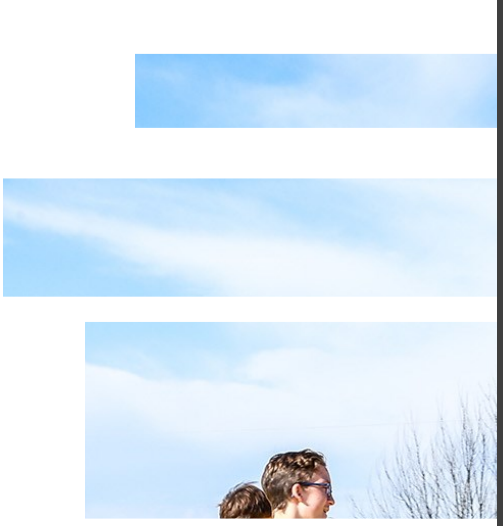
NOVA PARKS

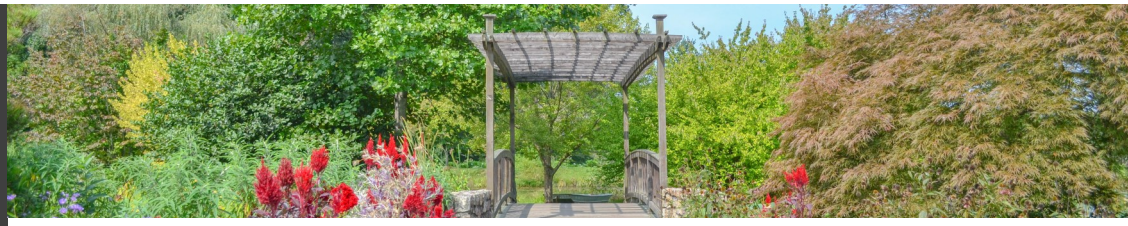


2025

Part-Time Employees

BENEFITS GUIDE

CONTENTS



Dear NOVA Parks Colleague:

NOVA Parks cares about the health and well-being of you and your family, and we are dedicated to providing you with a comprehensive benefits package. We encourage you and your dependents to become familiar with the resources and providers listed in this benefits guide.

As an active, part-time employee of NOVA Parks, you are eligible for health insurance as well as dental and vision benefits. Premiums for all health, dental, and vision benefits are deducted on a bi-weekly, pre-tax basis over 26 pay periods. Premiums for the accident, critical illness and pet coverages are deducted over 24 pay periods.

Consider your benefit options carefully before you make your benefit elections. The benefits you choose will be in place from your eligibility date through the end of the calendar year, unless you have an IRS qualifying event during the year such as marriage, birth, death, etc. It is the employee's responsibility to notify Human Resources of any mid-year qualifying events that affect their coverage within 30 days of the event.

MEDICAL

BENEFIT	HMO SIGNATURE IN-NETWORK ONLY	HMO SELECT IN-NETWORK ONLY
Primary Care Physician (PCP)	$10 copay[1]	$10 copay[1]
Specialty Care	$20 copay	$20 copay
Annual Deductible	**None**	**None**
Out-of-Pocket Maximum	**$3,500 Individual $9,400 Family**	**$3,500 Individual $9,400 Family**
Preventive Care—All Ages Routine Preventive Care Immunizations Mammogram, PAP, PSA Tests	No charge	No charge
Inpatient Hospital Facility	$100 per admission	$100 per admission
Outpatient Hospital Facility	$50 per visit	$50 per visit
Outpatient Professional Service	$50 copay	$50 copay
Chiropractic Care	Not covered	Not covered
Hearing Aids	Not covered	Not covered
Emergency Room	$50 copay[2]	$50 copay[2]
Urgent Care Facility	$20 copay	$20 copay
TMJ, Surgical and Non-Surgical Physician's Office	Copay costs vary based on location of service	Copay costs vary based on location of service
In-Patient Mental Health & Substance Abuse Treatment	$100 per admission[3]	$100 per admission[3]
Annual Prescription Drug Deductible	None	None
Annual Prescription Drug Out-of-Pocket Maximum	Combined with medical	Combined with medical
Prescription Drug **Kaiser Pharmacy** 30 day supply	Generic: $10 copay Preferred Brand: $20 copay Non-Preferred: $35 copay Mail Order[4]: $20/$40/$70	Generic: $10 copay Preferred Brand: $20 copay Non-Preferred: $35 copay Mail Order[4]: $20/$40/$70
Prescription Drug **Community Pharmacy** 30 day supply	Generic: $20 copay Preferred Brand: $40 copay Non-Preferred: $55 copay	Generic: $20 copay Preferred Brand: $40 copay Non-Preferred: $55 copay

