Employee Benefits Guide

Effective February 1, 2025 – January 31, 2026

girl scouts of eastern massachusetts

Medical | Dental | HRA | Flexible Spending
Retirement & More

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Benefits Overview

Benefit plan year runs from February 1 – January 31.

Eligibility

Employees classified as regular full-time or regular part-time (scheduled to work 1,000 hours or more in a year) are generally eligible for Girl Scouts of Eastern Massachusetts (GSEMA)- sponsored benefits.

Benefits include health, dental, vision, flexible spending –health and dependent care, health reimbursement arrangements, retirement savings as well as life and disability insurance plans.

Newly hired employees are eligible for benefits starting on their date of hire. Eligible dependents include your spouse, domestic partners*, and children to the age of 26.

*Domestic partnerships will require additional documentation.

Qualifying Events

Outside of Open Enrollment periods, you are not permitted to make changes to your benefit plans unless you experience a qualifying change in status.

A qualifying status change can include:

- Marriage
- Divorce
- Birth/adoption
- Change in employment for employee or spouse

Human Resources must be notified within 30 days of a status change in order to make changes.

You will be required to submit additional documentation. Human Resources will notify you of what is required.

If you are unsure if your event is a qualifying event, please contact Human Resources.

How to Enroll and/or Waive

New Hires: All newly hired employees will be required to complete the online New Hire Benefit Enrollment module to either waive or accept benefits. After enrollment, insurance cards will arrive within approximately 10-12 business days. When possible, Human Resources will provide a confirmation of enrollment that can be used until cards arrive.

Qualifying Event:
After notifying Human Resources of your qualifying event, you will be provided with the appropriate instructions to complete the change.

Open Enrollment

Open Enrollment period for group benefits usually runs for two weeks in mid-January.

Open Enrollment meetings are conducted to provide a detailed overview of your benefit options.

The enrollment process will occur online through the ADP Open Enrollment center.

During the online open enrollment period, you can:

- Add or waive medical, dental and/or vision coverage
- Enroll eligible family members or domestic partners in plans
- Add, drop, or change the level of your insurance coverage (individual, employee +1, or family plan)
- Enroll or re-enroll in a flexible spending account to pay for depdendent care or health expenses with pre-tax dollars
- Enroll in the parking or transit program

Plan Rates

Effective February 1, 2025- January 31, 2026

Mass General Brigham Health Plan

BI-WEEKLY COST *(Pre-Tax) (Per-pay-period)*	MGBH – HMO	MGBH – Allies	MGBH - PPO
Employee Only	$85.00	$68.01	$94.03
Employee + One – Tier 1*	$340.01	$272.03	$376.11
Employee + One – Tier 2**	$350.64	$280.53	$387.86
Employee + Family - Tier 1*	$570.03	$456.05	$630.54
Employee + Family – Tier 2**	$587.84	$470.30	$650.24

*Tier 1: Employees earning up to $75,000 annually will contribute 32% of the monthly premium while GSEMA will contribute 68%
**Tier 2: Employees earning $75,000 and over annually will contribute 33% of the monthly premium while GSEMA will contribute 67%

BI-WEEKLY COST *(Pre-Tax) (Per-pay-period)*	BCBSMA Dental Blue
Employee Only	$12.01
Employee + One	$32.19
Employee + Family	$52.27

Blue Cross Blue Shield MASSACHUSETTS

BI-WEEKLY COST *(Pre-Tax) (Per-pay-period)*	EyeMed
Employee Only	$2.03
Employee + Spouse	$3.86
Employee + Child(ren)	$4.06
Employee + Family	$5.97

EyeMed

GSEMA has 26 payroll periods per year

Medical: Mass General Brigham Health Plan

GSEMA's medical plans offer great flexibility in managing care for you and your family. You are covered at the highest level if you receive care through the networks outlined below. These plans are administered by Mass General Brigham Health Plan and feature Care Complement. The Care Complement benefits make it easier for you to access the care your doctor prescribes by removing cost sharing for certain services and therapies.

