Benefit Plan Effective

01/01/2025 – 12/31/2025

EMPLOYEE BENEFIT GUIDE

ImmaculateFlight

OVD INSURANCE

WELCOME TO YOUR BENEFITS!

Welcome to our employee benefits program! We know benefits are an important part of your total compensation, providing important protection and significant value to you and your family. This Guide is designed to help you understand your benefits.

Review this information carefully before making your enrollment decisions. It is important to take time to decide which benefits are right for you and your family. Please contact our Human Resource Department whenever questions arise regarding your benefits.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 19-20 for more details.

As part of health care reform law, the government established a health plan information document called the Summary of Benefits and Coverage (SBC). The SBC provides an overview of your medical plan(s) in a standard format and is designed to help you understand and compare different medical plan options. You can find a copy of your SBC's on the Employee Navigator website.

CONTENTS

The information in this Benefits Guide is presented for illustrative purposes. The text contained in this Guide was taken from various benefit summaries and carrier information. While every effort was made to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the 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 your Guide, contact Human Resources.

HOW TO LOGIN & ENROLL

To learn more about your benefit options, visit the **Employee Navigator** website. Detailed information for all plans is available online.

STEP 1: Go to**:** www.employeenavigator.com and click **Login** or **scan the QR code.**

New User: Click on your Registration Link in the email sent to you or click '**Register as a new user'.**
Create an account and create your own username and password.
The company identifier code is: **Immaculate-Flight**

Registered User: Type in your username and password. If you do not remember your password, click the 'Reset a forgotten password' link.

STEP 2: After you login, click **Start** to complete your enrollment.

TIP
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

STEP 3: After clicking **Get Started** you'll need to review and complete some personal & dependent information before moving to your benefit elections.

STEP 4: To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

If you have elected benefits that require a beneficiary designation or completion of an Evidence of Insurability form, you will be prompted to add in those details.

STEP 5: Review the benefits you selected on the enrollment summary page to make sure they are correct then **Click to Sign** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP
If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

ENROLLMENT DEADLINES:

NEW HIRE ENROLLMENT

All eligible employees, whether enrolling or waiving coverage, must complete enrollment **within 30 days** following your date of hire.

OPEN ENROLLMENT

All employees, whether enrolling or waiving coverage must complete enrollment no later than **December 6, 2024.**

CONTACTS

Refer to this list when you need to contact one of your insurance carriers.

Coverage	Carrier	Phone	Website
Medical	WellNet (Aetna)	(800) 727-1733	www.wellnet.com
Prescriptions (Rx)	TrueRX	(866) 921-4047	www.truerx.com
Dental	Delta Dental	(800) 524-0149	www.deltadentalmi.com
Vision	EyeMed	(866) 939-3633	www.eyemed.com
Basic Life/AD&D	Mutual of Omaha	(800) 948-9478	www.mutualofomaha.com
Short Term Disability	Mutual of Omaha	(800) 948-9478	www.mutualofomaha.com
Long Term Disability	Mutual of Omaha	(800) 948-9478	www.mutualofomaha.com
Employee Assistance Program	Mutual of Omaha	(800) 316-2796	www.mutualofomaha.com

Mobile apps are available with the insurance carriers. They can provide ID cards, benefits, claims, and more. Be sure to download them on your phone!

Download on the App Store

GET IT ON Google Play

QUESTIONS?

For general information, contact Human Resources: Brylee Gorham | bgorham@immaculateflight.com

OVD

OVD Insurance is your benefits broker! This means they are an intermediary between you and the insurance carrier. Please reach out to the contacts below if you have specific benefit questions.

Account Manager	Agent	Account Executive	Medicare Agent
Danielle Deur (616) 200-3170 danielled@ovdinsurance.com	Rebekah VanBeek (616) 200-3139 rebekahv@ovdinsurance.com	Katherine Johnson (616) 200-3186 katherinej@ovdinsurance.com	Jon Hayden (616) 342-3231 jonh@ovdinsurance.com
			
2780 44th St SW Wyoming, MI 49519	(616) 454-0800 (877) 544-0800	(616) 742-5133	eb@ovdinsurance.com www.ovdinsurance.com

ELIGIBILITY INFORMATION

ELIGIBILITY REQUIREMENTS
Employees must be working at least 30 hours per week to be eligible for insurance.

