burns • Imaging

TERMS TO KNOW

Discounted Rate

When you enroll in coverage you become a member of the plan. A member gets access to a network of providers (doctors and facilities) – these are in-network providers. Members receive Discounted Rates with these in-network providers.

Copays

Copays are set dollar amounts you pay for specific services. These costs are typically collected at the time of service. Copays are not applied toward the deductible.

Deductible

Services not subject to a copay are subject to your deductible. You pay first dollar costs for claims subject to your deductible and you receive the Discounted Rate for all covered claims with an in-network provider.

Coinsurance

Coinsurance is a cost share. Once you meet the deductible the insurance company will share in the cost of your claims. The percent is the cost for the claim you are responsible for. The amounts you pay in coinsurance applies to your out of pocket maximum.

Out-of-Pocket

This amount is the maximum amount you will pay towards covered services on the plan for the calendar year. This amount includes the amounts you pay in deductible, coinsurance, copays, and prescription copays.



IT PAYS
TO GET
HEALTHY

The Cigna MotivateMe Program rewards your health actions

Your employer wants to help you get healthy and stay healthy. So when you get involved in wellness goals you can easily earn up to \$300 in rewards per calendar year.. And the more you do, the more you earn.

Health assessment survey	A confidential questionnaire that asks you about your health and well-being and provides a personalized assessment.	\$25
Biometric Screening	Know your numbers. Complete blood pressure, cholesterol blood sugar and body mass index (BMI) screening.	\$75
Preventive Exam	A preventive exam that's used to reinforce good health, address potential and chronic problems.	\$100
Personalized Coaching	Whatever your goal, a nurse, health coach, nutritionist or clinician can help you create a step-by-step plan to achieve it.	\$50 (max) \$25 up to 2x
Physical Activity Check-In	Self report 1 time each month after you complete a total of 12 physical activities- such as walking, house cleaning, riding a bike.	\$20/mo \$240 max
Dental Preventive Exam	A preventive dental exam is used to reinforce good health and address potential and chronic problems.	\$50
Omada Diabetes Prevention	Learn how to reduce your risk for heart disease and diabetes related complications	\$100
Maternity	Get support through all stages of pregnancy to help ensure optimal health for both baby and parent.	\$150 1st trimester \$75 2nd trimester

Getting started is easy

Visit www.myCigna.com and select "Wellness" or View "my incentives" to:

- Find detailed instructions on how to get started
- View a list of eligible goals and matching rewards
- Check and track your completed goals and earned rewards.

The rewards you earn will be automatically applied toward a:

Debit/ gift card

The rest is up to you

For more information or help setting up your account, visit www.mycigna.com or call 1-800-244-6224. You can also find information by downloading the myCigna Mobile App for your mobile device.





You're invited to enjoy healthy rewards

Complete these healthy activities by December 31, 2025 and earn a \$200 reward card.

1

Join today

- Visit kp.org/engage and sign on with your kp.org user ID and password.*
- Accept the Wellness Program Agreement to be eligible to earn rewards.
- Visit the website often to view and track the status of your activities.

2

Here's what to do

- Complete your biometric screenings:
 - Blood glucose
 - Blood pressure
 - Body mass index (BMI)
 - Total cholesterol
- Take the Total Health Assessment

3

Enjoy the rewards

- Complete all your activities by December 31, 2025
- Earn a \$200 reward card from Kaiser Permanente.

Start now. Sign on at kp.org/engage

*If you're not yet registered at kp.org, click the "Register for an account" button to get a user ID and password.

The rewards program runs from January 1, 2025, through December 31, 2025, and is open to all benefits-eligible Kaiser Permanente subscribers 18 and older covered by the AIMS Trust Benefits health plan from Kaiser Permanente. Rewards cards expire 12 months from date issued.

Workforce health programs and rewards are separate services that are not health plan benefits and may be discontinued at any time.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852

DENTAL INSURANCE

We offer dental coverage through Cigna Healthcare and Dominion National. The Cigna Healthcare Dental PPO Plans allow you to use in-network or out-of-network benefits. [Click here](#) to learn how to find in-network providers. If out-of-network dentists are used, you will be responsible for paying the difference between Cigna's allowed amount and what the dentist may charge, also known as "balance billing".

The Dominion National plan allows for in-network benefits only. If out-of-network dentists are used you are responsible for all dental expenses. To find in-network providers go to www.dominionnational.com click on "Find Provider", select Dental and search the "Elite Plus ePPO" network.

The chart below provides a brief overview of the plans.

Please note: Benefit summaries and plan information for all plans offered by EBS will be included in links throughout this guide. Refer only to the options offered by the organization. If there is a discrepancy between this guide and plan document, the [plan document](#) will govern.





Cigna Dental
PPO 2500 MAC Plan

Cigna Dental
PPO 5500 MAC Plan



Dominion National
Elite Plus ePPO

IN-NETWORK

Calendar Year Deductible

	\$0 / \$0	\$0 / \$0	\$25 / \$75
Annual Maximum (per covered member)			
Per covered member	Year 1: \$2,500 Year 2: \$2,600 Year 3: \$2,700 Year 4: \$2,800	Year 1: \$5,500 Year 2: \$5,600 Year 3: \$5,700 Year 4: \$5,800	\$2,000
Preventive Services			
Exams, Fluoride (children up to 15), X-Rays, etc	Covered 100%	Covered 100%	See Fee Schedule
Basic Services			
Fillings, Simple Extractions, Endodontics, Periodontal Scaling & Root Planing, Oral Surgery	Covered 80%	Covered 90%	See Fee Schedule
Major Services			
Crowns, Bridges, Dentures, Inlays, Onlays, Implants	Covered 50%	Covered 60%	See Fee Schedule
Ortho	Child Only, 50% up to \$1,500 Lifetime Benefit	Child Only, 50% up to \$1,500 Lifetime Benefit	Individual Ortho Buy Up Plan Available

OUT-OF-NETWORK

Deductible	\$0 / \$0	\$0 / \$0	
Annual Max	See In-Network Above	See In-Network Above	No
Preventive Services	100% of allowed benefit	100% of allowed benefit	Out-of-Network
Basic Services	80% of allowed benefit	90% of allowed benefit	Benefits
Major Services	50% of allowed benefit	60% of allowed benefit	Available
Ortho	50% of allowed benefit	50% of allowed benefit	

Per Paycheck Cost for Coverage

Employee Only	\$19.22	\$27.66	\$8.65
Employee + Spouse	\$38.44	\$55.32	\$16.45
Employee + Child(ren)	\$28.84	\$41.50	\$16.45 one child
Employee + Family	\$49.97	\$71.91	\$21.16

ONLINE MEMBER RESOURCES

Dominion National recognizes that you need quick and convenient access to real-time benefit information and resources. We also understand that each of our customers is unique and has different communication preferences so we've created a variety of online tools to provide you with instant access to your account when and wherever you need it.



