WONDERWORKS™

Attraction Support Services



2024-2025 PLAN YEAR

EMPLOYEE BENEFITS PACKAGE

Welcome to your 2024-2025 Employee Benefits!

Attraction Support Services, LLC dba Wonderworks recognizes the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry and designed to protect your health, your family, and your way of life.

This guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

What's Inside

The information in this Benefit Guide is presented for illustrative purposes only. The text contained in this guide was taken from various plan documents and/or benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefit Guide and the actual plan documents, the plan documents will prevail. Please see your benefit portal for additional documentation. 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.

Eligibility

New full-time employees become eligible to enroll in benefits on the first of the month following or coinciding with 30 days from their full-time start date. Your dependent spouse and children are also eligible for our plan. A child is defined as any natural, adopted, stepchild or child for whom you have legal custody.

When Benefits Become Effective

All full-time employees, benefits will begin on the first of the month after **30 days** of employment. This coverage includes medical, dental, vision, and mental health benefits. Additionally, disability, life, accident, hospital indemnity, and critical illness benefits will begin on the first of the month following **90-days.**

Eligible Dependents

Your dependents are eligible to participate in the Company's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married
- A dependent child will be covered until the end of the calendar year that the dependent reaches age 26 for medical and dental. For vision until the 26th birthdate

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

When will my benefits end?

When your employment ends, or coverage is canceled due to a qualified life event, the following will apply.

- Last day of the month of your employment termination date for Medical, Dental and Vision.

If coverage is canceled due to a qualified life event, benefits will end on the same day of the qualified event.

When will dependent children be covered until?

- Medical, dental and vision: until the end of the calendar year in which they turn 26, provided the dependent child is unmarried and does not have a dependent of their own, not covered under a plan of their own or entitled to Medicare.

What if I need to continue my coverage?

You may be eligible to continue coverage under your group medical, dental and vision plan for up to 18 months. You will be notified of your rights and will be responsible for electing benefits and paying the full cost of benefits if you wish to continue under COBRA.

Pre-Tax Benefits: Section 125

The Company's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of medical, dental, and vision, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment.
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent.
- you, your spouse, or dependents terminate or begin employment.
- your dependent is no longer eligible due to attainment of age.
- you, your spouse, or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment, strike or lock-out; commencement of or return from an unpaid leave of absence).
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer.
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your medical, dental, and vision, coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for medical, dental, and vision coverage under this Plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan.
- you, your spouse or dependent become entitled to Medicare or Medicaid.
- you have a Special Enrollment Right.
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

It is important that you notify Human Resources of any changes within 30 days of the event to make any plan changes.

How to Enroll

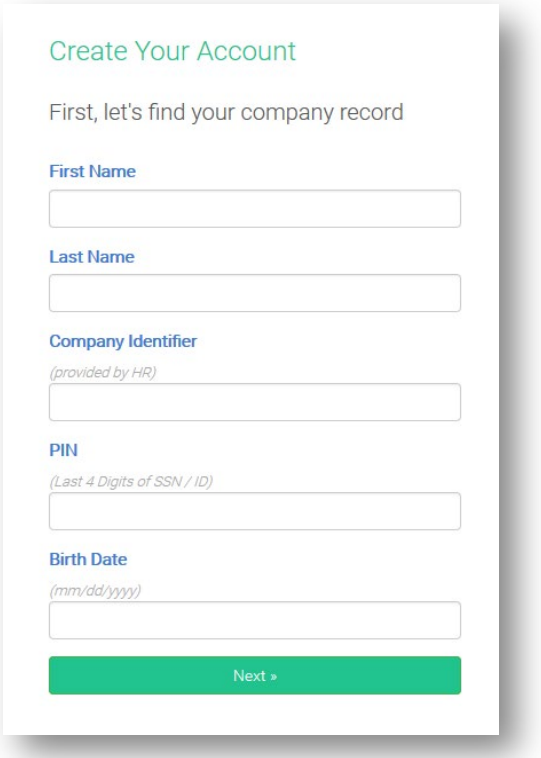
Are you ready to Enroll?

The Company's annual enrollment period will be held in **09/04/2024- 09/13/2024.** Log on to the enrollment site to review your current benefits, make any plan changes, or update dependent and/or beneficiary information.

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete online enrollment even if choosing to waive coverage to provide beneficiary information for your company-paid life insurance. Coverage, if elected, will begin on the first day of the month following 30 days of employment, provided you enroll online within **30 days of becoming eligible.**

Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.

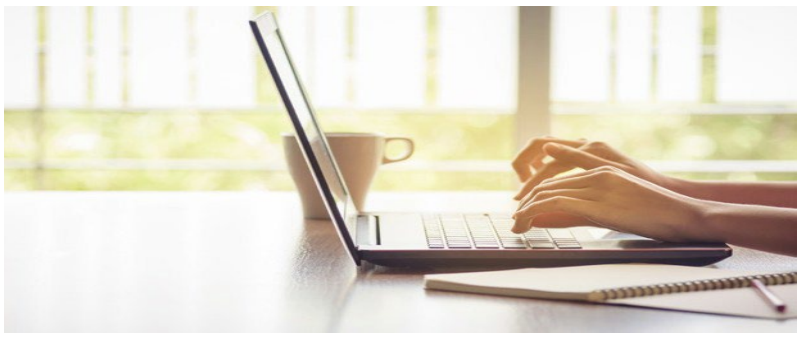


Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online between **09/04/2024 - 09/13/2025** or within 30 days of becoming eligible, to review your current benefits and make any changes for the upcoming plan year.