The following medications and therapies are included:

- $0 cost for first six acupuncture visits (20 visit limit)
- $0 cost for the first six chiropractor visits
- $0 cost for the first six physical or occupational therapy visits
- $0 cost for 11 medications that treat common chronic conditions such as high cholesterol, diabetes, high blood pressure, heart disease, and depression
- $0 cost for cardiac rehabilitation therapy
- $0 cost for certain services that reduce the risk of complications from diabetes, including an annual routine eye exam, diabetic education, and nutritional counseling

MEDICAL PLAN HIGHLIGHTS	MGBH HMO with Care Complement	MGBH PPO with Care Complement	MGBH Allies HMO with Care Complement
Deductible (Employee/Employee+1/Family)	$2,500/$5,000/$5,000	$2,500/$5,000/$5,000	$2,500/$5,000/$5,000
In-Network Out-Of-Pocket Maximum (Employee/Employee+1/Family)	$5,000/$10,000/$10,000	$5,000/$10,000/$10,000	$5,000/$10,000/$10,000
Office Visit Copayment (PCP & Specialist)	$25 copay		
Emergency Room Visits	$200 copay		
Urgent Care Copayment	$25 copay		
Inpatient Hospital Expenses	Covered in full after the deductible		
Outpatient Surgery	Covered in full after the deductible		
X-Rays, Lab Tests, & High Tech Radiology (MRIs, CT Scans, PET Scans)	Covered in full after the deductible		
Durable Medical Equipment	Deductible, then 20% coinsurance		
Acupuncture	Visits 1-6: Covered in full | Visits 7-20: $25 copay		
Chiropractic	Visits 1-6: Covered in full | Visits 7+: $25 copay		
Out-Of-Network Benefits	Not Covered	$5,000/$10,000 deductible, then 20% coinsurance until 20% reaches $10,000/$20,000, then full coverage	Not Covered
Prescription – Retail (30 Day Supply)	$5/$15/$30/$50$30/$50		
Prescription – Mail (90 Day Supply)	$10/$30/$60/$150		

MGBH Additional Plan Information

What is the difference between an HMO and a PPO?

HMO	• Your HMO starts by choosing a Primary Care Provider (PCP) to coordinate member care • Your PCP (primary care physician) treats you when are sick or hurt and provides referrals to specialists in the Mass General Brigham network for most specialty care
PPO	• The PPO plan does not require members to choose a primary care provider (PCP) to coordinate member care • You do not need a referral to see a Specialist • When you go outside of the robust network – you are subject to 20% coinsurance, which equals 20 cents on every dollar until you reach your out-of-pocket maximum

Allies HMO Plan

Enrolling in the Allies HMO

To enroll in the Allies program, you will need to select a Primary Care Provider (PCP) affiliated with three leading community hospitals: Newton-Wellesley Hospital, Salem Hospital, or South Shore Hospital.
And, you must live in one of the following towns:

Abington	Canton	Hanover	Medfield	Quincy	Tewksbury
Acton	Carlisle	Hanson	Medford	Randolph	Topsfield
Andover	Chelsea	Hingham	Medway	Raynham	Wakefield
Arlington	Cohasset	Holbrook	Melrose	Reading	Walpole
Ashland	Concord	Holliston	Middleton	Revere	Waltham
Avon	Danvers	Hopkinton	Millis	Rockland	Watertown
Bedford	Dedham	Hudson	Milton	Rowley	Wayland
Belmont	Dover	Hull	Nahant	Salem	Wellesley
Beverly	East Bridgewater	Ipswich	Natick	Saugus	Wenham
Billerica	Easton	Lexington	Needham	Scituate	West Bridgewater
Boston	Essex	Lincoln	Newbury	Sharon	Westborough
Boxford	Everett	Lynn	Newton	Sherborn	Weston
Braintree	Foxboro	Lynnfield	Norfolk	Somerville	Westwood
Bridgewater	Framingham	Malden	North Andover	Southborough	Weymouth
Brockton	Franklin	Manchester	North Reading	Stoneham	Whitman
Brookline	Georgetown	Marblehead	Norwell	Stoughton	Wilmington
Burlington	Gloucester	Marlborough	Norwood	Stow	Winchester
Byfield	Halifax,	Marshfield	Peabody	Sudbury	Winthrop
Cambridge	Hamilton	Maynard	Pembroke	Swampscott	Woburn