MEMBER PORTAL

DominionMembers.com

Online Access-Real Time, Password Protected

- ID Cards
- Dental Cost Calculator
- Dentist Search
- Customer Service Requests and Live Chat
- Obtain Plan Information and Certificates of Coverage



CONNECT ON DOMINION NATIONAL GO

Receive personalized account communications straight to your mobile device by connecting on Dominion National Go. Text notifications also provide an easier way to access your digital ID card, find a provider and stay informed. Call 888-596-0716 or go to bit.ly/connectongo to register.



MYDOMINION MOBILE APP

The MyDominion mobile app provides members with easy access to account and plan information.

- Find A Dentist
- View ID Cards
- View Plan Information

The MyDonimion app is compatible with iPhone and Android and can be downloaded through our website at DominionNational.com/mobile



HOW DO I FIND A PARTICIPATING DENTIST

Dominion National has extensive networks providing access to over 350,000 national PPO dentist listings and one of the largest Select Plan and ePPO networks in the Mid-Atlantic region. Follow the below instructions to find a participating dentist.

Go to DominionNational.com/find-a-dentist. Utilize the searchable features to find general dentists and specialists near your home or office. You may filter your search by city, state, zip code or dentist name and type. **You must select Elite Plus ePPO in the dropdown menu in order to determine the corresponding network.**

Prevention Rewards Program

Get your cleanings. Receive your reward!

Preventative dental care is important to your overall health and will help prevent costly dental work in the future. To encourage you to receive preventative services, we will pay \$20 for each family member enrolled with Dominion National who receives two cleanings from a network dentist during the plan year. For example, that's \$80 for a family of four enrolled members who each receive two cleanings from a participating Dominion network dentist within the plan year.

No additional action is required on your part to receive the reward as we will automatically send the primary subscriber the reward check for members who qualify. Simply make your semi-annual appointment and ask your dentist to submit a claim for your cleaning.

Rollover Benefits

Rollover benefits add extra value!

You can carry over a portion of your unused benefit maximum year after year. You are given the flexibility to save up and plan for more costly dental procedures in a way that works best for you. This feature is included with your plan.

Rollover benefits are easy and automatic. A member may be eligible to roll over a portion of unused annual maximum per benefit or calendar year for Diagnostic & Preventive (Class 1), Basic (Class II) and Major (Class III) services. The amount of rollover benefits may not exceed the rollover maximum. Rollover does not apply to benefits that are subject to lifetime maximum, such as orthodontics. To learn more, click [here](#).



Value-Added Member BENEFITS

As a Dominion National member, you have access to additional benefits to help support you on your path to health and wellness.

TELEDENTISTRY: ENJOY INCREASED CONVENIENCE AND ACCESS TO ORAL CARE

Receive a dental consultation without leaving your home or office! This innovative, easy to use mobile app for teledentistry services includes virtual exams and second opinions.

Learn more at
www.dominionnational.com/teledentistry

DISCOUNT HEARING PROGRAM THROUGH AMPLIFON HEARING HEALTH CARE

Dominion has partnered with global hearing care leader Amplifon to bring a hearing discount program that offers savings averaging 64% off the price on more than 1,400 hearing aid options. Visit amplifonusa.com/dn or call 855-565-1072 to connect with a hearing care advocate today.

MEMBER SAVINGS ON ORAL CARE PRODUCTS WITH Z DENTAL

Access exclusive discounts on premium oral care products and accessories offered by Z Dental. Members can access the following types of Z Dental products at 50% off the already discounted price:

- Z Sonic Water Flosser
- Z Sonic Featherweight Toothbrush
- Z Sonic Pulse Toothbrush
- Z Sonic Mini Toothbrush

Learn more and access products visit MyZSonic.com/DM and be sure to enter promo code "DOMINION."

SMILEDIRECTCLUB'S CLEAR ALIGNER PROGRAM

SmileDirectClub's orthodontic clear aligners offer a flexible and convenient alternative to traditional braces without the higher price tag or required monthly in-person visits. To learn more, visit DominionNation.com/sdc

Ortho Discount Program

PROGRAM FEATURES

- NO Deductibles
- NO Waiting Periods
- NO Pre-authorization
- NO Lifetime Maximums
- NO Pre-existing Condition Exclusion
- NO Claim Forms



Ortho Discount Program

Quality care at predetermined fees.

Choose any in-network orthodontist from one of the largest discount dental networks in the Mid Atlantic.

Family members may select different orthodontists.

All network orthodontists are licensed, regulated and must meet Dominion's Credentialing and Quality Assurance Program standards.



Is this a dental insurance plan?

No. This is not an insurance plan. It is a reduced fee-for-service program designed specifically for individuals. Members pay a predetermined reduced fee for listed services provided by contracted providers. Dominion does not pay contracted providers for services.



Who is Eligible?

Everyone is eligible to enroll. The program is available on a per member basis.



What is My Cost?

You will pay a one-time charge per member for three years of access to reduced fees.

Existing Dominion PPO
Member.....\$49

Non-Existing Dominion PPO
Member.....\$99



Secure Online Access to your Account

Access your digital ID card, find a provider and more through secure online resources.

MEMBER PORTAL

DomnionMembers.com

GO MOBILE COMMUNICATION SERVICE

Register by calling 888.596.0716 or texting "DN GO" to 73529

MyDominion Mobile APP

Download at

DominionNational.com/mobile

Ortho Discount Services and Member Fees

Service	Fee
Phase 1 Treatment	15% Discount
Pre-orthodontic treatment visit	\$ 413
Comp. ortho. treatment - transitional dentition	\$3,304
Comp ortho. treatment - adolescent dentition	\$3,433
Comp. ortho. treatment - adult dentition	\$3,658
Periodic ortho. treatment visit (as part of contact)	\$ 188
Orthodontic retention (rem of appl. and placement of retainer(s))	\$ 413

How do I Enroll?

Complete the [application](#).

You must receive care from a participating Discount Network orthodontist to receive discounts on services.

After your effective date, simply call the participating orthodontist and make an appointment.

You may pay a one-time payment by either credit card or check.

Return the completed application and payment to Dominion National; PO Box 75314; Charlotte, NC 28275

An ID card will be sent to you on or before your first day of eligibility.