www.Employeenavigator.com

- **Register** - Select New User Registration.
- **Verify** - Enter the following:
  - First Name
  - Last Name
  - Company Identifier: **Wonder-Works**
  - Last 4 Digits of SSN
  - Birth Date (ex. 01/01/1970)



Medical Plans

	Cigna OAPIN HMO Base Plan	Cigna OAP PPO Buy Up Plan
In Network Benefits		
Deductible (Individual / Family)	$3,000 / $6,000	$2,000 / $4,000
Out of Pocket Maximum	$7,150 / $14,300	$4,500 / $9,000
Coinsurance	80% / 20%	80% / 20%
Preventive Care	No Charge	No Charge
Office Visit	$20 Copay	$25 Copay
Specialist Visit	$75 Copay	$50 Copay
Diagnostic (x-ray, blood work)	No Charge	No Charge
Imaging: CT & PET Scans, MRI	$500 Copay	20% after Deductible
Urgent Care Center	$100 Copay	$125 Copay
Emergency Room	$500 Copay	$500 Copay
Outpatient Hospital	20% after Deductible	20% after Deductible
Inpatient Hospital	20% after Deductible	20% after Deductible
Prescription Drug *(Generic / Preferred / Non- Preferred)*	$15 / $35 / $70	$15 / $35 / $70
Mail Order Drug	$45 / $105 / $210	$45 / $105 / $210
Out of Network Benefits		
Deductible (Individual / Family)	N / A	$4,000 / $8,000
Out of Pocket Maximum	N / A	$9,000 / $18,000
Coinsurance	N / A	40% / 60%
Emergency Room	$500 Copay	$500 Copay
Rates per pay period (Weekly)		
Employee Only	$31.41	$41.62
Employee Spouse	$141.69	$175.58
Employee Child(ren)	$112.38	$139.25
Family	$190.55	$236.12

Prescription Coverage

Your prescription drug benefit is part of your medical plan. The prescription drug formulary generally lists many drugs and ranks them in groups described as tiers. Copayments and/or coinsurance is determined by the tier in which the health plan will pay for, and prefer you use.

To find individualized information on your benefit coverage, log in to www.mycigna.com or call customer service at 1-877-484-5968. On your portal, you will be able to determine tier status, check the status of claims and search for network pharmacies.

Rx Mail Order Program

Save time and money by filling maintenance drugs through the Mail Order Program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression, or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication at a discounted price. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.

Medicare Part D

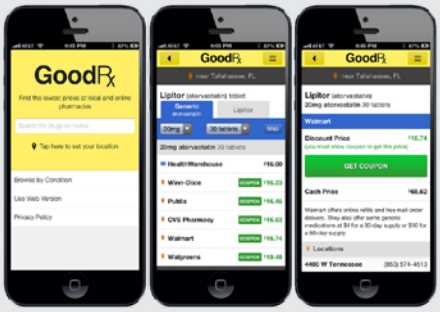
The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

GoodRx Mobile App

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts, and savings tips for your prescription at pharmacies near you.



Know Where to Go for Care

Choosing the right treatment option can help you avoid, higher out-of-pocket costs and hours of unnecessary waiting. Using the guide below can help you make the right decisions when your Primary Care Physician is not available.

Care Option	Cost Indicator	Treatment/Services	Availability
Telemedicine	$	Telemedicine allows you access to a licensed medical professional 24/7/365. With video or phone appointments you are able to get comprehensive care without leaving your home.	24/7/365
Primary Care Doctor	$	Primary Care Physicians can help with a little bit of everything and coordinate patient health care in one central location. Be sure to check to make sure your physicians are in your network!	Open Daily *Hours Vary by Center*
Convenience Care Centers	$	Convenience care centers usually have a similar copay to a PCP visit and treat things like cold/flu symptoms, sinus infections, urinary tract infections, and rash/skin conditions. Be sure to check to make sure the center is in your network!	Open Daily *Hours Vary by Center*
Urgent Care Centers	$$	Urgent care centers are less expensive than ERs and often have shorter wait times. And many will allow you to schedule an appointment. They have the ability to treat cold/flu symptoms, sprains and/or breaks, infections, some lacerations, and mild burns. To locate an urgent care center near you, visit www.cigna.com and select Find a Doctor or Facility.	Open Daily *Hours Vary by Center*
Emergency Room (ER)	$$$$	The ER is the most expensive option but may be necessary for the treatment of life-threatening conditions. There are many free-standing Emergency Rooms in the area, that may not have in-patient beds. To locate an Emergency Room, visit www.cigna.com if time permits to locate the nearest Emergency Room.	24/7/365

PREVENTIVE HEALTH CARE

Understanding what's covered.

What is preventive care?

Preventive care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam (check-up) and specific tests, certain health screenings, and most immunizations. Most of these services typically can take place during the same visit. You and your health care provider will decide what preventive services are right for you, based on your:

- Age
- Gender
- Personal health history
- Current health

Why do I need preventive care?