What this plan offers

Dedicated Allies Health Navigators:
- Helps members to get set up with plan and provider
- Assists in selecting PCPs and scheduling appointments
- Continues to support member when discharged
- Get answers to questions related to benefits, claims and billing

- **Quicker appointment times**: Select providers in the following 4 specialties can see members in 3 business days: orthopedics, cardiology, dermatology, gastroenterology—offering easier and quicker access
- **Virtual Care**: PCP and select specialty providers, urgent care visits through On Demand, and tele-behavioral health through Optum – all virtual visits at $0 cost sharing. In addition, Virtual first primary care group option featuring next-day appointments and online scheduling
- Referrals to specialty hospitals if needed (Mass General Hospital, Brigham and Women's Hospital, Massachusetts Eye and Ear, McLean Hospital, Spaulding Rehabilitation Center)

Mass General Brigham Health Plan: Member Perks

Some of the member perks available to plan members:

Mental and Behavioral Health	MGBH partners with Optum for behavioral health care. Please visit Optum's Live and Work Well website which offers self-care tools and answers to common mental health questions. You can also use their virtual visit platform to connect with many providers who can see patients both online and in-person. Visit liveandworkwell.com and create an account on the site with your member MGBH ID number to see personalized benefits, or browse as a guest with the access code ALLWAYSMA.
LYRA	Through Lyra, members can securely and confidentially seek clinically proven mental health services, find high-quality providers tailored to their individual needs, and book appointments quickly with a therapist or coach by video or in-person. Features include: guided self-care with a Lyra coach, in-person and video therapy, medication management, mental health coaching and more. To begin, please visit MGBHealthPlan.LyraHealth.com
DoctorSmart	Different providers may charge different prices for the same procedure, even when they're delivering the same level of care. When you choose a high-quality, lower-cost provider with DoctorSmart Rewards, you get a cash reward between $25-$500 depending on the service. Services include: biopsies, mammograms, ultrasounds, CT Scans, MRIs and more. To get started, log in to massgeneralbrighamhealthplan.org. Click *Track cost & claims* and then *Estimate Costs*. From there, search for your upcoming procedure and follow the steps to earn your reward.
Fitness and Weight Loss Benefits	Fitness Reimbursement: If you belong to a qualified fitness facility or engage in a qualified fitness program/subscription or activity, we'll reimburse you up to $150 (for an individual policy) or up to $300 (for a family policy). Qualifying expenses include: health clubs, gyms, Pilates, yoga, Zumba, aerobics, Peloton subscription, Virtual Fitness Subscriptions, and more. Weight Loss Reimbursement: MGBH will reimburse members for up to 6 full months of memberships for you or one of your enrolled dependents when you join Jenny Craig, WW, or Noom.
OnDemand	OnDemand is MGBH's virtual care platform. Staffed by leading Mass General Brigham providers, including providers from Massachusetts General Hospital, Brigham and Women's Hospital, and Community Physicians Organization – On Demand makes it easy for you to get high-quality, virtual urgent care for minor illness and injuries without the need for travel or referrals. You can do it 24/7, and right from the comfort of your home, office, or anywhere in the U.S.

For more information on all available member perks, view your claims, find urgent care, download your ID card and more – visit member.massgeneralbrighamhealthplan.org or download the Mobile App on the App Store or GooglePlay store.

SCAN ME

Health Reimbursement Arrangement

If you enroll in any of the MGBH plan offerings, you will be automatically enrolled in the Health Reimbursement Arrangement (HRA) offered by Girl Scouts of Eastern MA through VOYA.

Administered through

VOYA FINANCIAL

An HRA is a specific amount of pre-tax dollars set aside by your employer, on an annual basis, to reimburse employees for a portion of your deductible expenses.

Health Reimbursement Arrangement (HRA)					
Level Coverage	Level Deductible	GSEMA Responsibility*	GSEMA %	Employee Responsibility*	Employee %
Individual Employee	$2,500.00	$1,500.00	60%	$1,000.00	40%
Employee +1 (dual)	$5,000.00	$3,000.00	60%	$2,000.00	40%
Family	$5,000.00	$3,000.00	60%	$2,000.00	40%

* GSEMA's 60% portion of responsibility goes into effect after the employee has met their 40% portion of responsibility.