DEPENDENT COVERAGE
An eligible dependent is an employee's legally married spouse or the child of the employee by birth, legal adoption, legal guardianship, or is a stepchild. Dependent children may be covered through the end of the month in which they turn age 26 on the medical, dental and vision insurance and up to age 26 on the voluntary life insurance. Employees are responsible for notifying Human Resources if their child is disabled or handicapped as coverage may be able to be continued past age 26 with proper documentation from the child's physician.

EFFECTIVE DATE
Coverage will become effective on the first of the month following 30 days of full-time employment.

TERMINATION DATE
Coverage will terminate as of midnight at the end of the month following termination or lay-off from the employer.

OPEN ENROLLMENT
The Plan offers an annual open enrollment period in the month of November each year with plan changes effective January 1st. Unless you have a qualifying event under special enrollment rights, you are not permitted to make any changes to your elections until the next open enrollment period.

NOTICE OF SPECIAL ENROLLMENT RIGHTS
If you are declining enrollment for yourself or your dependents because you have other coverage, you will be able to enroll in this plan without waiting for the next open enrollment period if you lose the other coverage because of loss of eligibility or because employer contributions for your other coverage have been terminated. Loss of eligibility does not include loss of coverage because of failure to pay premiums on a timely basis. It also does not include voluntary termination of coverage under the plan (for example, due to a change in cost or benefits) nor does it include termination for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the coverage. To be eligible for the special enrollment, you must request enrollment within 30 days after your coverage ends and provide satisfactory proof of the loss of other coverage. If you gain a new dependent because of marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependents at that time, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. See following page for more information.

MEDICAL PLAN CREDITABILITY
A health plan's prescription drug coverage is creditable when the amount the plan expects to pay for prescription drugs for individuals covered by the plan in the coming year is, on average, the same or more than what standard Medicare prescription drug coverage would be expected to pay. Please reference the end of this guide for your Medicare Part D Prescription Notice.

QUALIFYING LIFE EVENTS (QLE)

You can typically only enroll in a qualified health plan once a year during the annual open enrollment period. If you've experienced certain changes in your life, however, you could be eligible for a special enrollment period to sign up for health coverage or to change your current plan.

You must sign up within 30 days of the event. You must also include written proof of the event.

	Qualifying Life Event	Proof Required
	Marriage	Copy of marriage certificate
	Name Change	Copy of updated Social Security Card
	Birth of a child	Copy of birth certificate or hospital documentation
	Adoption or Foster Child	Copy of certificate of adoption or placement papers
	Legal Guardianship	Copy of court documents
	Divorce or legal separation	Copy of divorce decree or legal separation papers
	Death of policyholder	Copy of death certificate
	Loss of COBRA benefits	Proof of loss of coverage showing date coverage ended
	Job Loss / New Employment	Proof of loss of coverage or new coverage confirming date coverage ended or began
	Losing or gaining eligibility for Medicaid or CHIP	Copy of letter from Medicaid or CHIP
	Becoming Medicare Eligible	Copy of Medicare Card
	Gain or Loss of coverage through Spouse or Parent	Proof of loss of coverage or proof of gaining coverage showing date coverage ended
	Gained U.S. citizenship or qualified immigration status	Copy of citizenship/immigration papers

Contact Human Resources if you have experienced a qualifying life event and need to make changes to your insurance.

Brylee Gorham | bgorham@immaculateflight.com

MEDICAL INSURANCE

(Medical benefits run on a plan year basis: January 1 – December 31)

The medical insurance is with WellNet/Aetna. You have the option of three medical insurance plans. Employees (and their dependents) are required to select a primary care physician (PCP). If you do not have a PCP, one will be assigned to you. To receive benefits, you must see a participating provider. There is no coverage with providers that do not participate with Aetna.

For a list of participating providers, go to https://www.aetna.com/individuals-families/find-a-doctor.html. Click on 'Plan from an employer' and choose your location and click Search**.** Select the Aetna Choice POS II (Open Access) network, click continue and search for providers by name, type etc.