BI-WEEKLY CONTRIBUTIONS	EMPLOYEE	NOVA PARKS	EMPLOYEE	NOVA PARKS
Individual	$50.37	$285.44	$52.60	$298.07
Two-Party	$167.90	$503.71	$175.33	$526.00
Family	$243.45	$730.38	$254.23	$762.70

[1] No charge for children under 5 years old
[2] Copay waived if admitted
[3] Outpatient: $10 per individual visit / $5 per group visit
[4] 90 day supply

KAISER PERMANENTE®

KAISER PERMANENTE INSURANCE PLANS

NOVA Parks offers two Kaiser Permanente insurance plans; the HMO Signature and HMO Select. These plans only provide in-network coverage — **no out-of-network benefits are available.**

The HMO Select plan has the same benefits as the HMO Signature plan, but offers a larger network of doctors to choose from. In other words, the HMO Select plan does not require you or your dependents to visit a Kaiser Permanente medical facility for care, while the HMO Signature plan is a local HMO medical center based design.

Visit www.kp.org or call 1.855.249.5018 for a list of network providers.

DENTAL

MetLife

METLIFE DENTAL

NOVA Parks offers two MetLife dental plans; the low plan and **new enhanced** high plan. To locate a dentist, visit www.metlife.com/dental or call 1.800.275.4638.

You may choose either an in or out-of-network dentist. However, if you choose an out-of-network dentist, your out-of-pocket costs may be higher. Before receiving service, MetLife recommends that you request a pre-treatment estimate for services in excess of $300. Your dentist can submit a request online at www.metdental.com or can call 1.877.MET.DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office!

Enhanced Benefits

	LOW PLAN		HIGH PLAN	
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150
Annual Maximum	$1,000		$2,000	
Diagnostic & Preventive Services Prophylaxis (Cleanings, up to 4 per plan year); Oral Examinations; Topical Fluoride (up to age 14); Bitewing; X-rays	100%	60%	100%	100%
Basic Services Problem Focused Examinations; Fillings; Extractions; Oral Surgery; Endodontics; Scaling, Root Planning, and Periodontal Surgery; Anesthesia; Repairs; Sealants and Space Maintainers (up to age 14)	80%*	40%*	90%*	90%*
Major Services Bridge and Dentures; Crowns, Inlays, Onlays, Implants; Consultations	50%*	10%*	60%*	60%*
Orthodontia Services	Not Covered		Not Covered	
BI-WEEKLY CONTRIBUTIONS	**EMPLOYEE**		**EMPLOYEE**	
Employee Only Employee + 1 Dependent Employee + Family	$12.76 $26.11 $45.14		$19.39 $39.48 $66.77	

