Band of Hands

2025 Employee Benefits Guide

An overview of the wide variety of benefits provided by Band of Hands to help you enjoy increased well-being and financial security.

Medical

Dental

Vision

Prepared by OHM Benefit & Insurance Solutions for Band of Hands.

OHM
Benefit & Insurance Solutions

As an employee of our company enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2025 plan year, we have worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and we are offering an overall benefits package that can be shaped and molded by you to fit your needs.

This benefits booklet is a summary description of your benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.

Should you have any questions, please contact our broker, OHM Benefit & Insurance Solutions at 1-877-650-0808.

Important Contacts

OHM BENEFIT & INSURANCE SERVICES:

Jason Sandler	1-877-650-0808 Ext. 101	jason@ohmbenefits.com
Melissa Renteria	1-877-650-0808 Ext. 103	melissa@ohmbenefits.com

Medical – Blue Shield	
Member Services	(888) 319-5999
Carrier Website	www.blueshield.com
Medical– Kaiser	
Member Services	(866) 973-4588
Carrier Website	www.kaiserpermanente.org
Dental – Ameritas	
Member Services	(800) 487-5553
Carrier Website	www.ameritas.com
Vision – Avesis	
Member Services	(800) 828-9341
Carrier Website	www.avesis.com

Enrollment Information

Who may enroll

All full-time employees working at least 30 hours per week and their eligible dependents may participate in our benefit programs. Your eligible dependents include:

- Spouse or Domestic Partner
- Adult children up to age 26 regardless of student or maritalstatus

When you can enroll

Eligible employees may enroll at the following times:

- During openenrollment
- Employees may enroll on the first day of the month following 60 days ofemployment
- Within30 days of a qualified change in family status as defined by the IRS (see below)

Changes to enrollment

Once you make your benefit elections, you cannot change them during the year unless you experience a qualified change in family status as defined by the IRS. Some common examples include:

- Marriage, divorce, legal separation orannulment
- Birth or adoption of achild
- Loss of coverage from another healthplan
- A change in your dependent's eligibilitystatus
- A qualified medical child supportorder
- Contact OHM for other less-common situations

Note:

- Coverage for a new spouse or newborn child is not automatic. If you experience a change in family status, you have 30 days to update your coverage. Please contact OHM immediately to receive instructions on how to update your family status. If you do not update your coverage within 30 days from the family status change, you must wait until the next annual open enrollment period.

Deductions

Deductions for all benefits are taken on a pre-tax basis.

Medical

blue of california

Summary of Coverage – HMO Options (California Employees Only)

Under the Blue Shield HMO option, you must choose a Primary Care Physician (PCP) and/or a medical group. All of your care must be directed through your PCP or medical group. Any specialty care would be coordinated through your PCP and will typically require a referral and authorization.

Benefits	Access+ Silver 70 HMO 2500/55
Your Costs:	**In-Network**
Annual Deductible: Individual / Family	$2,500/$5,000
Annual Out of Pocket Maximum: Individual / Family	$8,750/$17,500
Deductible Included in Out of Pocket Maximum?	Yes
Office Visit: Primary Care / Specialist	$55/$90
Preventive Services:	No Charge
Lab, X-Ray, CT/MRI:	$55/$90/$300 after Ded
Emergency Room Copay:	35%
Urgent Care Copay:	$55 Co-pay
Hospitalization : Inpatient	35%
Hospitalization: Outpatient	35%
Out of Network Payment Method:	N/A
Prescription Deductible	$300 Brand Only
Generic / Tier 1	$19 Co-pay
Brand Name / Tier 2	$85 Co-pay
Non-Formulary Brand / Tier 3	$100 Co-Pay
Specialty / Tier 4	30%; $250 max/script

*Prescription drugs will always be dispensed as ordered by your provider and by applicable state pharmacy regulations. However, you may have higher out-of-pocket expenses if you or your provider requests a brand-name drug when a lower-cost generic drug is available. In those situations, you will be responsible for the cost difference between the generic and the brand-name drug, in addition to your generic copayment. This cost difference does not contribute towards the out-of-pocket annual maximum.

Contact Band of Hands for premium information

Medical

blue of california

Summary of Coverage – PPO Options (Available to All Employees)

The PPO option eliminates the PCP requirement to give you more freedom of choice and ease of access.

Benefits	Bronze 60 PPO 5800/60	Silver 70 PPO 2500/55	Gold 80 PPO 350/25
Your Costs:	**In-Network**	**In-Network**	**In-Network**
Annual Deductible: Individual / Family	$5,800/$11,600	$2,500/$5,000	$350/$700
Annual Out of Pocket Maximum: Individual / Family	$8,850/$17,700	$8,600/$17,200	$8,500/$17,000
Deductible Included in Out of Pocket Maximum?	Yes	Yes	Yes
Office Visit: Primary Care / Specialist	$60/$95 after Ded	$55/$90	$20/$50
Preventive Services:	No Charge	No Charge	No Charge
Lab, X-Ray, CT/MRI:	$40/40%	$55/$90/35%	$25/$65/20%
Emergency Room Copay:	40%	35%	20%
Urgent Care Copay:	$60 Co-pay	$55 Co-pay	$25 Co-pay
Hospitalization : Inpatient	40%	35%	20%
Hospitalization: Outpatient	40%	35%	20%
Out of Network Payment Method:	N/A	N/A	N/A
Prescription Deductible	$450 Brand Only	$300 Brand Only	None
Generic / Tier 1	$19 Co-pay	$20 Co-pay	$15 Co-pay
Brand Name / Tier 2	40%; $250 max/script	$75 Co-pay	$50 Co-pay
Non-Formulary Brand / Tier 3	40%; $250 max/script	$105 Co-pay	$80 Co-pay
Specialty / Tier 4	40%; $250 max/script	30%; $250 max/script	25%; $250 max/script

