

2025 Salaried Benefits Enrollment Guide



NOTE: If you live in Texas or Illinois, you have a fourth medical plan option in addition to the Bronze Plus, Silver and Gold plans outlined in this guide. This Enrollment Guide does not apply to Next Level Hospitality employees and does not contain details on the Bronze Choice plan for Flowers Sanitation employees. Please review the Medical Plan Options Guides, FAQs, SPDs and other information on the Benefits Enrollment Website for your specific plans. Enrollment in an Aramark benefit plan is completely voluntary. Aramark does not require employees to enroll in any Aramark benefit plan.



Table of Contents

	PAGE
Get Ready to Enroll	2–3
How to Enroll	4
Whom You Can Cover	5
Automatic Benefits	6–8
Optional Benefits	10
Mental Wellbeing Resources	10
Medical Coverage	11–18
Medical Variations	19
Medical/Prescription Drug Coverage Insurance Carriers	19–20
Prescription Drug Coverage	21–22
Medicare Part D Creditable Coverage Notice	23
Preventive Care	24
Dental Plan	25
Vision Plan	26–27
Life Insurance and Disability Coverage	28–29
Flexible Spending Accounts (FSAs)	30
Health Savings Account (HSA)	31–32
After Enrolling	33
Key Contacts	34

This Enrollment Guide is a brief summary of the Aramark Benefits Program for Salaried employees, serves as the Summary of Material Modifications (SMM), and describes changes to your health benefits for the 2025 plan year. It describes certain key features of the Program but does not provide detailed information. While we have made every attempt to ensure the accuracy of the information in this Guide, if there is any discrepancy between this Guide and the official plan contracts and documents, the plan contracts and documents will rule. In addition, this Guide does not constitute or imply a contract of employment, nor does it guarantee the continuation of this benefits program.

Aramark reserves the right, within its sole discretion, to amend or terminate the benefits described in this Enrollment Guide at any time and for any reason as it relates to any former, current, or future employee, participant, dependent or beneficiary.



Get Ready to Enroll

When You Can Enroll

You can add, drop, change health and welfare benefits coverage, or enroll (or disenroll) your dependents:

- When you are first hired
- When you are newly eligible
- During the fall Annual Enrollment period
- If you experience a qualified life status change (see below) or a special enrollment right under HIPAA



NOTE: Retirement Plan Enrollment is a separate process. You will receive Retirement Plan enrollment information in the mail at home at the time you become eligible. If you have questions on the Retirement Plan, contact Fidelity Investment Services at 1-877-236-9472 or visit www.401k.com.

What Is a Qualified Life Status Change?

A qualified life status change is a significant event in your life that can affect your benefit needs. You may make applicable changes to your benefits coverage if you experience any of these qualified life status changes:

- You legally marry, enter into a civil union or meet the requirements of a domestic partnership
- You divorce, have an annulment or terminate a civil union or a domestic partnership
- You experience the birth, adoption or assumption of legal guardianship of a child
- Your spouse or domestic partner (which includes a civil union partner) or child dies
- Gain or loss of other employer sponsored coverage, including employment commences or terminates for you, your spouse/domestic partner or dependent
- You or your spouse/domestic partner or dependent experience a change in worksite; a change in residence; an increase or reduction in hours of employment; or begin or end an unpaid leave of absence, strike or lockout, or
- Your dependent satisfies or ceases to satisfy the requirements for coverage due to attainment of age or any similar circumstances provided by the plan



Additionally, under the Internal Revenue Code, your change in coverage must correspond with, and be consistent with, a qualified life status change. Financial hardship is not a qualified life status change.

Please be aware that if you enroll in an Aramark medical plan and later in the year wish to have coverage through the Health Insurance Marketplace (government exchange program), that is not considered a qualified life status change and you will be unable to drop Aramark coverage until the following Annual Enrollment period.

In order to make a change to your coverage due to one of the listed events, you must initiate your change through the Benefits Enrollment Website or by calling the Aramark Benefits Center at **1-855-528-BENE (2363)** within 31 days of the event or within 60 days of a divorce or dissolution of a domestic partnership.