* After deductible

VISION

AVESIS VISION

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10 copay	Up to $35 reimbursement
Frequency Exam/Lenses or Contacts/Frames	12 /12 /12 months	
Frames	$120 allowance[1]	Up to $45 reimbursement
Lenses		
Single Vision Lenses	Covered in full after $15 copay	Up to $25 reimbursement
Bifocal Vision Lenses	Covered in full after $15 copay	Up to $40 reimbursement
Trifocal Vision Lenses	Covered in full after $15 copay	Up to $50 reimbursement
Polycarbonate Lenses (Single/Multi-Focal)	Covered in Full	Up to $10
Standard Scratch-Resistant Coating	Covered in Full	Up to $5
Ultra-Violet Screening	Covered in Full	Up to $6
Solid or Gradient Tint	Covered in Full	Up to $4
Standard Anti-Reflective Coating	Covered in Full	Up to $24
Level 1 Progressive	$75 copay	Up to $40
Level 2 Progressive	$110 copay	Up to $40
All Other Progressive	$50 allowance + up to 20%	Up to $40
Transitions (Single/Multi-Focal)	$70/$80 copay	N/A
Polarized	$75 copay	N/A
PGX/PBX	$40 copay	N/A
Other Lens Options	Up to 20% discount	N/A
Contact Lenses[2]		
Standard Contact Lens Fitting & Follow-up	$50 maximum copay	n/a
Elective Contact Lenses	$110 allowance	Up to $85 reimbursement
Medically Necessary Contact Lenses[3]	Covered in full	Up to $250 reimbursement

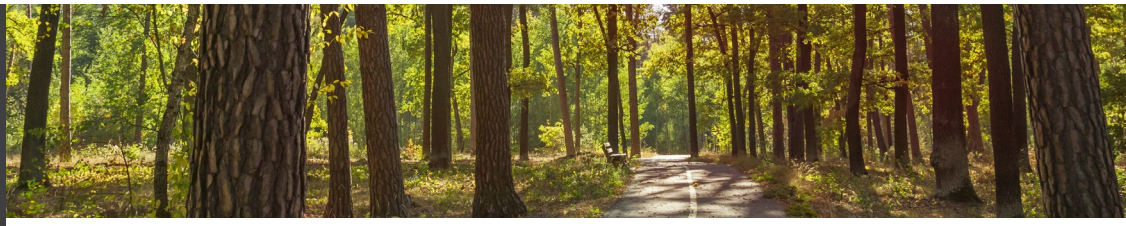
BI-WEEKLY CONTRIBUTIONS	EMPLOYEE
Employee Only	$3.65
Employee + Spouse	$7.01
Employee + Child(ren)	$7.65
Employee + Family	$9.88

avēsis ESSENTIAL BENEFITS

AVĒSIS VISION

To locate in-network providers in your area, call 1.800.828.9341 or visit www.avesis.com. Members who use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement

VISION & TUITION ASSISTANCE



KAISER PERMANENTE (KP) VISION

If your dependents under age 19 are enrolled in the Kaiser Permanente insurance plan offered by NOVA Parks, they have vision benefits included. You and your dependents over the age of 19 do not have vision benefits included in the plan, but may be eligible to receive a discount on your eyeglass lenses and frames. Visit www.kp.org for more information.

KAISER PERMANENTE®

KP VISION

BENEFIT	IN-NETWORK ONLY
Eye Exam	$10-20 copay[1]
Frames	
Frames from KP	No charge[2]
Lenses	
Single Vision Lenses	No charge[2]
Bifocal Vision Lenses	No charge[2]
Contact Lenses	
Lenses from KP	1 pair covered in full
Medically Necessary Lenses	2 pair covered in full
Frequency	
Exam	12 months
Frames/Lenses or Contact Lenses	12 months

[1] Optometrist $10 copay / Ophthalmologist $20 copay
[2] Some limitations apply

TUITION ASSISTANCE PROGRAM

NOVA Parks offers eligible part-time employees benefits under a Tuition Assistance Program. This program provides you tuition assistance to pursue undergraduate or graduate courses from accredited educational institutions so long as the course is related to your current job duties, advancement/ promotional opportunities with NOVA Parks, or is required as a core course to complete a job-related degree.

Eligible part-time employees are regularly scheduled to work 30 or more hours per week and have worked 12 consecutive months. If you are eligible, you can apply to receive reimbursement for up to 3 credit hours per fiscal year. This reimbursement is a tax-free benefit.

For questions or to apply for Tuition Assistance, please reach out to Human Resources

ACCIDENT AND CRITICAL ILLNESS

NEW

MetLife

Voluntary Accident and Critical Illness

NOVA Parks offers employees the opportunity to enroll in Accident and Critical Illness coverage through MetLife. Even with medical insurance, you could still be subject to unexpected out-of-pocket expenses in the form of copays, deductibles, and coinsurance. Voluntary Benefits provide lump sum payments to be used toward your health care expense, or however you see fit.