If your application and payment are received by the 25th of the month, your program is effective on the first day of the following month.

Program Exclusions

Services which are covered under Medicare, workers' compensation, employers liability laws.

Services which, in the option of the Program, are not necessary for the patient's dental health.

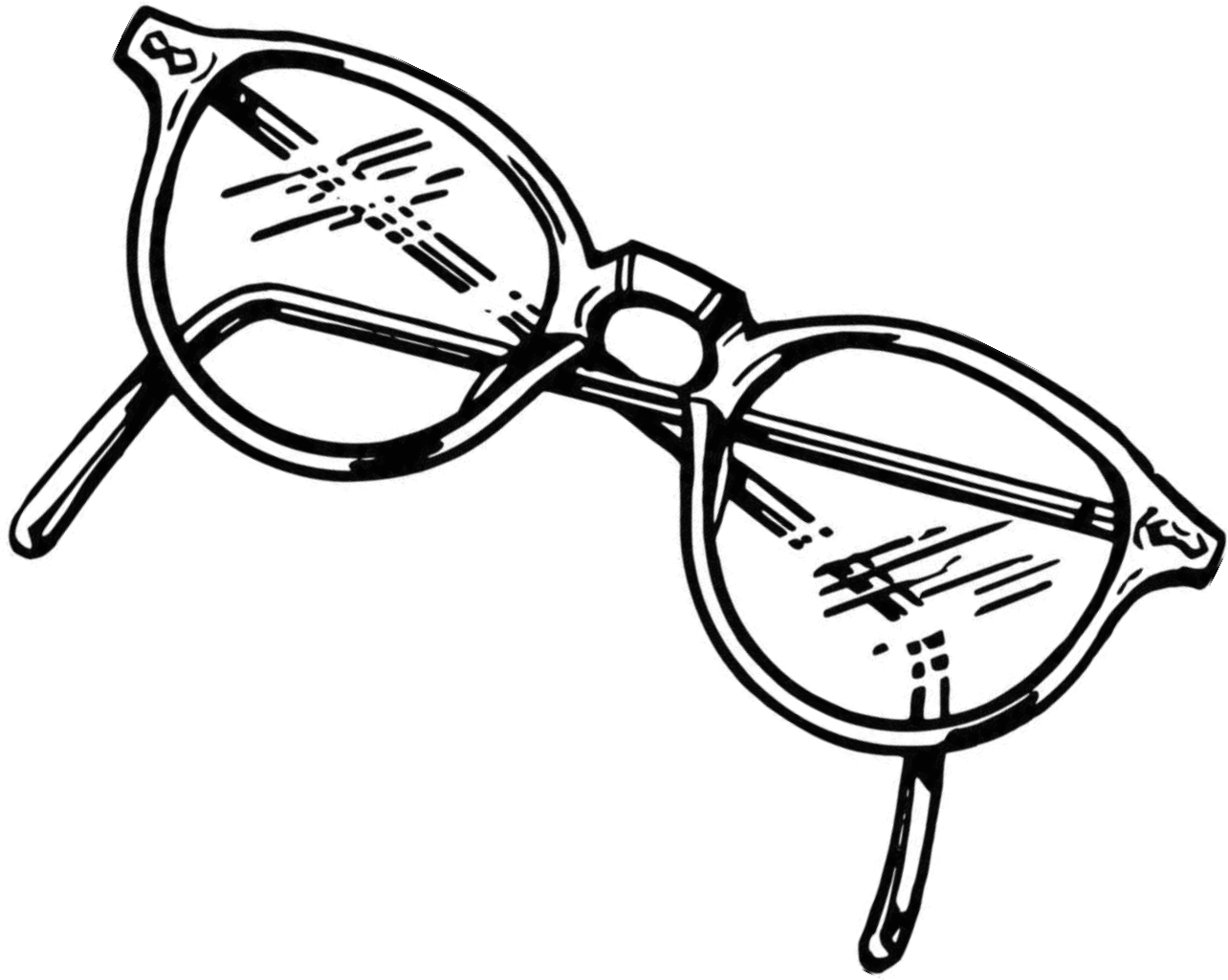
Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.

Hospitalization for any dental procedure.

Procedures not listed as covered benefits under this program.

Services obtained outside of the dental office which enrolled and are not pre-authorized.

For more exclusions click [here](#)



VISION INSURANCE

We offer vision coverage through VSP vision care. The PPO vision plan allows you to use in-network or out-of-network benefits. To find in-network providers go to www.vsp.com click on "Find a Vision Provider" and enter your search criteria. When you utilize an out-of-network provider you are responsible for expenses not covered. Contact VSP regarding out-of-network plan details.

IN-NETWORK

Routine Eye Exams	Every calendar year
	\$0 Copay
Lenses	Every calendar year
Single Vision	Included with Prescription
Standard Progressive	Covered
Premium Progressive	\$95-\$105 allowance
Custom Progressive	\$150-175 allowance
Frames	Every Calendar Year
Standard Frames	\$150 allowance
Featured Frames	\$200 allowance
Contact Lenses (in lieu of glasses)	Every calendar year
Contact Lenses	\$130 allowance
Contact lens exam (fitting)	Up to \$60 copay

OUT-OF-NETWORK

Routine Eye Exams	Every calendar year
	Cover up to \$45
Lenses	Every calendar year
Single	Cover up to \$30, \$50, or \$65
Standard Progressive	Cover up to \$50
Premium Progressive	Cover up to \$50
Custom Progressive	Cover up to \$50
Frames	Every calendar year
Standard Frames	Cover up to \$70
Featured Frames	
Contact Lenses (in lieu of glasses)	Every calendar year
Contact Lenses	Cover up to \$105
Contact lens exam (fitting)	

Per Paycheck Cost for Coverage

Employee Only	\$3.28
Employee + Spouse	\$6.56
Employee + Child(ren)	\$7.01
Employee + Family	\$11.21

PRE-TAX SAVINGS PROGRAMS

With pre-tax savings programs you can put more money in your pocket! Since you are setting aside money before federal, state, or social security taxes, it can help reduce your taxable income and increase your take home pay. Our plans offer a debit card for convenient payment of eligible expenses at qualified merchants.



HEALTH SAVINGS ACCOUNT (H.S.A.)