	H.S.A. PPO $3,300 Option #1	PPO $1,500 Option #2	PPO $5,000 Option #3
	In-Network Only Shown*	**In-Network Only Shown***	**In-Network Only Shown***
Deductible	$3,300 single $6,600 family	$1,500 single $3,000 family	$5,000 single $10,000 family
Deductible Details	For family coverage, one family member will not exceed the single deductible amount.		
Coinsurance %	80% (Wellnet) 20% (Employee)	80% (Wellnet) 20% (Employee)	80% (Wellnet) 20% (Employee)
Out-of-Pocket Maximum (Deductible, Coinsurance & Copays)	$6,900 single $13,800 family	$8,150 single $16,300 family	$8,150 single $16,300 family
Out-of-Pocket Details	For family coverage, one family member will not exceed the single out-of-pocket amount.		
Routine Preventive Care	Covered 100%	Covered 100%	Covered 100%
PCP Office Visit	Covered 80% after deductible	$20 Copay	$20 Copay
Specialist Office Visit	Covered 80% after deductible	$40 Copay	$40 Copay
Urgent Care	Covered 80% after deductible	$50 Copay	$50 Copay
Emergency Room	Covered 80% after deductible	$250 Copay after deductible	$250 Copay after deductible
Hospitalization	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Rx Copay – Retail Tier 1 Tier 2 Tier 3 Tier 4 **Mail Order (90-day supply)**	**Copay applicable after deductible* *$10 Copay *$60 Copay *$80 Copay *20% Copay. Max $200. *3X Copay	 $10 Copay $60 Copay $80 Copay 20% Copay. Max $200. 3X Copay	 $10 Copay $60 Copay $80 Copay 20% Copay. Max $200. 3X Copay
Employee Only: **Employee + One:** **Employee + Family:**	$19.96 $143.70 $179.64	$94.06 $321.55 $401.94	$14.70 $127.91 $163.84

COORDINATION OF BENEFITS

AUTO / MOTORCYCLE INSURANCE COORDINATION

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS:

- THIS PLAN WILL PAY SECONDARY.
- To protect yourself and your family from financial catastrophe, it is strongly recommended that you continue to purchase unlimited, lifetime Personal Injury Protection (PIP) coverage on your automobile insurance, but in no event less than $250,000 of Personal Injury Protection (PIP).
- For participants who are not Michigan residents, if a covered person fails to maintain automobile insurance as required by law, and subsequently incurs automobile-related injuries, no benefits for those or related injuries or illnesses will be payable under this Plan. If a covered person is not required by law to carry automobile insurance, this Plan shall be the secondary plan for purposes of paying benefits and any insurer or other plan that may have liability for the automobile accident-related expenses will be the primary plan.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF MOTORCYCLE ACCIDENTS:

- If a covered person is injured in an accident that involves a motor vehicle, claims will be processed in accordance with the Plan's position on motor vehicle accidents above.
- IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE A MOTOR VEHICLE, THIS PLAN WILL EXCLUDE COVERAGE FOR THE FIRST $20,000 IN ELIGIBLE CHARGES OR, IF GREATER, THE AMOUNT OF HEALTH BENEFITS PAYABLE BY THE MOTORCYCLE INSURANCE POLICY.
- It is the responsibility of any covered person who operates a motorcycle to ensure that he or she is covered under a motorcycle insurance policy that will pay at least $20,000 in health benefits for him/her per accident. This requirement applies even if the covered person is not legally required to have such health benefit coverage. If the covered person fails to maintain $20,000 of coverage through a motorcycle insurance policy, the difference between the policy's maximum payout per accident (if any) and $20,000 will be the covered person's responsibility.

OTHER MEDICAL INSURANCE FOR YOURSELF AND/OR FAMILY MEMBERS

If you and/or any family members are enrolled under Immaculate Flight's medical insurance and also have medical insurance through another source (spouse's employer, Medicaid, Medicare, etc.) it is important that you notify the medical insurance carriers of your dual coverage so that they can establish which coverage should pay primary versus secondary. Failing to do so could result in denied claims.

PRESCRIPTION COVERAGE

IS MY PRESCRIPTION COVERED?

Your prescription coverage is based on an "approved drug list," also called a formulary, which is a list of medications that TrueRx will cover for you. Call the True Rx Patient Care Team at (866) 921-4047 or visit the True Rx website by going to https://truerx.com/formularies and select the Universal (Open) Formulary.

WONDERING IF A GENERIC DRUG WILL WORK JUST AS WELL AS THE NAME BRAND?

CHECK OUT THESE FOUR FACTS ABOUT GENERIC MEDICATIONS.