Please note that availability of these coverages is dependent on NOVA Parks meeting minimum participation requirements.

Accident

Accident Insurance is an extra layer of protection that gives you a cash payment to cover out-of-pocket expenses when you suffer an unexpected, qualifying accident. This add-on provides a lump sum benefit after you suffer an accident such as a severe burn, broken bone, or emergency room visit. This is a voluntary benefit. *Employees are responsible for the cost of this benefit.*

ACCIDENT (PER PAY PERIOD CONTRIBUTIONS)	LOW PLAN	HIGH PLAN
Employee Only	$4.48	$5.88
Employee + Spouse	$8.87	$11.59
Employee + Child(ren)	$10.60	$13.81
Family	$12.56	$16.37

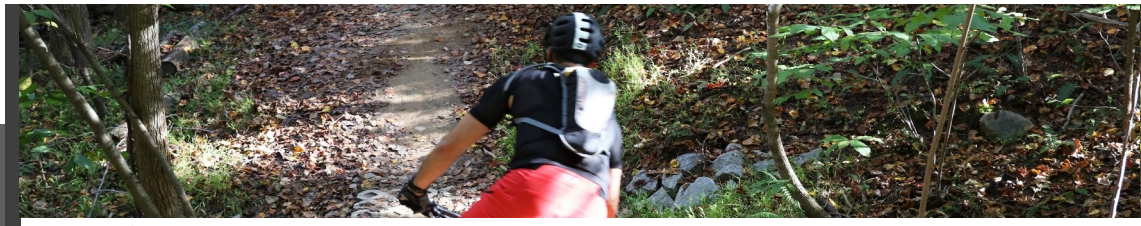
Critical Illness

Critical Illness Insurance is designed to provide payment for expenses not covered by your health insurance relating to a serious injury like cancer, heart attack, or stroke. This is a supplemental policy for people already covered by health insurance to help cover expenses such as deductibles, treatments, and living costs. This is a voluntary benefit. *Employees are responsible for the cost of this benefit.*

Critical Illness premiums vary based on age, tier, and benefit amount. The critical illness plan allows for the choice of either a $15,000 or $30,000 benefit for the employee, with a spouse and children benefit amount of 50% of the employee's election.

Premiums can be obtained from Human Resources.

PET BENEFITS



NEW

Pet Benefit Solutions (PBS)

NOVA Parks offers employees the opportunity to enroll in pet benefits through PBS because pets are family too! The Total Pet and Wishbone Plans include a variety of benefits to meet the needs of employees and their animal companions.

Total Pet Plan - (Total Pet Plan Intro Video)

- **ASKVET** Connect with a licensed veterinarian 24/7 and have access real-time vet support, even when your vet's office is closed. AskVet provides unlimited support on your pet's health, wellness, behavior and more. overs dogs & cats.
- **PET ASSURE** Veterinary Discount Plan that provides a 25% discount on in-house medical services at any participating vet and Lost Pet Recovery Service from ThePetTag. You can search for participating practices by visiting www.petbenefits.com/search. Mention that you're a Pet Assure member when you call to make an appointment. If a vet you would like to visit does not participate, you can invite them to join by clicking the "Invite to Pet Assure" button. Pet Assure offers no exclusions for type, breed, age, or pre-existing conditions. Covers all pets.
- **PETPLUS** Receive member-only pricing (up to 40% off) on prescription medications, preventatives, food, toys, treats & more. Shipping is always free and same-day pickup is available for human-grade medications. PetPlus covers dogs & cats.
- **PETTAG** A durable tag can be scanned from any smart phone to access your contact information. Instantly update contact information online, even after your pet goes missing. PetTag covers any pet wearing a collar!