2025 IRS Annual Maximum* HSA Contribution Limits

Employee Only	\$4,300
Employee + Dependent(s)	\$8,550

Additional \$1,000 annually catch-up amounts available for employees 55 years or older

With an HSA you are setting aside money to help cover your health care expenses now or in the future, even into retirement. It is like a 403(b) or 401(k) for health care, with option to invest and grow your balance. And it gets even better- your contributions, earnings and withdrawals are all tax-free if used on qualified expenses. If you do not use your money, that's OK. It will rollover year after year. And if you change employers or health plans, the HSA goes with you! Our plan offers a debit card for convenient payment of eligible expenses at qualified merchants.

Contribute up to the IRS limit for eligible expenses such as deductible, co-pays, co-insurance, dental, vision, prescription and over the counter medications.

For a complete list of eligible and ineligible expenses visit www.optumbank.com.

- Covers you, your spouse and your tax dependents.
- Only the funds you have deposited from your paycheck are available for reimbursement.
- 100% of your unused funds rollover year to year.
- Must be enrolled in a qualified high-deductible health plan.
- You may not contribute to an HSA if:
 - You are enrolled in Medicare or TRICARE.
 - You have other health coverage that pays out-of-pocket health care expenses before you meet the plan deductible.
 - Veterans Affairs medical benefits have been used in the last three months, unless the services were for service connected disability.
 - Someone claims you as a dependent on their tax return (such as your parents).
 - You or your spouse contribute(d) to a medical FSA in the same calendar year or until the medical FSA balance is \$0.

FLEXIBLE SPENDING ACCOUNTS

MEDICAL CARE FSA

IRS Contribution Limit for 2025: \$3,300

- Contribute up to the IRS limit for eligible out-of-pocket medical care expenses such as deductible, co-pays, co-insurance, dental, vision, prescription and over the counter medications.
- Covers you, your spouse and your tax dependents.
- Your full contribution is available at the beginning of the Plan Year.
- At the end of each plan year, any unused funds above the annual carryover amount will be forfeited.

For a complete list of eligible and ineligible expenses view the [IRS 502 Publication](#)

LIMITED PURPOSE FSA

IRS Contribution Limit for 2025: \$3,300

- Contribute up to the IRS limit for eligible dental and vision expenses only.
- This plan works best if you are already maximizing your Health Savings Account contributions and you are looking for an additional pre-tax savings. Limited purpose can be used for dental and vision expenses only.
- Your full contribution is available at the beginning of the Plan Year.
- At the end of each plan year, any unused funds above the annual carryover amount will be forfeited.

For a complete list of eligible and ineligible expenses view the [IRS 502 Publication](#)

DEPENDENT CARE FSA

IRS Contribution Limit for 2025: \$5,000

- Contribute up to the IRS limit for eligible day care, elder care, and even care for dependents with disabilities. Does not cover overnight camps.
- Covers dependent(s) age 13 or younger or a spouse or dependent incapable of selfcare.
- Only the funds you have deposited from your paycheck are available for reimbursement.
- This plan does not have a carryover feature. Therefore, any unused funds will be forfeited at the end of the plan year.

For a complete list of eligible and ineligible expenses view the [IRS 503 Publication](#)

WORKSITE BENEFITS

We offer you additional benefits on a complimentary and voluntary basis. Please see the below list of benefits that are offered to you. The premiums for some of the elected voluntary benefits below may be deducted from your paycheck. For some benefits, if you elect coverage, you have the option to cover your spouse and/or child(ren). Premiums will vary by employee and policies selected.



EMPLOYER PROVIDED BENEFITS

BASIC TERM LIFE/ACCIDENTAL DEATH & DISMEMBERMENT

Through Reliance



Basic life insurance coverage is offered to employees (75% FTE or more) and is equal to two times an employees annual earnings rounded to the nearest \$1,000 to \$175,000 whichever is less. The policy reduces at age 65 to 65%, age 70 to 40%, and age 75 to 20%. The life insurance is a term policy with the term being the period of employment with the School. The policy does not earn interest or pay dividends to policy holders. Life insurance coverage in excess of \$50,000 is subject to SS, or Federal and/or state taxes.

This benefit is employer paid.

SHORT TERM DISABILITY

Through Garrison Forest School



Full-time employees working 30 hours or more per week and who have completed 12 months of continuous employment will be eligible for short-term disability. This will apply in the event the employee cannot work due to his or her own serious health condition for absences up to three months in any twelve-month period. Coverage is based on length of service and is described in more detail in the employee handbook. Employees have a 5 day elimination period before short-term disability benefits begin..

This benefit is employer paid.

LONG TERM DISABILITY

Through Reliance



If you are out of work for more than 3 months, you may be eligible for Long Term Disability benefits.

Monthly Benefit: 60% of your monthly earnings

Monthly Maximum: \$5,000 per month

Maximum Benefit Period: Social Security Normal Retirement Age unless otherwise noted.



Contact Human Resources before any absence, and if you have any questions about these benefits.

VOLUNTARY BENEFITS

GROUP ACCIDENT INSURANCE

Through Reliance

Accident Insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment (if included). These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care. You may be eligible to purchase additional accident insurance coverage for you, your spouse, and/or children, based on your employment status. Applicants must be under age 70 at date of application.

- Schedule Benefit:** Each eligible employee may elect a Plan Type and Coverage Option from the table below.
- **Plan Type:** Choose from the options below. Please refer to the [plan highlight sheet](#) for plan details.
 - **Coverage Options:** Employee Only, Employee and Spouse, Employee and Child(ren), or Employee & Family (which includes both spouse and child(ren))

Monthly Premiums

Plan Type	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
Plan A (Low)	\$6.74	\$10.56	\$14.59	\$18.59
Plan B (High)	\$9.92	\$15.44	\$21.16	\$26.97

* Your benefit volume(s) will age reduce to 50% at age 65 and 25% at age 70.



Contact Human Resources to enroll or if you have any questions about this benefit.