1. Effectiveness
Generic medications are tested and thoroughly reviewed to make sure they are just as effective as the brand-name drug.

2. Safety
Generic medications must use the same active ingredients as the name brand.

3. Quality
The FDA requires that a generic drug manufacturing plant meets the same high standards as a plant for a brand-name drug. The FDA conducts more than 3,500 on-site inspections each year.

4. Cost
Generic drugs can cost 30 to 95% less than brand-name drugs. Brand-name drugs are pricier because they had to be developed from scratch, a process that takes 12 or more years.

ORDER PRESCRIPTIONS BY MAIL

Save money on the medications you take every day! If you're on daily medications, then using the home delivery pharmacy may save you money. You may obtain a **90-day supply** of most maintenance medications for the cost of **2 copays** through mail order. Please call WB Rx Express at (833) 391-0126 to setup your mail order delivery service.

SPECIALTY MEDICATION

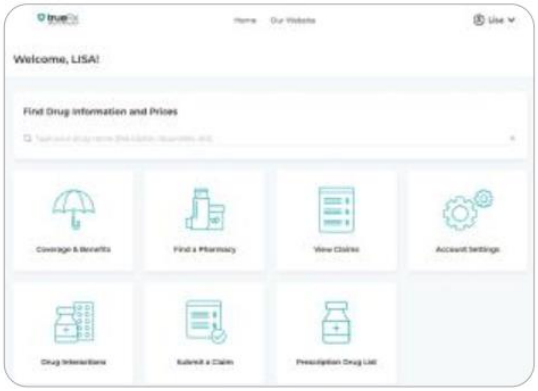
True Advocate is a specialty medication program providing you with a dedicated case manager to help lower your specialty medication cost. Your case manager will assist in getting you signed up with available assistance programs to lower your cost, in some instances even to $0 for up to one year.

PHARMACY BENEFIT MEMBER PORTAL AND MOBILE APP

Visit www.truerx.myrxplan.com and click on the **Register Now** button. Use information from your ID card to complete your registration.

For the mobile app, download the **MyRxPlan** app in your app store.

- ✓ **View and Compare Medication Prices**
- ✓ **View Your Insurance Card**
- ✓ **View Pharmacies Near You**
- ✓ **View prescription drug history**
- ✓ **Check Medication Information**



HEALTH SAVINGS ACCOUNT (HSA)

If you are enrolled in the HSA medical plan, you can contribute pre-tax dollars into a health savings account.

HOW DOES AN HSA WORK?

A Health Savings Account (HSA) is a safe and convenient way to pay for healthcare expenses. Contributions to the account can be made by an individual, an employer, or both. The contributed dollars are used to save for current (and future) qualified medical, dental and vision expenses tax-free. And, since an HSA works like a checking account, your expenses can be conveniently paid by check or debit card.

WHY CHOOSE AN HSA?

- A health savings account (HSA) can help you lower your taxes, pay for health care more easily and even save for retirement. HSAs are known for their triple tax advantage — contributions are made pre-tax through payroll deductions, growth is tax-free and withdrawals used for qualified health-care expenses are also untaxed.
- The money in your HSA remains available for future qualified medical expenses even if you change health insurance plans, go to work for a different employer, or retire. Essentially, your HSA is a bank account in your name, where you decide how and when to use the funds.
- Just like a traditional savings account, your HSA earns interest which is not taxed. This makes your HSA an effective component of your retirement strategy. Once your account meets a certain threshold, you can invest in mutual funds to maximize your HSA earning potential.

Unused funds in your HSA Account rollover each year and can be accumulated like a savings account.

DO YOU QUALIFY?

You can open an HSA and contribute to an HSA if:

- ✓ You enroll in a high-deductible health plan (HDHP)
- ✓ Your only coverage is a high-deductible health plan
- ✓ You are not entitled to Medicare coverage.

If you're covered under your spouse's plan and that plan is not a high-deductible plan or your spouse contributes to a Health Care Flexible Spending Account (FSA), then **you cannot** contribute to an HSA.

Anyone eligible to be claimed as a tax dependent of someone else is not eligible to open or contribute to an HSA.

HOW IT WORKS:

1

You pay 100% of medical and prescription expenses until you reach your deductible (except for preventive care services, which are covered in full).

Once your deductible is met, you only pay applicable copayments and coinsurance.