TOTAL PET PLAN RATES	PER PAY PERIOD CONTRIBUTIONS
1 Pet	$5.88
2+ Pets	$9.25

Wishbone Accident and Illness Pet Plan - (Wishbone Intro Video)

- **Benefits** 90% reimbursement and $250 deductible means that your pet will get quality care at a price that is right for you.
- **PETTAG** A durable tag can be scanned from any smart phone to access your contact information. Instantly update contact information online, even after your pet goes missing. PetTag covers any pet wearing a collar!
- **ASKVET** Get help anytime from an AskVet veterinarian 24/7 via live chat.

Wishbone Wellness Plans:

- **Plans** Two care plan options with up to $575 of annual benefits, no accident and illness coverage required to enroll.
- **Benefits** Receive reimbursement on wellness visits, vaccinations, preventatives and more

WISHBONE WELLNESS RATES	DIRECT PAY
Essential	$14 a month
Premium	$25 a month

Wishbone Accident and Illness Rates:

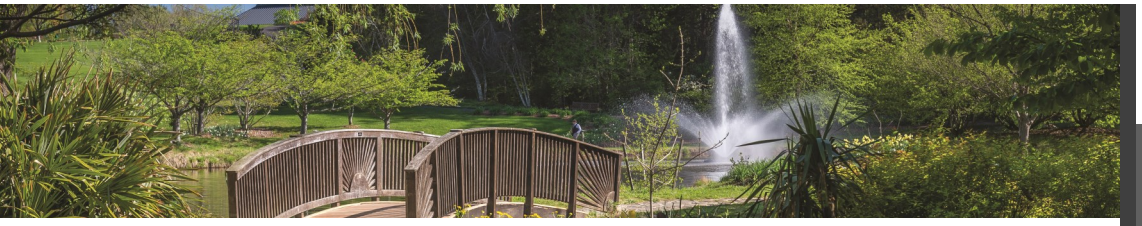
Wishbone Accident and Illness rates vary and are based on zip code, age of pet, and additional factors, starting at $12/month.

Wishbone Enrollment and Direct Pay:

Enrollments and Payments for Wishbone Wellness Plans and Accident and Illness Plans are made directly at www.wishboneinsurance.com/novaparks.

Wishbone Enrollment, Coverage and Contact Info:

The Wishbone Insurance plan covers dogs and cats only. If you are interested in enrolling or have questions on the Wishbone Wellness Plan or Accident and Illness Coverage, please contact: customercare@petbenefits.com or call (800) 891-2565.



MEDICARE PART D

IMPORTANT NOTICE FROM NOVA PARKS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you and/or your covered dependents are not Medicare eligible, this document is for information purposes only.

However, if any of your covered benefit eligible dependents are Medicare eligible, please read this information carefully so that you and your dependents can make an informed decision regarding their prescription drugs.

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with NOVA Parks and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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. NOVA Parks has determined that the prescription drug coverage offered by Cigna and Kaiser Permanente is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current NOVA Parks group health plan coverage may be affected.

You have the following options regarding your health and prescription drug coverage:

- Keep your current NOVA Parks health plan coverage (which includes prescription drug coverage) and don't enroll in a different Medicare Part D plan; or

- Opt out of your current NOVA Parks health plan coverage (which includes prescription drug coverage) and enroll in a different Medicare Part D plan. You will not be able to get your NOVA Parks health plan coverage back if you opt out of it, unless (as a dependent) you become eligible to re-enroll due to a Qualifying Change in Status Event.

Remember: Your current NOVA Parks health coverage pays for other health expenses, in addition to prescription drugs, and you will not be eligible to receive all your current health and prescription drug benefits if you choose to enroll in a different Medicare prescription drug plan and drop your health coverage with NOVA Parks.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with NOVA Parks 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 NOVA Parks Human Resources at (703) 352-5900 for further information or call CIGNA at (800) 244-6224 or Kaiser Permanente at (800) 777-7902.

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 NOVA Parks 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).

DISCLOSURES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S 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).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes 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. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:
You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.
The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

NO SURPRISES ACT

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.
What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.
You're protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.
When balance billing isn't allowed, you also have these protections:

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

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864

DISCLOSURES

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
Iowa Medicaid | Health & Human ServicesMedicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov1-877-267-2323, Menu Option 4, Ext. 61565

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