Schedule of Benefits

Group Accident Insurance

	Plan A (Low)	Plan B (High)
Emergency Care Benefits		
Ambulance Transportation	\$100 Ground, \$500 Air	\$150 Ground, \$750 Air
Emergency Treatment	\$150	\$200
Diagnostic Examination (one per covered accident)	\$100	\$200
Initial Physician Office Visit (one per covered accident)	\$50	\$75
General Treatment Benefits		
Initial Hospital Admission (one per covered accident)	\$500	\$1,000
Initial ICU Hospital Admission	\$1,000	\$1,500
Hospital Confinement per day	\$200, 365 days max	\$250, 365 days max
ICU Confinement per day	\$400, 30 days max	\$500, 30 days max
Rehabilitation Facility Confinement	\$50/day, 30 days max	\$100/day, 30 days max
Follow-up Physician Office Visit (once per covered accident)	\$50	\$75
Transportation (more that 100 miles, 3 roundtrips max)	\$300	\$450
Lodging (for 1 person, more than 100 miles from residence)	\$100/ 30 days max	\$150/ 30 days max
Paralysis Benefits		
Paralysis Benefits	\$10,000 quadriplegia; \$5,000 paraplegia./hemiplegia	\$15,000 quadriplegia; \$7,500 paraplegia/hemiplegia
Surgery Benefits		
Surgery Benefits	\$100 for Explorotory no repair; \$300 for knee Cartilage; \$1,000 for abdominal or thoracic; \$500 for Ruptured Disc; up to \$600 Tendon, Ligament, or Rotator Cuff	\$150 for Exploratory no repair; \$450 for knee Cartilage; \$1,500 for abdominal or thoracic; \$750 for Ruptured Disc; up to \$900 Tendon, Ligament, or Rotator Cuff
Transitional Benefits		
Medical Appliance	\$100	\$150
Prosthesis	\$1,000 for two or more, \$500 for one	\$1,500 for two or more, \$750 for one
Physical Therapy	\$25 per session, up to 6 sessions	\$35 per session, up to 6 sessions
Specific Covered Injury & Treatment Benefits		
Fractures	Up to \$5,000 for certain surgical repair; up to \$2,500 for non-surgical; Chip: 25% of non-surgical full fracture benefits; Multiple: 100% of highest sustained fracture	Up to \$7,500 for certain surgical repair; up to \$3,750 for non-surgical; Chip: 25% of non-surgical full fracture benefits; Multiple: 100% of highest sustained fracture
Dislocation	Up to \$3,200 for surgical; Up to \$1,600 for non-surgical; Partial - 25% of non-surgical full dislocation; Multiple-100% of highest dislocation benefit	Up to \$4,800 for certain surgical repair; up to \$2,400 for non-surgical; Chip: 25% of non-surgical full fracture benefits; Multiple: 100% of highest sustained fracture
Blood/Plasma/Platelets	\$200	\$300
Burns	Up to \$800 for 2nd degree burns; Up to \$6,400 for 3rd degree burns; Skin Graft- 25% of benefit payable for burns	Up to \$1,600 for 2nd degree burn; Up to \$12,800 for 3rd degree burns; Skin Graft- 25% of benefit payable for burns
Coma	\$5,000	\$7,500
Concussion	\$100	\$150
Dental Injury	\$150 for Crown; \$50 for Extraction	\$300 for Crown; \$75 for Extraction
Lacerations	Up to to \$400	Up to \$600
Accidental Death and Dismemberment Benefits		
Accidental Death	Employee \$25,000/Spouse \$12,500/ Child \$5,000 per child	Employee \$50,000/Spouse \$25,000/ Child \$10,000 per child
Common Carrier	100% of Accidental Death Benefit	100% of Accidental Death Benefits
Single Loss-hand/foot/leg/sight in one eye/hearing in one ear	50% of Accidental Death Benefit	50% of Accidental Death Benefit
Catastrophic Loss- 2+ losses (except thumb, finger or toe)	100% of Accidental Death Benefit	100% of Accidental Death Benefit
Thurmb/Finger/Toe	\$250 - \$750	\$500-\$1500
Catastrophic Loss of Speech	100% of Accidental Death Benefit	100% of Accidental Death Benefit

VOLUNTARY BENEFITS

GROUP CRITICAL ILLNESS INSURANCE *Through Reliance*

Critical Illness Insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care. Applicants must be under age 70 at date of application.

You may be eligible to purchase additional coverage for you, your spouse, and/or children, based on your employment status. The benefit volumes are:

- **Employee:** \$5,000, \$10,000, \$15,000, or \$20,000
Initial enrollment guaranteed issue: \$20,000
- **Spouse:** \$5,000, \$10,000, \$15,000, or \$20,000 (not to exceed 100% of approved employee amount)
Initial enrollment guaranteed issue: \$20,000
- **Dependent Child(ren):** 25% of approved employee amount up to a maximum of \$5,000.
All child amounts are guaranteed issue.

If you elect not to purchase critical illness insurance when you initially become eligible or during an open enrollment period and later decide to take advantage of this benefit, you will be required to provide evidence of insurability regardless of the amount of coverage you elect. If you are denied by the insurance carrier for additional coverage amounts you will not be eligible for any amounts beyond what the carrier approved.

* Your benefit volume(s) will age reduce to 50% at age 70.

Monthly Premiums

Benefit Amount	Age <30	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75-79	Age 80-84	Age 85+
\$5,000	\$0.90	\$1.30	\$1.70	\$2.60	\$4.15	\$6.15	\$8.45	\$12.00	\$17.40	\$26.15	\$43.45	\$54.35	\$86.30
\$10,000	\$1.80	\$2.60	\$3.40	\$5.20	\$8.30	\$12.30	\$16.90	\$24.00	\$34.80	\$52.30	\$86.90	\$108.70	\$172.60
\$15,000	\$2.70	\$3.90	\$5.10	\$7.80	\$12.45	\$18.45	\$25.35	\$36.00	\$52.20	\$78.45	\$130.35	\$163.05	\$258.90
\$20,000	\$3.60	\$5.20	\$6.80	\$10.40	\$16.60	\$24.60	\$33.80	\$48.00	\$69.60	\$104.60	\$173.80	\$217.40	\$345.20

*Separate premium charges apply for Employee and Spouse elections

Child(ren) Monthly Premiums

Benefit Amount	Monthly Premium	Benefit Amount	Monthly Premium	Benefit Amount	Monthly Premium	Benefit Amount	Monthly Premium
\$1,250	\$0.55	\$2,500	\$1.10	\$3,750	\$1.65	\$5,000	\$2.20

*One rate and benefit amount for all eligible children in family, regardless of number of children.

Plan Features

Critical Illness Insurance

ADULT DIAGNOSIS	BENEFIT
Benign Brain Tumor	100%
Carcinoma in Situ- Partial Benefit	25%
Coma	100%
Coronary Disease-Partial Benefit	25%
Heart Attack	100%
Life Threatening Cancer	100%
Loss of Sight	100%
Loss of Hearing	100%
Major Organ Failure (ie Heart Failure, Renal Failure)	100%
Motor Neuron Disease (ie. ALS, Lou Gehrig's)	100%
Paralysis	100%
Ruptured Cerebral; Carotid or Aortic Aneurysm	100%
Stroke	100%

CHILD DIAGNOSIS	BENEFIT
Cerebral Palsy	25%
Cleft Lip or Palate	25%
Cystic Fibrosis	25%
Down Syndrome	25%
Muscular Dystrophy	25%
Spina Bifida	25%
Type 1 Diabetes	25%

- Lifetime Maximum Benefit - 1,000% of insurance amount
- Subsequent Occurrence Benefit - 100% of benefit if diagnosed 3 months or later
- Recurrence Benefit (same illness) - 50% if diagnosed 6 months or later
- FMLA/MSLA Contribution
- Portability to employee age 70

*For a complete list of exclusions and limitations please see the [Highlight Sheet](#) or contact EBS for a copy of the Certificate of Insurance.