2

If your family is covered by your plan, all expenses count toward one deductible and one out-of-pocket maximum, so you can apply your HSA to your family's expenses too.

3

The out-of-pocket maximum provides a limit to how much you spend in a year.

Once this maximum is met, all covered services are covered in full.

4

All contributions (including employer payments) are tax free, lowering your income taxes.

The account can earn interest, and when the money is withdrawn for eligible expenses, it's tax free as well!

HOW MUCH CAN I SAVE IN MY HSA EACH YEAR?

Health Savings Account: The Annual Maximum Limit:		
	Annual Max HSA Limit 2025	**Employee Bi-Weekly Contribution Limit**
Single Coverage	$4,300.00	$159.61
Two Person Coverage	$8,550.00	$319.23
Family Coverage	$8,550.00	$319.23
Employees age 55 or older may contribute an additional $1,000 to their Health Savings Account.		

WHERE CAN I OPEN A HEALTH SAVINGS ACCOUNT?

Once your account is setup please be sure to give your HSA bank account information to human resources so that they can deposit the HSA money into your account.

WHAT HAPPENS AT THE END OF THE YEAR?

After the end of the year, you will be sent tax forms from your HSA administrator that indicate how much you contributed to your HSA account for the calendar year, how much you withdrew from the account during the year, and your ending balance on December 31. You will need to file a tax form **(Form 8889)** with your tax return which documents your HSA account activity.

Keep track of all your explanation of benefits and receipts. This is the only proof you have that your expenses are "qualified healthcare expenses". You are responsible for using your account funds appropriately. You need to keep good records to indicate that you used your HSA account funds exclusively to pay for or reimburse qualified healthcare expenses. If your tax return is audited by the IRS, you will need to prove that your medical expenses were "qualified". You will have to pay income taxes and a tax penalty (20%) on the amount that was not "qualified".

HSAstore.com is everything flex spending with zero guesswork. It's both the largest online marketplace for guaranteed HSA-eligible products and an educational resource. You can search for items to see if they are eligible, access an HSA tax-savings calculator, order eligible items online and they also provide member perks!

ELIGIBLE HSA EXPENSES

Below is a partial listing of eligible HSA Expenses. This listing is subject to change.

HSA ELIGIBLE MEDICAL ITEMS: That DO NOT require a Doctor's Prescription

- Acne Remedies
- Acupuncture
- Allergy & Sinus Medicine
- Baby Electrolytes
- Bandages
- Blood Pressure Monitors
- Braces & Supports
- Breast Pumps/Accessories
- Blood Pressure Monitors
- Children's First Aid
- COBRA Premiums
- Cough/Cold/Flu Medicine
- CPAP Machines
- Crutches
- Contact Lens Solution
- Denture Adhesives/Cleansers
- Diabetes Testing & Aids
- Digestive Remedies
- Eye Glass & Lens Care
- First Aid Kits
- Glucosamine Supplements
- Glucose Products/Monitors
- Hearing Aids & Batteries
- Home Medical Equipment
- Heating Pads & Wraps
- Hot & Cold Packs
- Incontinence products
- Insulin
- Laser Eye Surgery
- Laxatives
- Lip Balm
- Medical Devices
- Menstrual Care Products
- Motion Sickness Treatment
- Nasal Spray
- Nebulizers
- Orthopedic Supports
- Orthodontia
- Pain Relievers
- Pregnancy & Fertility Tests
- Prenatal Vitamins
- Reading Glasses/Magnifiers
- Retiree Medical Premiums
- Shoe Insoles & Inserts
- Sleep Aids/Sedatives
- Stomach Remedies
- Sunscreen (SPF 15+)
- Syringes
- Thermometers
- Vaporizers & Inhalers
- Walking Aids
- Wheelchairs

HSA ELIGIBLE MEDICAL ITEMS: That REQUIRE a Doctor's Prescription

- Antibiotics
- Antidepressants
- Birth Control
- Contraceptive Medications
- Medicated Face Cream
- Probiotics
- Sedatives
- Skin Treatments
- Testosterone
- Vitamins / Supplements

HOW TO USE A HEALTH SAVINGS ACCOUNT

AT A DOCTOR'S OFFICE

Step 1:

- While you are at the doctor's office for medical services, be sure to present your medical ID card to verify that your insurance information on file is accurate and so the doctor's office can bill your medical carrier for your service.
- Note – you should not pay anything at the time of service.
- The doctor will submit your claim to your medical carrier for processing.