A qualified life status change also occurs if:

- You or your dependents lose Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of a loss of eligibility for such coverage and you request enrollment within 60 days of such loss of coverage or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage within 60 days of the eligibility determination date



NOTE: Newborns are eligible for coverage on the date of their birth. Newborns must be enrolled on the Benefits Enrollment Website within 31 days of birth in order to be covered under the Plan. If the child is not enrolled within 31 days of birth, charges/services provided to the newborn may not be covered under the plan during the first 31 days of birth and thereafter. This provision also applies to newly adopted children.



Get Ready to Enroll (continued)

Coverage Effective Dates

For Annual Enrollment:

- Enrollments or changes submitted during the fall 2024 Annual Enrollment period are effective January 1, 2025.

For New Hires or Newly Eligibles:

- For enrollments that take place at other times during the year (e.g., for new hires), the coverage effective date is generally the first of the month following one full calendar month of service, provided you enroll during the time period specified on your enrollment postcard.

During the last three months of the calendar year, new hires will need to enroll twice – once for the remaining months of the current year (2024) and again for coverage effective January 1, 2025. You will receive two sets of enrollment communications: one for the current year (2024) and one for calendar year 2025.

Be sure to review both sets of materials. Your medical coverage options and costs may be different for 2024 and 2025. Your other benefit coverage options and costs may also be different from year to year.

Your Choices for Health Coverage

1. Enroll in Aramark-sponsored coverage. This Enrollment Guide provides the information you need to select your benefits for 2025 and complete your enrollment on the Benefits Enrollment Website. That's also where you can see costs and how much Aramark contributes to your coverage.
2. Enroll in coverage through a state or federal exchange. Go to www.healthcare.gov for information about a Health Insurance Marketplace in your area. Government premium assistance may be available for some individuals.
3. Enroll in coverage through Medicaid if you meet your state's income eligibility requirements. Many state programs have expanded and are offering coverage to more individuals. Go to www.medicaid.gov.
4. Enroll in coverage through your spouse's or domestic partner's employer, if available to you.
5. Don't enroll in any coverage.

To enroll or make changes, go to the [Benefits Enrollment Website](#).

If you choose to enroll, during the enrollment process, you'll need to:

- Enroll eligible dependents you want to cover in 2025 under your medical benefits.
- Choose the insurance carrier you want for your 2025 medical benefits.
- Select the medical coverage level you want: Bronze Plus Plan, Silver Plan or Gold Plan.
- Review or enroll in the rest of your benefits (e.g., dental, vision, disability, life insurance and supplemental benefits). Make sure to confirm your dependents' coverage for these plans, as they are separate from the medical plan enrollment.
- Indicate smoker and working spouse/domestic partner status. You cannot complete your enrollment without indicating smoker and working spouse/domestic partner status.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from Aramark but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. For more information, see the [CHIP Notice](#).



NOTE: The Benefits Enrollment Website may not be available during scheduled maintenance from 3:00 a.m. through 6:00 a.m. (ET) Monday through Saturday, and 12 a.m. (midnight) through 7 a.m. (ET) on Sunday.



How to Enroll

Healthcare Advocacy

Quantum Health is the front door to your health benefits. Navigating healthcare is costly and complicated. For this reason, we instituted Quantum Health, a healthcare advocacy and navigation resource to make your benefits smarter, simpler and more cost-effective. Quantum Health has replaced the customer service and care management functions of the insurance company. Aramark has chosen to partner with Quantum Health to change how we deliver health benefits to our employees.

Medical Insurance Contact Information

If you are enrolling in Aetna or IBC, to determine if your doctors are in network or if your prescription drugs are covered, please call Quantum Health at **1-855-497-1241** or go to <https://aramarktakecare.com>. Quantum Health is your one-stop shop for all your health insurance needs.

Communications, including your new medical ID card, will come from your insurance carrier's Third-Party Administrator (Aetna: Meritain; IBC: Independence Administrators). Always show your medical ID card when visiting a provider for medical care.



NOTE: Not applicable for regional carriers (Kaiser, Geisinger and UPMC).

If you are already enrolled in Aramark medical benefits and do not change your carrier or plan, you will not receive a new medical ID card for the new plan year.

Log In



Access the [Benefits Enrollment Website](#) from any computer or mobile device with an internet connection.

NOTE: You'll need to be set up on Aramark's myAccess Single-Sign-On.

Enroll



Enroll and make your elections on the Benefits Enrollment Website. The benefit options available to you along with their costs will be shown on the website.