Contact Human Resources to enroll or if you have any questions about this benefit.

VOLUNTARY BENEFITS

Pet Insurance Through Figo

It's easier to get pet insurance plans now that your organization is teaming up with Figo. Choose from customized plans, each designed to help take good care of your pet if unexpected injuries and illness arise.

Plan benefits for you

- Freedom to see any veterinarian for your pet's care
- 24/7 access to Live Vet for virtual visits
- A simpler claims process
- Direct deposit reimbursements
- An inbox for your pet's records and plan documents

Head to tail coverage for your pet

- | | |
|--|---|
| - Cancer treatments | - Knee conditions |
| - Chronic conditions | - Prescriptions |
| - Emergency and hospitalization | - Prosthetics and orthopedics |
| - Exam and consultation fees | - Surgeries |
| - Hereditary and congenital conditions | - Third party property damage liability |
| - Hip dysplasia | - Veterinary specialists |
| - Imaging | - Wellness and dental |



Enroll in Figo Today

1. Choose a plan with a deductible and reimbursement levels that meet your needs.
2. Add optional powerups like dental and wellness coverage

Scan the Code



or

Click Here



Connect and Explore

Be in the know- and know where to go- with the Figo Pet Cloud app, designed to help make pet parenting a breeze with tips, reminders and search tools. You can download it from the App Store or Google Play.

Questions?



1-888-246-6918



support@figopetinsurance.com



VOLUNTARY BENEFITS

Student Loan Advisors Through Silver Lion

Silver Lion Student Loan Advisors helps individuals with Federal Student Loan Debt. We offer Free Loan Review and Analysis to determine if borrowers and their loans are eligible for an Income Driven Repayment Programs and/or Loan Forgiveness. Silver Lion offers Loan Consolidation, IDR Enrollment, Loan Forgiveness, PSLF, Default & Garnishment Relief, and more.

What We Do:

- Conduct Free Loan Review for Federal Student Loans
- Determine the best program that suits the borrower's goal
- Confirm Eligibility
- Provide program payment projection and loan forgiveness opportunities
- Help get your loans to good standing
- Handle all enrollment and administration
- Help to re-certify annually

How to Get Started

Process

In a quick, 30 minute call, your Advisor will be able to determine if you qualify to enroll in a Department of Education Income Based Repayment Program.

If you decide to enlist our services, we'll take it from there.

Every Step of the Way

We consolidate your loans, enroll your loan into an IBR program and take all the processing and documentation off your plate.

We will ensure, on an on-going basis, that your loan stays compliant and help you re-certify your income & family size every year.

We're so sure you will be happy with our services that we offer a 100% money back guarantee.

Program Fees Discounted Rate

Advisory Loan & Review Consultation	\$0
Program Change	\$595
Consolidation & Enrollment in Income	\$895
Rehabilitation	\$1,495
Garnishment	\$1,795
Ongoing Support and Re-Certification	\$24.99/month

Contact Us

- Call one of our knowledgeable Student Loan Advisors
- Free Student Loan Review & Analysis
- Your Advisor will request information about your loans, income, employer & family size to determine your program options.
- Please have your FSA ID available if possible.

Call today to get started

 855-433-7893

 www.silverlionsla.com





EAP -EMPLOYEE ASSISTANCE PROGRAM

Through BHS

What is an EAP?

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 program, 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.*

Program Features:

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 permission.

Available 24/7

Services are available 24-hours a day, 7-days a week at portal.BHSONline.com (username: Educators) or by phone at 1-800-327-2251.

Common Reasons to call the EAP:

CHILD CARE	BHS provides up-to date, carefully screened, national resources and referrals for a range of childcare needs including: - Adoption - Family Daycare/ Group Homes - Nurseries/Preschool - Before and After School programs - Nanny and Au Pair Services - Summer Camps
ELDERCARE	BHS provides up-to date, national resources and referrals for a range of eldercare needs including: - Home-Based Services: Nutrition, Meals on Wheels, Cleaning, Repair - In-Home Care - Older Adult Services - Inpatient Services - Transportation Services - Housing
LEGAL	When faced with a legal matter, simply contact BHS and you will be connected to an attorney with experience specific to your needs. Legal benefits under the program include: - Free 30-minute consultation - Each consultation must be over a new legal topic - 25% off the attorney's hourly rate
FINANCIAL	You and your household members can access unlimited telephonic financial counseling, information and education from BHS's team of highly-trained counselors. Typical financials include: - Budgeting - Credit Counseling - Retirement Funding - College Funding - Debt Management and Consolidation
CONVENIENCE CARE	With the EAP, finding what you are looking for is just a phone call away. BHS provides up-to-date, national resources and referrals for a range of needs, such as: - Adult Education Classes - Concert, Sport, and Theater Tickets - Personal Shoppers - Airfare, Hotel, and Car Rental - Contractors, Handymen, Plumbers, etc. - Pet Care

* If you require a referral for long-term treatment, costs may be incurred. Please reach out to your insurance provider for further details on your health plan.



CONTACT:

Phone: 800-327-2251

Website: portal.BHSONline.com
(username: EDUCATORS)

next steps - prepare. decide. act.

1

Prepare: Review all plan information, benefit summaries and plan documents.

2

Decide: Complete open enrollment online. Please review [online enrollment instructions](#).

3

Act: Open enrollment is November 1st- 15th and most benefit plans have a 30-day enrollment period from your benefit eligibility date.

Important Information



Medical ID Cards

Cigna Healthcare medical ID cards can be obtained online through the Cigna app or online portal within 72 hours after enrollment has been processed. **Kaiser** members will be mailed medical ID cards to their home address within 10 business days after their enrollment is processed. Members may obtain a temporary ID card online before their card arrives in the mail. Please allow 72 hours after enrollment for benefit information to be updated.. Instructions on how to view and print digital ID cards can be found [here](#).