How Claims are Paid

A member visits their medical provider and incurs an eligible expense toward the deductible.

Your medical provider bills Mass General Brigham Health Plan.

Mass General Brigham Health Plan sends claim information directly to VOYA – No need for you to do a manual submission!

VOYA processes the claim and sends payment to members.

Members must pay the provider's bill with the HRA payments received from VOYA.

Dental: Blue Cross Blue Shield of MA

GSEMA offers a dental plan, *Dental Blue,* with Blue Cross Blue Shield of MA (BCBSMA). Included in the plan is the rollover maximum feature. This means employees can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures.

If your total claims do not exceed $500 in a benefit period, BCBSMA will allow you to rollover up to $350 to use for future plan years. Employee's total rollover is capped at $1,000.

The rollover maximum will apply automatically if you: receive at least one service during the benefit period, remain a member of the plan throughout the benefit period, and do not exceed the claims payment threshold in the benefit period.

Coverage	Dental Blue
Deductible – *Waived for Preventive*	
Individual	$50
Family	$150
Preventive Services	100% coverage
Basic Services	80% coverage after deductible
Major Services	50% coverage after deductible
Orthodontia Services	$1,000 lifetime maximum to age 19
Annual Maximum	$1,000
Maximum Rollover Benefit	Included

Vision: EyeMed Health

GSEMA offers a vision plan with four coverage levels. You do not need to participate in our medical insurance to elect this plan.

Plan Highlights

- Exam – once every plan year; copay of $0 or $10
- Frame Allowance - $130 – once every other plan year
- Lens – once every plan year
- Contact Lens Allowance - $130 – once every plan year
- 40 % off additional complete pair of prescription eyeglasses
- 20% off non-covered items, including non-prescription sunglasses

- Do not need be a MGBH plan subscriber
- Many other benefits!

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 1.866.939.3633 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

IRS Tax Advantage Plans (Section 125 &132)

IRS TAX ADVANTAGE PLANS (Section 125 and 132)

Administered through

VOYA FINANCIAL

Administered through VOYA, GSEMA offers employees the choice of participating in a Medical Flexible Spending Account (FSA) and/or a Dependent Care Flexible Spending Account (FSA). These accounts allow you to set aside pre-tax dollars from each paycheck to help pay for unreimbursed eligible health care and dependent care expenses for you and your family.

Flexible Spending Account – Health/Medical

The Medical FSA allows you to use pre-tax dollars to pay for your eligible out-of-pocket health care expenses for you and your family members. Eligible family members include any person you claim as a dependent for income tax purposes. You can set up a Medical FSA regardless of whether you or your dependents have enrolled in a health plan offered by GSEMA.

Eligible medical expenses not covered by your plan include deductibles, co-payments and amounts you pay out-of-pocket for eligible medical, dental, vision, and prescription drug expenses. **You can contribute a minimum of $260 up to a maximum of $3,000 per year into your Medical FSA**.

GSEMA also allows employees to rollover up to $500 of Medical FSA funds remaining at the end of the runout period to automatically roll over into the next plan year.

Participants who elect to enroll in the Medical FSA will automatically receive a VISA Debit card. This card is similar to a credit card in that it debits funds directly from your Medical FSA account to pay for qualifying expenses. The advantage to you is that there is no out-of-pocket expense at the time of service, no claim forms, and no waiting for reimbursement. Payments are made directly from your FSA account to the approved provider. It's a good idea to retain all of your receipts as you may be required to submit them for proof of an FSA expense.

Dependent Care Account (DCA)

The Dependent Care FSA allows you to use your pre-tax dollars to pay for eligible dependent care expenses, such as day care for your child or care for an older family member. Eligible expenses include care at a qualified day care center, nursery school expenses, before and after school child care for dependents up through age 13 and certain types of expenses related to elder care.