Preventive care can help you detect problems at early stages, when they may be easier to treat. It can also help you prevent certain illnesses and health conditions from happening. Even though you may feel fine, getting your preventive care at the right time can help you take control of your health.

Make a plan for preventive care.

Use this space to write down the details for your next periodic wellness exam.

Date: _____

Time: _____

Questions for my provider: _____

_____

What's not considered preventive care?

Once you have a symptom or your health care provider diagnoses a health issue, additional tests are not considered preventive care. Also, you may receive other medically appropriate services during a periodic wellness exam that are not considered preventive. These services may be covered under your plan's medical benefits, not your preventive care benefits. This means you may be responsible for paying a share or all of the cost depending on your plan, including deductible, copay or coinsurance amounts.

Which preventive services are covered?

Many plans cover preventive care at no additional cost to you when you use a health care provider in your plan's network. Use the provider directory on **myCigna.com** for a list of in-network health care providers and facilities.

See the following pages for the services and supplies considered preventive care under most health plans. Coverage for services recommended specifically for "men" or "women" is provided based on the anatomical characteristics of the individual and not necessarily the gender of the individual as indicated on the claim and/or an enrollment form.

Questions?

Check your plan materials, talk with your health care provider or call the number on the back of your Cigna ID card.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Wellness exams

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	● ● ●	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2–4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21, once a year • Ages 22 and older, periodic visits as doctor advises

Routine immunizations covered under preventive care

SERVICE	SERVICE
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP, Tdap, Td)	Meningococcal (meningitis)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Abnormal blood glucose and type 2 diabetes screening/counseling	● ●	Adults ages 40–70 who are overweight or obese; women with a history of gestational diabetes mellitus
Anxiety screening	●	Adult and adolescent women including pregnant and postpartum women
Aspirin to prevent cardiovascular disease and colorectal cancer; or to reduce risk for preeclampsia[1]	● ●	Adults ages 50–59 with risk factors; Pregnant women at risk for preeclampsia
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Bilirubin screening	●	Newborns before discharge from hospital
Breast cancer screening (mammogram)	●	Women ages 40 and older, every 1–2 years
Breast cancer-discussion of benefits/risks of preventive medication	●	Women at risk
Breast-feeding support/counseling, supplies[2]	●	During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test alone or with Pap test	●	Women ages 21–65, every 3 years Women ages 30–65, every 3 years
Chlamydia screening	●	Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening[1]	● ● ●	• Screening of children and adolescents ages 9–11 years and 17–21 years; children and adolescents with risk factors ages 2–8 and 12–16 years • All adults ages 40-75
Colon cancer screening[1]	● ●	The following tests will be covered for colorectal cancer screening, ages 45 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every ten years + annual FIT • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires prior authorization • Stool-based deoxyribonucleic acid (DNA) test (i.e., Cologuard) every 1–3 years

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Congenital hypothyroidism screening	🟢	Newborns
Critical congenital heart disease screening	🟢	Newborns before discharge from hospital
Contraception counseling/education (including fertility awareness-based methods); contraceptive products and services[1,3,4]	🔴	Women with reproductive capacity
Dental application of fluoride varnish to primary teeth at time of eruption (in primary care setting)	🟢	Children to age 6 years
Dental caries prevention Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1]	🟢	Children older than 6 months
Depression screening/Maternal depression screening	🔵🔴🟢	Ages 12–21, All adults, including pregnant and postpartum women
Developmental screening	🟢	9, 18, 30 months
Developmental surveillance	🟢	Newborn, 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Fall prevention in older adults (physical therapy)	🔵🔴	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation[1]	🔴	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	🔴	Women at risk • Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	🔴	Pregnant women
Gonorrhea screening	🔴	Sexually active women age 24 years and younger and older women at risk
Healthy diet and physical activity counseling	🔵🔴🟢	Ages 6 and older - to promote improvement in weight status; Overweight or obese adults with risk factors for cardiovascular disease
Hearing screening (not complete hearing examination)	🟢	All newborns by 2 months. Ages 4, 5, 6, 8, 10. Adolescents once between ages 11–14, 15–17 and 18–21
Hemoglobin or hematocrit	🟢	12 months
Hepatitis B screening	🔵🔴🟢	Pregnant women; adolescents and adults at risk
Hepatitis C screening	🔵🔴	Adults ages 18–79
High blood pressure screening (outside clinical setting)[2]	🔵🔴	Adults ages 18 and older without known high blood pressure
HIV Preexposure Prophylaxis (PrEP) for prevention of HIV infection[1] HIV PrEP related services (HIV screening, kidney function testing, hepatitis B & C screening, pregnancy testing, sexually transmitted infection screening / behavioral counseling, adherence counseling)	🔵🔴🟢	Individuals at risk
HIV screening and counseling	🔵🔴🟢	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women (adolescent/adult), annually
Intimate partner/interpersonal violence screening	🔴	All women (adolescent/adult)
Lead screening	🟢	12, 24 months
Lung cancer screening (low-dose computed tomography)	🔵🔴	Adults ages 50 to 80 with 20 pack year smoking history, and currently smoke, or have quit within the past 15 years. Computed tomography requires precertification
Metabolic/hemoglobinopathies (according to state law)	🟢	Newborns
Obesity screening/counseling	🔵🔴🟢	Ages 6 and older, all adults
Ocular (eye) medication to prevent blindness	🟢	Newborns
Oral health evaluation/assess for dental referral	🟢	6, 9 months. Ages 12 months, 18 months-6 years for children at risk