Dental ID Cards

Cigna Healthcare dental ID cards can be obtained online through the Cigna app or online portal within 72 hours after enrollment is processed. Instructions on how to view and print Cigna ID cards can be found [here](#). **Dominion** dental will mail 2 ID cards in the subscriber's name to the address on file. The cards may be used by anyone covered under your plan. Members may obtain a temporary ID card online before their card arrives in the mail. Please allow 72 hours after enrollment for benefit information to be updated. Instructions on how to view and print your Dominion ID cards can be found [here](#).



HSA Debit Cards

HSA debit cards will be delivered to your home address in a nondescript envelope within 10 days after you open your HSA account at Optum Bank.



Vision Cards

VSP vision does not provide vision ID cards. You can access your plan information, in-network doctors, and view savings by creating an account online at www.vsp.com.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

The newborn's and mother's health protection act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

Further, a health insurer or health maintenance organization may not:

1. Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
2. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
3. Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
4. Require a mother to give birth in a hospital; or
5. Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

Mental Health Parity Act

Except in limited circumstances, federal law requires that any mental health care coverage provided by a group health plan may not be subject to annual or lifetime dollar maximums that are less than those applied to any other sickness.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires the School to notify you, as a participant or beneficiary of the AIMS Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

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

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

Patient Protection

If the Group Health Plan generally requires the designation of a 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.

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 the network who specializes in obstetrics or gynecology. The health care professionals, 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, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Health Insurance Marketplace Coverage Options and your Health Coverage

When key parts of the health care law took effect in 2014, there was 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 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 2022 for coverage starting as early as January 1, 2023.

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

¹ 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

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 your Human Resources Department or Business Office.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

HIPAA Notice of Special Enrollment Rights

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

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself in your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your Human Resources Department.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment"

opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility:

ALABAMA – Medicaid

 <http://myalhipp.com/>
 1-855-692-5447

FLORIDA – Medicaid

 <http://flmedicaidtprecovery.com/hipp/>
 1-877-357-3268

ALASKA – Medicaid

 The AK Health Insurance Premium Payment
 <http://myakhipp.com/>
 1-866-251-4861
 CustomerService@MyAKHIPP.com
Medicaid Eligibility:
 <https://health.alaska.gov/dpa/Pages/default.aspx>

GEORGIA – Medicaid

 <http://dch.georgia.gov/medicaid>
Click on Health Insurance Premium
Payment (HIPP)
 678-564-1162, Press 2

ARKANSAS – Medicaid

 <http://myarhipp.com/>
 1-855-MyARHIPP (855-692-7447)

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
 <http://www.in.gov/fssa/hip/>
 1-877-438-4479
All other Medicaid
 <http://www.in.gov/medicaid/>
 1-800-457-4584

CALIFORNIA – Medicaid

 <http://dhcs.ca.gov/hipp>
 1-916-445-8322

IOWA – Medicaid

 <http://dhs.iowa.gov/ime/members>
 1-888-338-8366

COLORADO – Medicaid

 <http://www.healthfirstcolorado.com>
 Health First Colorado
1-800-221-3943

KANSAS – Medicaid

 <https://www.kancare.ks.gov>
 1-800-792-4884

KENTUCKY – Medicaid

 <http://chfs.ky.gov>
 1-855-459-6328

NEVADA – Medicaid

 <http://dhcfp.nv.gov>
 1-800-992-0900

LOUISIANA – Medicaid

 <http://www.medicaid.la.gov>
 1-888-342-6207
 <http://www.ldh.la.gov/lahipp>
 1-855-618-5488

NEW HAMPSHIRE – Medicaid

 <http://www.dhhs.nh.gov>
 1-603-271-5218

MAINE – Medicaid

 <http://www.maine.gov/dhhs>
 1-800-442-6003

NEW JERSEY – Medicaid

 <http://www.state.nj.us/humanservices/>
 1-609-631-2392
CHIP Information:
 <http://www.njfamilycare.org>
 1-800-701-0710

MASSACHUSETTS – Medicaid

 <https://www.mass.gov/masshealth/pa>
 1-800-862-4840

NEW YORK – Medicaid

 <http://www.health.ny.gov>
 1-800-541-2831

MINNESOTA – Medicaid

 <http://mn.gov/dhs>
 1-800-657-3739

NORTH CAROLINA – Medicaid

 <http://medicaid.ncdhhs.gov/>
 1-919-855-4100

MISSOURI – Medicaid

 <http://dss.mo.gov/mhd/participants/>
 1-573-751-2005

NORTH DAKOTA – Medicaid

 <http://www.nd.gov/dhs/services>
 1-844-854-4825

MONTANA – Medicaid

 <http://dphhs.mt.gov>
 1-800-694-3084

OKLAHOMA – Medicaid

 <http://www.insureoklahoma.org>
 1-888-365-3742

NEBRASKA – Medicaid

 <http://www.ACCESSNebraska.ne.gov>
 1-855-632-7633

OREGON – Medicaid

 <http://healthcare.oregon.gov>
 1-800-699-9075

PENNSYLVANIA – Medicaid

 <http://www.dha.pa.gov/Services>
 1-800-692-7462

VERMONT – Medicaid

 <http://www.greenmountaincare.org>
 1-800-250-8427

RHODE ISLAND – Medicaid

 <http://www.eohhs.ri.gov/>
 1-855-697-4347

VIRGINIA – Medicaid

 <http://www.coverva.org/en/famis-select>
 <https://www.coverva.org/en/hipp>
 1-800-432-5924

SOUTH CAROLINA – Medicaid

 <http://www.scdhhs.gov>
 1-888-549-0820

WASHINGTON – Medicaid

 <http://www.hca.wa.gov/>
 1-800-562-3022

SOUTH DAKOTA – Medicaid

 <http://dss.sd.gov>
 1-888-828-0059

WEST VIRGINIA – Medicaid

 <http://dhhr.wv.gov/bms/>
 <http://mywvhipp.com/>
 1-304-558-1700

TEXAS – Medicaid

 <http://gethipptexas.com/>
 1-800-440-0493

WISCONSIN – Medicaid

 <http://www.dhs.wisconsin.gov/badgercareplus/>
 1-800-362-3002

UTAH – Medicaid

 <http://medicaid.utah.gov>
 1-877-543-7669

WYOMING – Medicaid

 <https://health.wyo.gov/healthcarefin/>
 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022 or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee
Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

COBRA Continuation Coverage Notice

[General Notice of COBRA Continuation Coverage Rights](#)

Your eligibility for benefits (and that of your enrolled dependents) ceases at the end of the month in which your employment is terminated or if the benefits program is discontinued. Insurance coverage for dependents will also terminate at the end of the month in which your dependent is no longer eligible.