You can contribute up to a **maximum of $5,000 per year per household** into your Dependent Care FSA (unless you and your spouse file separate tax returns, then the maximum you can contribute is $2,500 per year). *The rollover feature does NOT apply to Dependent Care FSAs.*

Parking and Transit Accounts

GSEMA offers parking and transit accounts for work-related parking and transit costs, including parking garages, metered parking, parking lots, subway fares, train, bus, ferry, and qualified commuter vehicles. **You may set aside up to a pre-tax maximum monthly election amount of $325 for parking and $325 for transit.**

Retirement Savings Plan

All benefits eligible employees may elect to enroll in the GSEMA Retirement Savings Plan through BPAS.

Administered through

BPAS

Dollars can be deducted from your paycheck pre-tax or post-tax (Roth) and invested in various investment options to assist you in preparing for retirement.

Who can Participate?

All current employees are eligible to participate in the employee contribution portion of the Plan. Participation in the employer contribution portion of the Plan is open to employees who have met the following requirement(s):

- Attained age 21.

The Plan does not allow participation by employees who are:

- Nonresident aliens with no U.S. earned income.
- Employees who normally work less than 20 hours per week.
- Other requirements may also have to be met, as described in the Summary Plan Description.

When can I Join?

Eligible employees can join the Plan on the first day of the month coinciding with or the next following the date on which the eligibility requirements are met.

How do I Contribute to the Plan?

If you are a new employee, you will be automatically enrolled in the plan on the plan entry date. This means that elective deferrals in the amount of 2% of compensation will automatically be deducted from your compensation, unless you elect to decline participation in the Plan or change or stop your contributions. Enrollment packages from BPAS are received within the first 60 days of your employment.

Discretionary Match

At the end of each fiscal year, the council's Board of Directors decides on a discretionary match of up to 3%.

The maximum amount an employee can contribute to a 403(b) retirement plan for 2025 is **$23,500.** If you're 50 or older, you can contribute an additional $**7,500** as a "catch-up" contribution, bringing your annual total contribution total to **$31,000**. If you are between 60 and 63, the catch-up contribution is $11,250 annually, brining your annual total contribution to **$34,750**.

Life Insurance & Disability Plans

Administered through

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Life Insurance
Life insurance is offered to employees for one time the employee's base annual earnings. The maximum benefit is $300,000. There is a matching accidental death and dismemberment benefit. Benefits reduce to 65% at age 65 and 50% at age 70. *GSEMA pays for this coverage for all regular full-time and part-time employees scheduled to work more than 1000 hours per year.*

Accidental Death and Dismemberment
Accidental Death and Dismemberment insurance is offered to employees for one time the employee's base annual earnings. The maximum benefit is $300,000. Benefits reduce to 65% at age 65 and 50% at age 70. *GSEMA pays for this coverage for all regular full-time and part-time employees scheduled to work more than 1000 hours per year.*

Long Term Disability
Long Term Disability is offered to employees and is payable at a rate of 60% of monthly earnings, with a monthly maximum benefit of $7,500. There is a 90 day waiting period for the benefit. Benefits last until an employee's Social Security normal retirement age. A pre-existing condition may apply to new hires if the condition existed three months prior to hire. All benefits under this plan are subject to conditions and medical documentation as set forth by the carrier. All payments received are treated as taxable benefits. *GSEMA pays for the coverage for all regular full-time and part-time employees scheduled to work more than 1000 hours per year.*

Short Term Disability
Benefits under Short Term Disability are available, subject to approval by the carrier, after a 7 calendar day waiting period for an illness or accident. Benefits are payable at the rate of 60% of an employee's weekly earnings, with a weekly maximum of $2,500. The benefit duration period is 13 weeks following the date of disability.