🔵 = Men 🔴 = Women 🟢 = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by a Clinical Risk Assessment Tool). Computed tomographic bone density study requires precertification
PKU screening	●	Newborns
Perinatal depression preventive counseling	●	Pregnant and postpartum women with risk factors
Preeclampsia screening (blood pressure measurement)	●	Pregnant women
Prostate cancer screening (PSA)	●	Men ages 45 and older or age 40 with risk factors
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	● ● ●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	Adolescents ages 11–21
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	● ● ●	Ages 6 months – 24 years
Syphilis screening	● ● ●	Individuals at risk; pregnant women
Tobacco use cessation: counseling/interventions[1]	● ●	All adults[1]; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculosis screening	● ● ●	Children, adolescents and adults at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Unhealthy alcohol use and substance abuse screening	● ● ●	All adults; adolescents age 11–21
Unhealthy drug use screening	● ●	All Adults
Urinary incontinence screening	●	Women
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, and 15 or as doctor advises

● = Men ● = Women ● = Children/adolescents

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

Head-to-toe virtual care[1] from MDLIVE.®

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

That's why Cigna has partnered with MDLIVE 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.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- 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[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

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[4]

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

- Board-certified dermatologists 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

Cigna®

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. (No phone calls for virtual dermatology.)

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

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®

Cigna®

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Flexible Spending Account

A Flexible Spending Account (FSA) allows you to pay for certain medical and/or dependent care expenses with pre-tax dollars. Tax savings result because you do not have to pay income or FICA taxes on the amount withheld from your paycheck.

Health Care FSA

In 2024, you have the option to allocate up to **$3,200** into a Health Care FSA, exempt from taxation. This allocated sum can be utilized to cover eligible out-of-pocket healthcare costs that aren't covered by your health, dental, and/or vision insurance. Some examples of qualifying healthcare expenses include:

- Deductibles
- Coinsurance
- Copays
- Prescription Drugs
- Vision Care, Eyeglasses and Contact Lenses
- Dental Care and Orthodontia
- Hearing Aids

You determine the deduction from your gross pay by estimating your healthcare expenses. This chosen healthcare amount is automatically withdrawn from your paycheck and deposited into your flexible spending account via payroll deductions. Subsequently, you can utilize your FSA debit card for payments or submit a claim to receive reimbursement for your incurred expenses.

Planning Ahead

Use the worksheet to the right to estimate eligible medical expenses that you, your spouse or domestic partner and your qualified dependents may incur during the plan year.

Base your contribution on your anticipated expenses for the plan year which are not covered by other insurance or benefit plans. Be conservative. Any unused funds cannot carry forward beyond the grace period and are forfeited.

For a complete list of eligible expenses, refer to IRS publications #502 and #969, available on the IRS website at irs.gov/publications.

Contact: Chard-Snyder
Customer Service: (800)-982-7715
www.chard-snyder.com

Dental Coverage

Maintaining your dental health can lead to significant expenses. This emphasizes the significance of having suitable dental insurance. Besides safeguarding your smile, dental insurance aids in covering dental treatments, often encompassing routine checkups, cleanings, and X-rays. Research indicates that oral conditions like periodontitis (gum disease) can impact other aspects of your health, including the heart. Consistent dental care can offer protection against costs associated with dental issues for you and your family.

The chart below provides an overview of the dental benefits available for the plan year starting on October 1, 2024.

BENEFITS ***Orthodontia:** N/A		**Low Plan**		**High Plan**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-Of- Network**
Preventive Oral Examinations Cleanings Routine X-rays Sealants Space Maintainers Non-Routine X-rays	**How Many/How Often** 2 in 12 months 2 in 12 months 2 in 12 months Limited per tooth See summary 1 in 36 months	Plan pays 100%	*Plan pays 100% of contracted in-network rate after CYD*. You pay 0%.	Plan pays 100%	*Plan pays 80% of contracted in-network rate after CYD*. You pay 20%.
Basic Emergency care to relieve pain Fillings (Amalgam, Composite Resin) Oral Surgery – simple extractions Oral Surgery – all except simple Surgical Extraction of impacted teeth Anesthetics Minor and Major Periodontics Root Canal / Endodontics Relines, Rebases and Adjustments Brush Biopsy	Covered if more than 6 months after installation	Plan pays 80% after CYD. You pay 20%.	*Plan pays 50% of contracted in-network rate after CYD*. You pay 50%.	Plan pays 80% after CYD. You pay 20%.	*Plan pays 80% of contracted in-network rate after CYD*. You pay 20%.
Major Repairs – Bridges, Crowns and Inlay Repairs – Dentures Crown/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	1 per tooth and then reviewed 1 per tooth and then reviewed 1 in 60 months 1 in 60 months 1 in 60 months 1 in 60 months 1 per tooth and then reviewed	Plan pays 50% after CYD. You pay 50%.	*Plan pays 25% of contracted in-network rate after CYD*. You pay 75%.	Plan pays 50% after CYD. You pay 50%.	*Plan pays 50% of contracted in-network rate after CYD*. You pay 50%.
Deductible (Individual / Family)		$50 / $150	$150 / $450	$25/ $50	$75 / $150
Plan Year Maximum		$1,000	$1,000	$1,500	$1,000
Rates per pay period (Weekly)					
Employee		$3.95		$5.57	
Employee Spouse		$8.15		$11.50	
Employee Child(ren)		$8.62		$11.61	
Family		$13.30		$18.13	

This above is intended as a resource and discrepancies and omissions are possible. The chart is intended for illustrative purposes only. The full description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. For additional information please refer to the Benefit Summary that is posted on the Benefit Portal.