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and their qualified beneficiaries the opportunity to continue benefit coverage under the employer's medical plans, dental plans, vision plan, and flexible spending accounts when a "qualifying event" would normally result in the loss of eligibility. Examples include termination of employment, death of the employee, reduction in work hours, divorce or loss of eligibility by a dependent child.

The plans available through COBRA continuation coverage are the same plans currently offered by the School; however, you or your dependent(s) must pay the full cost of the health, dental and vision plan, plus an administrative fee. COBRA premiums are due monthly, and failure to pay on time will result in loss of coverage.

[Length of COBRA Continuation Coverage](#)

Coverage may continue for differing lengths of time depending upon the reason for eligibility.

- Up to 18 months if loss of coverage is due to termination of employment or reduction in work hours
- Up to 36 months for dependents if loss of coverage is due to death, divorce, or a dependent child's loss of eligibility
- Up to 29 months if the individual is disabled at the time of eligibility for continued coverage or is disabled within 60 days of eligibility for continued coverage

[Notifying Benefits Office of a Qualifying Event](#)

To apply for COBRA coverage, contact the Business Office to complete a Qualified Life Event form when a divorce is final, a dependent child no longer meets age and/or dependency eligibility requirements as outlined in each specific plan, you get married or you have a baby.

Within 14 days, Educators Benefit Services will provide you and/or your qualified dependent pertinent information on the application procedure and eligibility for continuation of coverage through COBRA.

Medicare part D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

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 medical plan and about your options under Medicare's prescription 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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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 medical plan has determined that the prescription drug coverage offered by the Welfare Plan for Employees of the School under the medical plan options are, on average for all plan participants, expected to pay out as much as the 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.

You should also know that if you drop or lose your coverage with the medical plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

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 medical plan coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current medical plan coverage, be aware that you and your dependents will be able to get this coverage back during the annual Open Enrollment period or following a qualifying event.

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 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 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 our office for further information (see contact information below). 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 changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You can find a copy online at www.medicare.gov. 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 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 notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: 10/01/2024

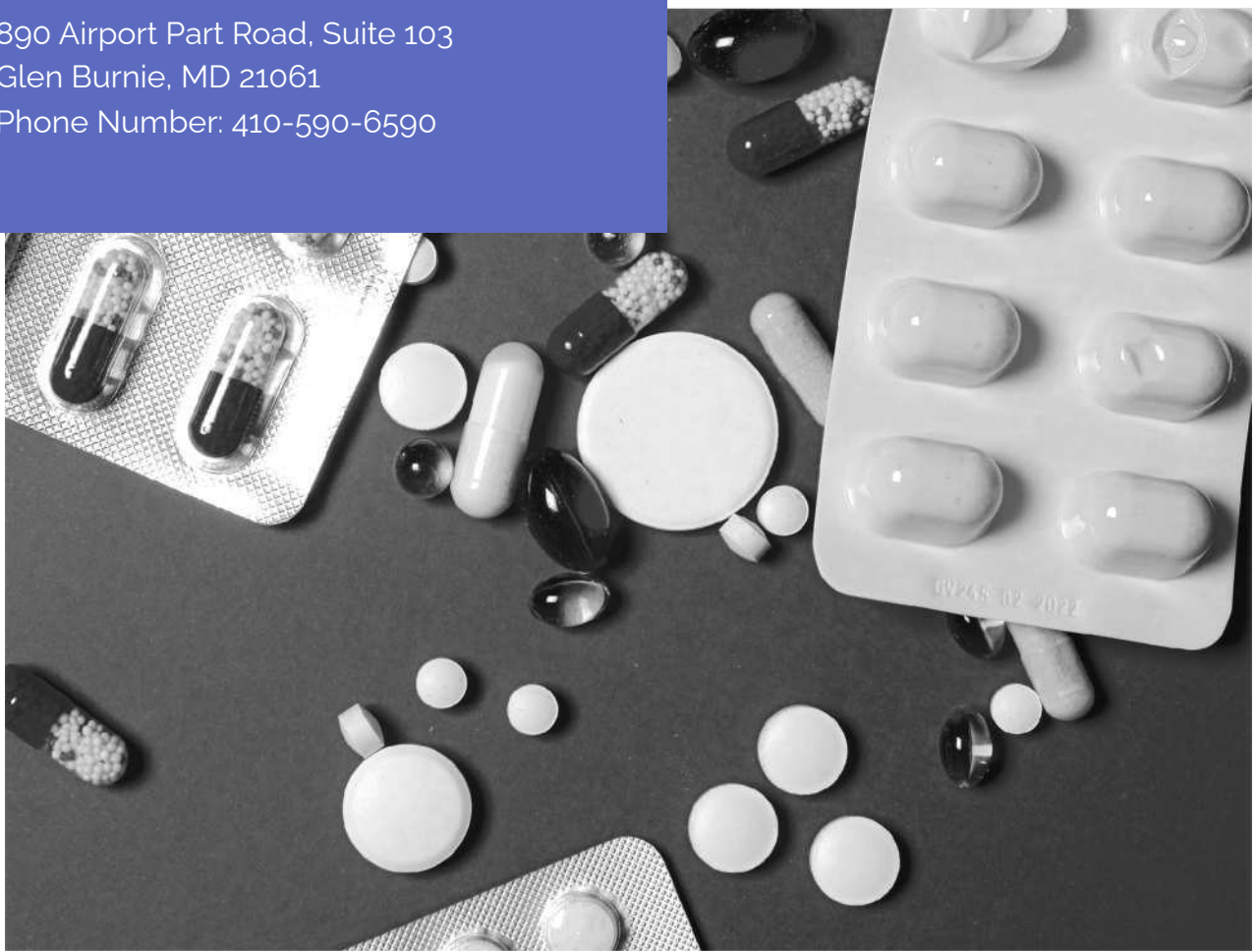
Name of Entity/Sender: AIMS Health Plan

Contact-Position/Office: HR Department

890 Airport Part Road, Suite 103

Glen Burnie, MD 21061

Phone Number: 410-590-6590



Your Rights and Protections Against Surprise Medical Billing

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Educators Benefit Services at 410-590-6590.

The information in this Benefits Guide is presented for illustrative purpose and is based on information provided by your employer. The text contained in this guide was taken from various summary plan description and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this guide, contact Human Resources.

CONTACT

For general information contact Human Resources or reach out to an EBS Benefit Support Specialist at 410-590-6590 or clientservices@ebsonline.net.