*Prescription drugs will always be dispensed as ordered by your provider and by applicable state pharmacy regulations. However, you may have higher out-of-pocket expenses if you or your provider requests a brand-name drug when a lower-cost generic drug is available. In those situations, you will be responsible for the cost difference between the generic and the brand-name drug, in addition to your generic copayment. This cost difference does not contribute towards the out-of-pocket annual maximum.

Contact Band of Hands for premium information

Medical

KAISER PERMANENTE®

Summary of Coverage – HMO Options (California Employees Only)

Under any Kaiser plan, you must choose a Primary Care Physician (PCP). All of your care must be directed through your PCP, and any specialty care would also be coordinated through your PCP. Except in the case of emergency care, you will receive benefits only if you use Kaiser facilities.

Benefits	Bronze 60 HMO 5800/60 Ded	Silver 70 HMO 1900/65Ded	Gold 80 HMO 250/35Ded
Your Costs:	**In-Network**	**In-Network**	**In-Network**
Annual Deductible: Individual / Family	$5,800/$11,600	$1,900/$3,800	$250/$500
Annual Out of Pocket Maximum: Individual / Family	$8,550/$17,100	$8,750 / $17,500	$7,800 / $15,600
Deductible Included in Out of Pocket Maximum?	Yes	Yes	Yes
Office Visit: Primary Care / Specialist	$60/$95	$65/$100	$35/$55
Preventive Services	No Charge	No Charge	No Charge
Lab, X-Ray, CT/MRI	$40/40%/40%	$30/$75/$400	$35/$55/$250
Emergency Room	40%	45%	$250
Urgent Care	$60 Co-pay	$65	$35
Hospitalization: Inpatient	40%	45%	$600
Hospitalization: Outpatient	40%	45%	$335
Out of Network Payment Method:	N/A	N/A	N/A
Prescription Drugs			
Prescription Deductible	$19 Co-pay	None	None
Generic / Tier 1	40%; $500 max/script	$20	$15
Brand Name / Tier 2	40%; $500 max/script	$100	$40
Non-Formulary Brand / Tier 3	40%; $500 max/script	$100	$40
Specialty / Tier 4	**In-Network**	20%; $250 max/script	20%; $250 max/script

*Prescription drugs will always be dispensed as ordered by your provider and by applicable state pharmacy regulations. However, you may have higher out-of-pocket expenses if you or your provider requests a brand-name drug when a lower-cost generic drug is available. In those situations, you will be responsible for the cost difference between the generic and the brand-name drug, in addition to your generic copayment. This cost difference does not contribute towards the out-of-pocket annual maximum.

Dental

Summary of Coverage (Available to All Employees)

Band of Hands offers employees a dental plan with one of the nation's largest dental providers, Ameritas.This PPO option includes a vision indemnity benefit of up to $150 per year!

Benefits	PPO	
Your Costs:	**Premier PPO Network**	**Out-of-Network**
Deductible: Individual / Family	$ 50 / $150	$50 / $150
Deductible Waived for Preventive?	Yes	Yes
Annual Maximum	$1,500	$1,500
Waiting Period	None	None
Preventive Services: Cleanings & X-Rays	No Charge	No Charge
Basic Services: Fillings/Composites	20% - 10% - 0% (yr 1- yr 2 - yr 3)	20%
Major Services: Crowns & Bridges	Yes-50%	Yes – 50%
Periodontal Services	20% - 10% - 0% (yr 1- yr 2 - yr 3)	20%
Endodontic Services	20% - 10% - 0% (yr 1- yr 2 - yr 3)	20%
Out of Network Payment Method	N/A	80th UCR
Orthodontics	Not Covered	
VISION INDEMNITY	**Up to $150 per insured toward any covered eye care expense**	

Vision

Summary of Coverage

Our vision plan provides professional vision care and high quality lenses and frames through a large network of both retail and private practice opticians. Stay in-network for the most cost savings. Although you may go out of network, you will be responsible to pay all charges at the time of your appointment and will be required to file an itemized claim with the vision plan.

avēsis

Benefits	PPO Option	
Your Costs:	**In-Network**	**Out-of-Network Reimbursement**
Exam Copay	$10	Up to $45, after copay is applied
Exam Frequency	12 Months	
Materials Copay	$25	N/A
Lenses: Single / Bifocal / Trifocal	No Charge after Co-pay	Up to $25/$40/$50
Lens Frequency	12 Months	
Frame Allowance	$130	Up to $45
Frame Frequency	24 Months	
Contact Lens Allowance	$130	Up to $110
Contact Lens Frequency	12 Months	