Vision Coverage

In-Network Benefits	
Copays Exam(s)	$10 copay
Frame Benefit	$130 allowance for a wide selection of frames; 20% off amount over allowance
Lens Options Single Bifocal Trifocal Lenticular	$25 copay $25 copay $25 copay $25 copay
Contacts (in lieu of glasses) Elective Medically necessary	Up to $60 copay for standard and premium elective contact lens exams (Fitting and evaluation) $130 allowance for elective contacts $25 Copay Covered in full for members who have specific conditions. Contact lenses can be chosen instead of glasses.
Out-of-Network Benefits	**Reimbursement up to: (Copays do not apply)**
Exam(s)	Up to $45
Frames	Up to $70
Single Vision Lenses	Up to $30
Bifocal Lenses	Up to $50
Trifocal Lenses	Up to $65
Lenticular Lenses	Up to $100
Contacts in Lieu of Eyeglasses Elective Medically necessary	 Up to $105 Up to $210
Frequency – Calendar Year Basis	
Exams	12 months
Lenses	12 months
Frames	24 months
Contacts (in lieu of glasses)	12 months
Rates per pay period *(weekly)*	
Employee Only	$1.23
Employee Spouse	$2.61
Employee Child(ren)	$2.45
Family	$3.83

This above is intended as a resource and discrepancies and omissions are possible. The chart is intended for illustrative purposes only. For additional information please refer to the Benefit Summary that is posted on the Benefit Portal.

Group Life and AD&D Insurance

Employer Paid Benefit

Summary of Benefits

Life Benefit

Life insurance serves to support your family in case of unforeseen events. Attraction Support Services, LLC, also known as WonderWorks, offers full-time employees group term life insurance and accidental death and dismemberment (AD&D) insurance. The entirety of the cost for this benefit is covered by Attraction Support Services, LLC, relieving you from monthly premium payments once the Benefit Waiting Period is fulfilled. To gain deeper insight into this important benefit and the date at which your coverage will begin, please access the Benefit Portal.

Life and AD&D Benefit and Eligibility

Life Benefit	1 x annual salary to a maximum of $150,000
Accidental Death Dismemberment Benefit	Initial Guaranteed Issue Amount up to $150,000
Eligibility	Full-time employees working 30 hours or more per week

Benefit Reduction	Employee
	Benefits will reduce: The benefits will be reduced to 65% of original amount at age 65, 50% of the original amount at age 70

Additional Benefits	Employee
	Portability- you may be able to keep coverage if you leave the company, retire, or change the number of hours you work. **Waiver of premium -** Your cost could be waived if you experience total disability for a certain duration.

Voluntary Life and AD&D Insurance

Employee Paid Benefit

Voluntary Life and AD&D

Voluntary Life Benefit

You have the option to purchase additional Life insurance, allowing you to secure extra life insurance coverage for yourself, your spouse, and your dependent children. Further details about the available voluntary life insurance choices are outlined in the Exhibit below.

Summary of Benefits	
Employee Life Benefit	$10,000 increments up to a maximum of $500,000 not to exceed 5x annual salary. You can get up to $100,000. This is the amount of coverage you can qualify for with no medical underwriting.
Spouse Benefit	$5,000 increments up to $500,000 (not to exceed the 100% of the employees' selection)
Children Benefit	Age 6 months- 26 years; $10,000 benefit (One policy covers all your children until their 26th birthday) The maximum benefit for children live birth to 6 months is $1,000.
Benefit Reduction	
	Benefits will reduce: 65% at age 65 50% at age 70
Additional Benefits	
	Waiver of premium - Your cost could be waived if you experience total disability for a certain duration. **Portability**- you may be able to keep coverage if you leave the company, retire, or change the number of hours you work.
Guarantee Issue	
Employee Life Benefit	5x annual salary, up to $100,000
Spouse Benefit	100% of employee's benefit, up to $25,000 with no medical underwriting
Children Benefit	100% of employees' benefit or $10,000 applied for by the employee and approved by Mutual of Omaha

**See Employee Navigator for rates*

Short Term Disability

Employee Paid Benefit

WonderWorks offers you the opportunity to select Short and Long-Term disability insurance, providing an extra layer of security for both you and your family. The term "disabled" applies when you're unable to carry out the essential duties of your job due to an illness or injury.

Short- Term Disability

Mutual of Omaha offers weekly benefits for income protection in cases of temporary inability to work caused by non-work-related accidents or illnesses, which also includes pregnancy. This policy includes restrictions related to pre-existing conditions and a waiting period before benefits commence. Refer to the details provided below for more information.