Step 2:

- If the services are billed as preventive, the office visit will be covered at 100%.
- If services are not billed as preventive, any discounted charges will be applied to your deductible. You will then receive an Explanation of Benefits (EOB) in the mail outlining the charges you are responsible for as well as an invoice from the doctor's office.
- **Pay attention!** Your EOB and invoice from the doctor's office should match.

Step 3:

- Use your HSA Debit Card to pay for the charges you are responsible for.
- Be sure to keep a copy of your receipt!

AT A PHARMACY

Step 1:

- Obtain the prescription (Rx) from your doctor and go to the pharmacy of your choice to pick up your prescription.
- Be sure to present your medical ID card.

Step 2:

- If your deductible has not yet been met, you will be responsible for paying the full amount of the prescription, less any discounts.
- If you have already met your deductible, you will be responsible for paying the applicable copay amount.

Step 3:

- Use your HSA Debit Card to pay for your prescription.
- Be sure to save your receipt!

HSAs & MEDICARE

As you approach retirement age your health plan needs will be changing. It is important to understand how Medicare may impact your HSA. By law, people enrolled in any part of Medicare are no longer allowed to contribute to an HSA. Use the below chart to determine when you should cease contributing to your HSA and how you should manage and utilize the account going forward.

THE IMPACT OF MEDICARE ON HSA

ELIGIBLE: If you met the requirements to qualify for Medicare Part A, but have not yet enrolled, you may continue to contribute to your HSA account past age 65 if you postpone applying for Social Security and Medicare until after you stop working. There is no penalty for this delay as long as you maintain creditable prescription drug coverage with your health plan.

If you work for an employer with less than 20 employees, you need to enroll in Medicare Part A&B because Medicare is primary and the group health plan is secondary coverage.

ENTITLED: If you are entitled to Medicare because you signed up for Medicare Part A at age 65 or later or have applied for Social Security Benefits you cannot continue to contribute to an HSA. However, you can continue to spend any remaining funds in your health savings account for qualified expenses.

If you are entitled to Medicare because you signed up for Medicare Part A at age 65 or later but have not yet applied for Social Security Benefits, you may withdraw your application for Part A. There are no penalties or repercussions and you are free to reapply for Part A at a future date. This will allow you to continue to contribute to the HSA until you decide to reapply for Part A.

ENROLLED: If you are receiving Social Security Benefits - which automatically enrolls you to Part A - you cannot continue to contribute to an HSA. However, you can continue to use any remaining funds in your account.

If working past 65, employees should stop contributing to their HSA six months *before** applying for Social Security retirement benefits to avoid potential tax penalties.

** When you sign up for Social Security retirement benefits, or Medicare and if you're already six months beyond your full retirement age, Social Security will give you six months of retro Part A - since there is no premium for Part A. This means that your enrollment in Part A will also be backdated by six months. Under IRS rules, that leaves you liable to pay six months of excess contributions on your HSA.*

Please reference the "HSAs & Medicare" brochure included in the 'Documents' section of Employee Navigator for more information and common FAQs.

DENTAL INSURANCE

(Dental benefits run on a calendar year basis: January 1 – December 31)

The dental insurance is with Delta Dental. You may choose any dentist that you want. However, to receive the highest benefits you must use a PPO or Premier Dentist. When you receive services from a Nonparticipating dentist, the percentages in the chart below indicate the portion of Delta Dental's Nonparticipating dentist fee that will be paid for those services. This amount may be less than what the dentist charges and you are responsible for that difference, also known as balance billing. All payments are based on the allowed amount of the service.

For participating providers, visit www.deltadentalmi.com and click on Find A Dentist. Search under the **Premier or PPO Network.**

Dental Benefits	In & Out-of-Network *
Deductible	$50 individual | $150 family
Preventive Services	Covered 100%
Basic Services	Covered 80%
Major Services	Covered 50%
Orthodontic Services	Covered 50%, up to $2,000 per child under age 19 per lifetime
Annual Plan Maximum	$2,000 per person
Benefit Waiting Periods	None
Employee Bi-Weekly Contribution:	
Employee Only: **Employee + One:** **Employee + Family:**	$1.12 $2.17 $4.70

*When you receive services from a non-participating dentist, the percentages in the chart above indicate the portion of your dental carrier's non-participating dentist fee that will be paid for those services. This amount may be less than what the dentist charges and you are responsible for that difference, also known as balance billing.