Maternity benefits are included and typical maternity claims last six weeks from the date of delivery. This 60% coverage is paid for by GSEMA. Disability benefits received are treated as taxable income. Per policy, all claims are administered by the carrier for medical certification and processing. *GSEMA pays for the coverage for all regular full-time and part-time employees scheduled to work more than 1000 hours per year.*

Paid Leave and Holidays

GSEMA offers an extensive paid time off plan for staff. Paid vacation leave is available for full-time and regular part-time employees. The amount of paid vacation is based upon the number of continuous service years with GSEMA. Eligible employees accrue vacation leave from their dates of hire, based on the number of hours worked and paid during the pay period (but not to exceed seventy-five), as well as the employee status as an exempt, non-exempt or Chief level position. For example, new full-time nonexempt staff accrue 10* days of paid vacation leave per year; new full-time exempt staff accrue 15* days per year; and new Chief level staff (including CEO) accrue 20 days per year. (*Incrementally earning one more day per year for first five years)

All full-time employees accumulate one-half day of paid **sick** leave per month (6 days per year) and are granted two paid **personal** days each year. **13 holidays** (11 designated and 2 floating**)** are celebrated as paid holidays throughout the calendar year.

2025 Holiday Schedule

Day/Date	**Holiday Observed**
Monday, January 1, 2025	New Year's Day *
Monday, January 20, 2025	Martin Luther King, Jr. Day
Monday, February 17, 2025	Presidents' Day
Monday, April 21, 2025	Patriots' Day
Monday, May 26, 2025	Memorial Day
Thursday, June 19, 2025	Juneteenth Day Observance
Friday, July 4, 2025	Independence Day Observance
Monday, September 1, 2025	Labor Day
Thursday, November 27 and Friday, November 28, 2025	Thanksgiving Days
Thursday, December, 25, 2025	Christmas Day
Two (2) Floating Holidays are provided each calendar year and are automatically uploaded in ADP effective January 1.	Floating Holidays must be taken within the calendar year. **

* When a fixed holiday falls on a Sunday, it is observed the following Monday; when it falls on a Saturday, it is observed the previous Friday. Full-time employees are paid their regular salary/pay rate for any and all holidays when GSEMA is officially closed. Regular part-time employees are eligible to be paid at their pro-rated rate for official holidays when they fall on their regularly scheduled workdays.

** Floating Holiday hours must be taken within the calendar year at a time that is mutually agreed upon by the employee and their supervisor. All time off requests must be submitted through the ADP payroll system. Floating holidays cannot be carried over to another calendar year. Note: Employees hired after July 1, receive one floating holiday and 1 personal day in the first calendar year.

Paid Leave and Holidays, cont.

In addition to the formal holidays, in 2025, GSEMA will be offering additional time off through our Summer Fridays and a Winter Break Closure!

Summer Fridays

Staff will be able to have 5 additional Fridays off (1 fixed and 4 employee choice) during the months of July and August.

The **Fixed Summer Friday** is August 29, 2025.

Staff will be able to choose their **Staff Choice Summer Fridays (up to 4 days)** from the following dates: July 11, July 18, July 25, August 1, August 8, August 15, or August 22.

Winter Break Closure

GSEMA will close December 24 – January 1 for winter break.

This is an opportunity to allow all staff to rest and recharge.

CHIP Notice

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).

To access the full CHIP Model Notice, visit:
https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

Important Notices

Federal regulations require Girl Scouts of Eastern MA to provide benefit eligible employees with the following notices

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

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE NOTICE
IMPORTANT NOTICE 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 Your Employer 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 covers 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. Your Employer has determined that the prescription drug coverage offered by Your Employer 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 15 to December 7. 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 Employer coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will be able to get this coverage back.
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 Your Employer 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 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).

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Important Notices

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8- month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is elective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you. If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov. Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Plan contact information. Please contact Human Resources hr@gsema.org.

Disclaimer

The information provided by Cabot Risk Strategies and/or its affiliates ("Company") in this Guidebook is advisory. Separate plan documents explain each benefit in more detail, and the various benefits are controlled by the language of the plan documents. Benefits may be modified, added, or terminated at any time, at the Company's discretion, or by the insurance company. This information is provided for general information purposes only and should not be considered legal, tax, accounting or other professional advice or opinion on any specific facts or circumstances. Readers are urged to consult their legal counsel, tax or other professional advisor concerning any legal, tax or related questions that may arise. Any tax information contained in this communication (including any attachments) is not intended to be used, and cannot be used, for purposes of (i) avoiding penalties imposed under the U. S. Internal Revenue Code or (ii) promoting, marketing or recommending to another person any tax-related matter. The Company assumes no liability whatsoever in connection with the use of such information or documents.

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This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

January 31, 2025