Short-Term Disability	Benefit Description
Elimination Period for injury	7 Days (benefits begin on the 8th day after injury)
Elimination Period for Sickness	7 Days (benefits begin on the 8th day after illness)
Benefit	60% of before-tax weekly earnings; up to $1,500/ week
Maximum Benefit Duration	12 Weeks
Pre-Existing Condition Limit	3/12 (Condition that occurred 3 months prior to effective date, that resulted in disability within the 1st 6 months of coverage)

Disability worksheet

1 Calculate your weekly disability benefit.

$_____ Your annual earnings	÷ 52=	$_____ Your weekly earnings	x	60%= (Max % of income covered)	$_____ Max weekly benefit available (if the amount exceeds the plan mac of $1,000, enter $1,000				
2 Calculate your cost per paycheck									
$_____ Your weekly benefit amount	÷ 10=	$_____	x	$0.53= Your Rate	$_____ Your monthly cost	x	12= $_____ Your annual cost	÷ 52= Number of paychecks per year	$ _____ Your cost per paycheck

**Calculation is already completed and shown for your current income when electing benefits in Employee Navigator*

Frequently as questions

What is the duration of benefit payments? Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be impacted by additional sources of income? Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan offer coverage if I become disabled due to a workplace injury? No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations of exclusions? Yes. Please see benefit summary for details.

Long Term Disability

Employee Paid Benefit

Long-Term Disability

Mutual of Omaha offers monthly benefits for income protection in case you're incapable of working due to a non-work-related injury or illness. Long-Term Disability benefits become effective after the conclusion of Short-Term Disability or following a minimum of 12 weeks of disability, subject to approval by Mutual of Omaha.

Long-Term Disability	Benefit Description
Minimum hours for Eligibility	30 hours per week
Elimination Period	90 days
Definition of Disability	2-year own occupation
Monthly Benefit %	60%
Maximum Monthly Benefit	$5,000
Accumulation Period	180 days
Pre-Existing Condition	3/12 exclusion: Received medical treatment, consultation, care, or services including diagnostics measures, or took prescribed drugs or medicines in the 3 months just prior to his/her effective date of coverage; and The disability begins in the first 12 months after the employee's effective date of coverage

**Use the rate table to find the rate based on your age.*

Disability worksheet						
1 Enter your annual earnings and calculate your maximum monthly benefits available.						
$_____ Your annual earnings	÷	12 = $_____ Your monthly earnings	x	60%= (Max % of income covered)		$_____ Monthly benefit available
2 Calculate your cost per paycheck						
$_____ Your annual earnings	÷	100= $_____	X $_____ = Rate	$_____	÷ 52= Number of paychecks per year	$_____ Total cost per paycheck

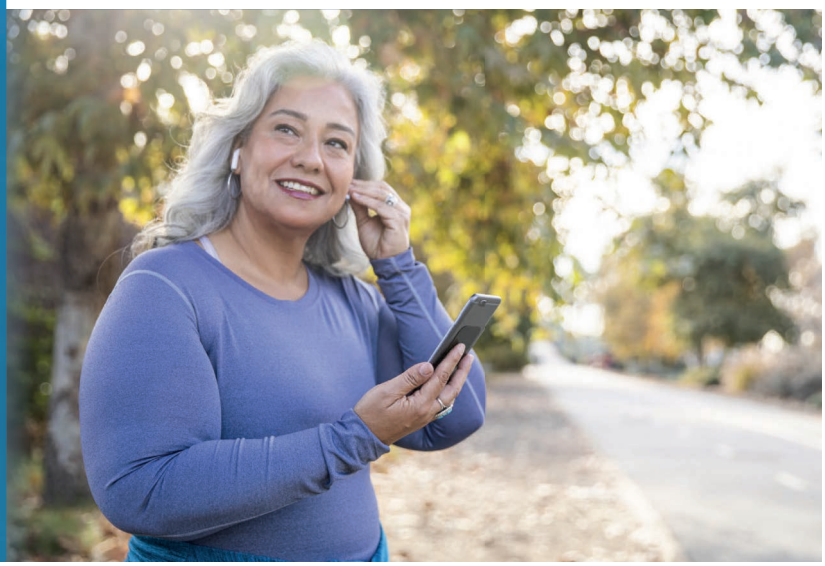
Age	Rates
15-24	*$0.300*
25-29	*$0.330*
30-34	*$0.230*
35-39	*$0.420*
40-44	*$0.690*
45-49	*$0.890*
50-54	*$1.600*
55-59	*$1.290*
60-64	*$1.110*
65-69	*$0.910*
70+	*$0.570*

**Calculation is already completed and shown for your current income when electing benefits in Employee Navigator*

Employee Assistance Program

Available Services When You Need Help the Most

Attraction Support, LLC DBA Wonderworks
G000B3LC



Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Mutual of Omaha

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources – legal libraries, tools and forms – available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney • 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

Critical Illness

Employee Paid Benefit

Critical Illness Insurance offers a one-time cash benefit intended to assist in addressing costs related to eligible severe illnesses, including:

- Cancer
- Heart Attack
- Strokes
- End Stage Renal Failure

Portability: When insurance ends, you have the right to continue group Critical Illness insurance.
Health Screening Benefit: Annual Benefit of $100 for health screening.
Reoccurrence Benefit: The reoccurrence benefit is equal to 100% of the CI principal sum.
Benefit Waiting Period: There is no benefit waiting period.

Rate determined by current age.