VISION INSURANCE

(Vision benefits run based on last date of service)

Vision insurance is offered through EyeMed. To receive benefits, you must see a participating provider. Out-of-network coverage is available for some benefits; however, the member will pay more out of pocket.

For a list of participating vision providers, go to https://eyemed.com/en-us and click on Find an Eye Doctor.
Choose from the Insight Network.

Vision Benefits	In-Network
Exam Copay	$10 Copay. Limit of once every 12 months. *For PLUS Providers $0 Copay!*
Lens Copay	$10 Copay. Limit of once every 12 months.
Additional Lens Options	Additional lens options are available at different copay amounts or discounts
Frames	$130 Allowance. *For PLUS Providers $180 Allowance!* Limit of once every 12 months.
Contacts	Elective: $130 Allowance | Medically Necessary: 100% Covered in Full Limit of one payment (fill at least $130 of contacts) every 12 months.
Employee Bi-Weekly Contribution:	
Employee Only: **Employee + One:** **Employee + Family:**	$0.29 $1.74 $2.88

SHORT TERM DISABILITY INSURANCE

This benefit is provided at no cost to you.

The short term disability insurance is with Mutual of Omaha. Short term disability insurance pays a percentage of your salary for a specified amount of time, if you are ill or injured (non-work related), and cannot perform the duties of your job.

Benefits & Coverage	
Weekly Benefit	60% up to a maximum of $1,000 per week
Elimination Period for an Accident	0 days - benefits begin on the 1st day
Elimination Period for a Sickness	7 days - benefits begin on the 8th day
Benefit Duration	Up to 13 weeks - this includes the elimination period
Pre-Existing Conditions Limitation	None – Pre-existing conditions are covered.
Definition of Disability	Unable to perform the duties of your own occupation, including partial disability
Definition of Income	Basic Weekly Income

LONG TERM DISABILITY INSURANCE

This benefit is provided at no cost to you.

The long term disability insurance is with Mutual of Omaha. Long term disability insurance replaces a portion of your income during an extended period of a disabling illness or accident (non-work related). By providing a steady stream of income while you are unable to work, long term disability insurance can help you meet your financial obligations.

Benefits & Coverage	
Monthly Benefit	60% up to a maximum of $6,000 per month
Benefit Waiting Period	90 Days
Benefit Duration	To age 65 or Social Security Normal Retirement Age (SSNRA)
Pre-Existing Conditions Limitation	Any condition diagnosed 3 months prior to the employee's coverage effective date will be covered once the employee has been insured under the plan and is actively at work for 12 consecutive months "3/12"
Definition of Disability	Unable to perform the duties of your own occupation for 2 years; thereafter any occupation
Definition of Income	Basic Monthly Income
Mental Illness/Drug/Alcoholism Limitation	Benefits are limited to 24 months for any one period of disability unless the employee is confined to a hospital

BASIC LIFE / AD&D INSURANCE

This benefit is provided at no cost to you.

The basic life insurance is with Mutual of Omaha. Life insurance provides an important source of income and financial security for your family in the event of your death. The Accidental Death & Dismemberment (AD&D) benefit provides additional insurance protection to you and your family in the case of your accidental death or a specific accidental injury.

Benefits & Coverage	
Employee	$25,000
Benefit Reduction Schedule	Benefits will reduce to the following percentage: 65% at age 70 and 50% at age 75

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) through Mutual of Omaha can be the answer for you and your family. Your EAP benefits are provided through your employer**. There is no cost to you for utilizing EAP services.** If additional resources are needed, your EAP will help locate appropriate providers in your area.

PRE-TAX PREMIUM CONVERSION PLAN

Your employer has established an IRC **Section 125 Premium Conversion Plan.**

How does this affect me?

A Premium Conversion Plan allows employees to pay for their share of insurance premiums with **Pre-Tax dollars** through payroll deduction. Your election to pay your insurance premiums with pre-tax dollars saves you money and is generally a good financial decision.

What should I consider before making elections?

Pre–Tax insurance elections **CANNOT** be changed during the plan year and will remain the same until the next open enrollment period, at which time you can change your election.

However, an insurance election change may be made if you have a **Qualified Status Change** including, but not limited to:

1. Marriage
2. Divorce
3. Birth or adoption of a child, or
4. Change in employment status for you or your spouse
5. Change in coverage under a plan of the employer of an employee's spouse or dependent (i.e. Spouse's Open Enrollment).
6. Enrollment in individual health coverage during the Marketplace Annual Open Enrollment.

Consistency Rule: In all cases, any election change as a result of any change in status must be on account of, and correspond with, a change in status that affects eligibility for coverage under the plan.

For example: If the change in status is the employee's divorce from a spouse, the death of a spouse or dependent child, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election to cancel coverage will apply only to the spouse involved in the divorce, the deceased spouse or dependent child, or the dependent that ceased to satisfy the eligibility requirements.

Carefully consider the irrevocable nature of pretax elections when deciding whether to pay for your share of insurance premiums with pre-tax or after-tax dollars.

If you anticipate needing to change your insurance elections during the plan year for any reason other than a qualified status change listed above, you should consider declining participation in the premium conversion plan and paying your share of medical, dental and vision insurance premiums with after tax dollars.

ANNUAL NOTICES

The following legal notices and documents are available on the online Employee Navigator website.

- Summary of Benefits and Coverage (SBC)
- Medicare D Prescription Notice
- Notice of Privacy Practices
- Marketplace Notice

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

Effective April 1, 2009, if you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for the coverage. These states use funds from the Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your children are not 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.

You can contact your state Medicaid or CHIP office, or dial **1-877-KIDS NOW**, or www.insurekidsnow.gov to determine if your state has a program that might help you pay the premiums for an employer sponsored plan, or to apply for coverage. **(Michigan does not currently offer premium assistance).** You may also contact the U.S. Department of Health and Human Services at www.cms.hhs.gov, or 1-877-267-2323.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, or you lose coverage under Medicaid or a state child health insurance plan, your employer's health plan is required to permit you and your dependents to enroll in the plan. This is called a "special enrollment" opportunity, and you **must request coverage within 60 days of being determined eligible for premium assistance.**

Genetic Information Nondiscrimination Act of 2008 (GINA)

Effective May 21, 2008, The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in health coverage and employment, based on genetic information.

The Newborn Act

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

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

Notice of Patient Protection

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact your Human Resources Department.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecology care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining authorization for certain services, following a pre-approved treatment plan, or following certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources Department.

Michelle's Law

Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Further, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice of Privacy Practices Available

The U.S. Department of Health and Human Services has issued regulations as part of the Health Insurance Portability and Accountability Act of 1996. These regulations, known as the Standards for Privacy of Individually Identifiable Health Information, were effective April 14, 2003 (or April 14, 2004 for small health plans) and control how your medical information may be used and disclosed and how you can access this information. Please be advised that your health benefits plan maintains a current Notice of Privacy Practices to inform you of the policies that is has established to comply with the Standards for Privacy. This Notice describes the responsibilities of the plan and any third party assisting in the administration of claims regarding the use and disclosure of your protected health information, and your rights concerning the same.

This Notice is available to you upon request by contacting your company's Privacy Official or Human Resource Director. A brief summary of the policy is described below.

Non-Opioid Directive Form

Patients in the State of Michigan can now complete a form that directs health professionals and emergency medical services personnel to not administer opioids to them. The nonopioid directive form can be filled out by the patient or a person's legal guardian or patient advocate. Once submitted, the directive must be included in the patient's medical records. This form can be found (along with other resources regarding opioid abuse) at https://www.michigan.gov/opioids/find-help

MEDICARE D PRESCRIPTION NOTICE

IMPORTANT NOTICE FROM IMMACULATE FLIGHT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Immaculate Flight** has determined that the prescription drug coverage offered by **Immaculate Flight**, is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15th through 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 **Immaculate Flight** coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage with **Immaculate Flight**, be aware that you and your dependents will not be able to get this coverage back unless you experience a qualified status change, or until the next open enrollment period.

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 coverage with **Immaculate Flight** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a Penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Immaculate Flight** changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	11/12/2024
Name of Entity:	**Immaculate Flight**
Contact:	Brylee Gorham
Address:	5088 Corporate Exchange Blvd
Phone:	1-616-278-5501 X4