All full-time employees can choose between **two plan benefit amounts: **$10,000** and $**20,000***

Critical Illness	
Heart/Circulatory/Motor Function • Heart attack, Heart Transplant, Stroke, ALS, Advanced Alzheimer's, Advanced Parkinson's • Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	100% 25%
Organ • Major Organ Transplant/Placement on UNOS List. End-Stage Renal Failure • Acute Respiratory Distress Syndrome (ARDS)	100% 25%
Childhood/Development *Benefits only available to children • Cerebral Palsy, Structural Congenital Defects, Genetic Disorders, Congenital Metabolic Disorders, Type 1 Diabetes	100%
Cancer • Cancer (Invasive) • Bone Marrow Transplant • Carcinoma in Situ, Benign Brain Tumor	100% 50% 25%

Coverage Guidelines			
	Minimum	**Maximum**	**Guarantee Issue**
Employee (Elect in $10,00 increments)	$10,000	$20,000	$20,000
Spouse (Elect in $5,000 increments)	$5,000	100% of employee's CI Principal Sum, up to $20,000	$20,000
Children *benefit for each child	50% of employee's CI Principal Sum, up to $5,000		$10,000

Rate Summary	Weekly-Rates	$10,000	$20,000
Under 25		$0.74	$1.48
25 – 29		$1.08	$2.17
30 – 34		$1.41	$2.82
35 – 39		$1.89	$3.78
40 - 44		$2.79	$5.58
45 – 49		$4.15	$8.31
50 – 54		$6.44	$12.88
55 – 59		$9.05	$18.09
60 – 64		$11.58	$23.17
65 -69		$15.83	$31.66
70 – 74		$22.73	$45.46

Hospital Indemnity

Employee Paid Benefit

Hospital Indemnity insurance is a plan designed to provide you with benefits during hospitalization, whether it's due to scheduled or unforeseen circumstances, or for various medical services as outlined in the policy.

All full-time employees can choose between **two plan options: the **Base Plan** and the **Buy Up Plan**.*

- Help fill in financial gaps
- Added protection
- Flexible plan designs
- Affordable group rates

Hospital Indemity – Base Plan (Low)	
Hospital Admission	$500
Daily Hospital Confinement	$100 per day
ICU Admission	$1000 per day
Daily ICU Confinement	$200 per day
Health Screening Benefit (1 x per insured per calendar year; up to 6 family per calendar year)	$50
Express Benefits (1 benefit per hospital admission)	$100
Rate Summary	**Weekly-Rates**
Employee	$2.08
Employee & Spouse	$4.62
Employee & Child(ren)	$4.15
Family	$7.62

Hospital Indemity – Buy Up Plan (High)	
Hospital Admission	$1,500
Daily Hospital Confinement	$200 per day
ICU Admission	$3,000 per day
Daily ICU Confinement	$400 per day
Health Screening Benefit (1 x per insured per calendar year; up to 6 family per calendar year)	$50
Express Benefits (1 benefit per hospital admission)	$200
Rate Summary	**Weekly-Rates**
Employee	$4.62
Employee & Spouse	$12.92
Employee & Child(ren)	$11.08
Family	$19.85

**See summary details in Employee Navigator portal*

Accident

Employee Paid Benefit

Accident insurance is a financial product that provides a lump-sum payout in the event you experience types of injuries due to an accident.

Accident	
Coverage Type	24-hour (On and off-job)
Portability	Included
Benefits	**Amounts**
Initial Care & Emergency- Most treatment/service required within 72 hours of accident; Once per accident per insured person	
Emergency Room	$250
Urgent Care Center	$175
Initial Physician Office Visit	$150
Ambulance	Up to $2,000
Fractures (Surgical/Non-surgical)	Up to $5,000/Up to $2,500
Dislocations (Surgical / Non- surgical)	Up to $6,000/Up to $3,000
Lacerations	Up to $600
Burns	Up to $10,000
Dental	Up to $200
Hospital Admission	$2,000
Daily Confinement (Up to 365 days per accident)	$500 per day
ICU Confinement (Up to 15 days per accident)	$1,000 per day
Rehab. Facility Confinement (Up to 30 days per accident)	$150 per day
Surgical	Up to $2,000
Diagnostic	Up to $200
Follow Up Care- Treatment /service required within 365 days of accident: Medical device once per accident per insured person	
Physician Follow-Up Office Visit	$75; Up to 6 per accident
Therapy Services	$50; Up to 6 per accident
Medical Device	$100
Prosthetic Device(s)	$750; Up to 2 per accident
Additional Benefits – Benefits are payable within 365 days of accident	
Transportation (Up to 3 trips per accident)	$600 per trip
Lodging (Up to 30 nights per accident)	$200 per night
Childcare (Up to 30 days per accident)	$30 per day
Catastrophic Benefits- Benefits are payable within 365 days of accident: Once per accident per insured person	
Principal Sum (PS)	You: $30,000 Spouse: $10,000 Child(ren): $5,000
Rate Summary	**Weekly-Rates**
Employee	$1.15
Employee & Spouse	$1.85
Employee & Child(ren)	$2.54
Family	$3.69

**See summary details in Employee Navigator portal*

Pet Insurance

Have pets? Our furry companions require insurance as well. Pet Insurance provides you with the flexibility to choose any veterinarian, regardless of location, including specialists and emergency providers. Nationwide presently covers more than 600,000 pets, encompassing dogs, cats, birds, and exotic animals (without age restrictions) for medical situations connected to illnesses, accidents, injuries, and wellness care.

Simply choose between My Pet Protection or My Pet Protection Wellness.

- You have the option of selecting **My Pet Protection** at 50% or 70% reimbursement levels.
- **New coverage option – My Pet Protection Wellness500**. Starting on 09/01/2023, new members can select this option.
    - If you currently have a plan, you can get in touch with Nationwide to inquire about modifying the plan to include wellness coverage.

Choose from two easy ways to sign up:

Call **877-738-7874** and tell the pet insurance professional the name of your organization.

You'll receive preferred pricing on your base medical policy.

Visit **PetsNationwide.com** and enter the name of your organization to enroll online.

The rates given will include your preferred pricing.

During enrollment, you may be asked for the following information:

- Name
- Address
- Home or primary telephone number
- E-mail address
- Name and age of your pet
- Pet's species (canine, feline, etc.)
- Payment information/plan*

*Applications approved between the 1st and the 15th of the month become effective on the 1st of the following month. Applications approved from the 16th through the end of the month become effective on the 1st of not the following month, but the month thereafter.

Example: May 1 approval = June 1 effective date
May 16 approval = July 1 effective date

Mental Health Support

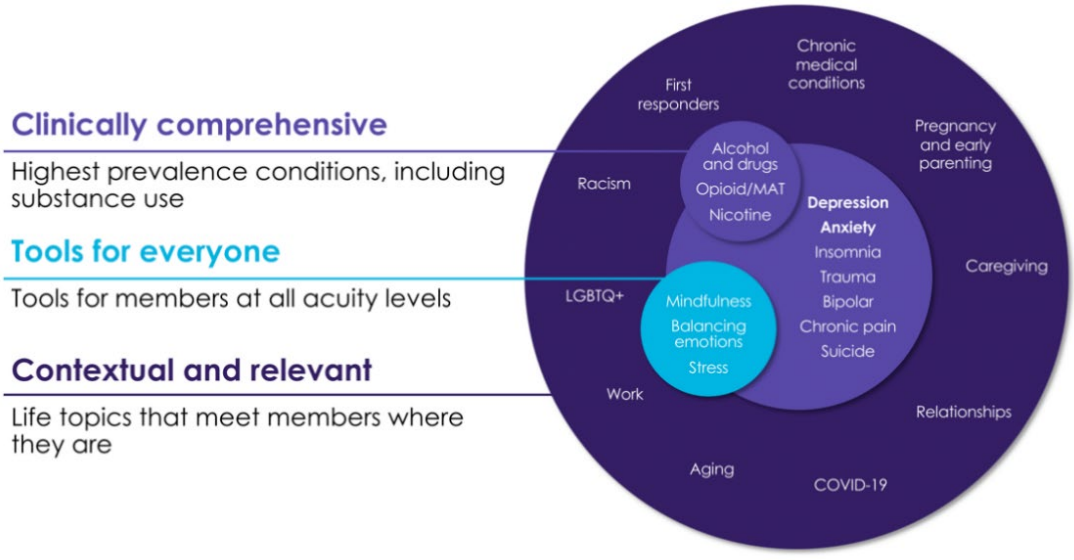
Employee Paid benefit

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. This benefit allows you and your dependents to speak with a licensed therapist virtually with no additional costs.

MYSTRENGTH COMPLETE OFFERS:

Broadest Set of Conditions: Engaging, guided programs for depression, anxiety, stress, mindfulness, substance use disorders (including opioid use disorder), chronic pain, pregnancy and early parenting, nicotine recovery, trauma/PTSD, bipolar disorder and insomnia, as well as a wide range of wellness resources incorporating more than 1,600+ activities and 30+ life topics including coping with COVID-19, first responders' mental fitness, managing chronic conditions, LGBTQ+, caregiving, nutrition, relationships and more.

If you are interested in this additional benefit, it is available for $2.27 weekly.



"Mental health…is not a destination, but a process. It's about how you drive, not where you're going." ***— Noam Shpancer, PhD***

Please note the effective date of this benefit will be November 1st, pending 25 or more employees elect this benefit during open enrollment.

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

Carriers	Phone	Email
Questions about your elections or deductions:	**Corporate Human Resource Manager:** Chelsea Davis (407) 732-0204 ext. 231	hr@attractionsupportservices.com
	Account Manager: Raene Chambers (321) 275-5394	Raene.chambers@theenterpriseteam.com
Medical		
Cigna Group Number: 0630604	Customer Service (800) 997-1654	www.cigna.com
Dental Coverage: Locate a Dentist, Check Claims or Benefits		
Cigna Group Number: 0630604	Customer Service (800) 997-1654	www.cigna.com
Vision Coverage: Find a participating Vision Provider or Contact Customer Service		
Principal Group #:	Principal (Administered by VSP) (800) 877-7195	www.principal.com
Mutual of Omaha (Group Life, STD, LTD, Voluntary Life, Critical Illness, Hospital, Accident)		
Group#: G000B3LC	Customer Service (877) 478-7557	www.mutualofomaha.com
Chard-Snyder (Flexible Spending)	Customer Service (800) 982-7715	www.chard-snyder.com

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

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

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

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

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

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

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

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

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

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

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

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), 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.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

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

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

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

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. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usuallycharge for the same or similar medical service. 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.

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