Be sure to review all important documents in the Resource Library, including: Enrollment Checklist, Enrollment Guide, Medical Plan Options Guide, FAQs (if applicable), Summary of Benefits and Coverage document, HIPAA Privacy Notice, Initial COBRA Rights Notice, and more.

In the event your wages in any pay period are insufficient to cover the entire amount of your insurance premium deductions, you authorize Aramark to deduct any remaining unpaid insurance premium amounts in future pay periods until paid in full.

If you need assistance during the enrollment process, call the Aramark Benefits Center, Monday through Friday, at **1-855-528-BENE (2363)**.

Coverage Tiers

The following four coverage tiers are available, depending upon whom you enroll:

- Employee Only
- Employee Plus Spouse or Domestic Partner
- Employee Plus Child or Children (regardless of how many children you enroll)
- Employee Plus Family (meaning you, your spouse/domestic partner and at least one child)



NOTE: When you enroll, you are authorizing Aramark to deduct applicable insurance premiums from your wages, including any insurance premiums related to smoker status and/or a working spouse/domestic partner (if applicable).



Whom You Can Cover

The following are eligible for coverage under the same Aramark medical, prescription drug, dental and vision plans that you are enrolled in:

Spouse

You can enroll your spouse (same or opposite sex) or your common-law spouse, if recognized by law in the state in which you resided at the time of such marriage.

Domestic Partner

You can enroll a domestic partner in coverage if:

- You and your domestic partner meet all of the requirements of an affidavit partnership; or
- You and your domestic partner have entered into a civil union; or
- You and your domestic partner have met state or local requirements applicable to domestic partners and have registered your domestic partnership at your local domestic partnership registry.

You must certify your domestic partner and/or his/her children online when you enroll. You must complete the "Affidavit of Partnership and Dependent Status Form" if you do not have a Registration of Domestic Partnership. This can be found on the Benefits Enrollment Website. Benefits provided to a domestic partner are subject to taxes, unless you can complete the "Affidavit of Legal Tax Dependency Form."

Children

You can enroll child(ren) up to age 26,* including:

- Biological children
- Legally adopted children (including those placed with you prior to adoption)
- Step-children
- Children of a domestic partner (if domestic partner is also enrolled)
- Children for whom you are the legal guardian.

You can enroll your children age 26 or older who are physically or mentally disabled and rely on you for at least 50% of their support.

Children and spouses of your eligible children are not eligible for coverage.

Please refer to the Life Insurance section for dependent eligibility rules specific to Life Insurance.

***If enrolled, coverage remains in effect through the end of the month in which the child turns age 26.**

Working Spouse Premium

If you are enrolling your spouse or domestic partner in medical coverage through Aramark for the first time, you must answer "Yes" or "No" on the Benefits Enrollment Website to indicate whether he or she has other employer-based medical coverage available to him or her. Premiums to cover spouses/domestic partners who have other medical coverage available are \$25 per month higher than premiums for those who do not have other coverage available. The higher premium applies for all of 2025; it cannot be changed once Annual Enrollment closes.

The increase in premium will appear on your pay statement as "WSPREM." This additional premium does not apply if your spouse/domestic partner is receiving Medicare or military benefits or is an Aramark employee.

NOTE: Premiums are deducted on a pre-tax basis and generally cannot be stopped mid-year.

Dependent Verification

Aramark routinely audits all enrolled dependents to ensure correct eligibility for medical, dental, vision and spouse/domestic partner optional life insurance coverage. During an audit, you will be asked to provide proof of their eligibility, such as copies of a marriage license, birth certificates, etc. Failure to do so within the specified timeframe will result in the cancellation of the dependent's coverage and the dependent will not be able to continue coverage under COBRA. If you add any new dependents during Annual Enrollment, you will be required to provide proof of their eligibility. Be sure to review the dependents you are covering to make sure they satisfy the eligibility rules and drop coverage for any ineligible persons.

Also, you **must** provide a valid Social Security number for any dependent you wish to enroll.



NOTE: Aramark will request proof of your legal marriage, civil union or domestic partnership registration. If appropriate certification/documentation is not submitted within the designated timeframe, coverage for your dependents will not be processed and you will need to wait until the next Annual Enrollment period or until you experience a qualified life status change to add your dependents.



Automatic Benefits

As a full-time, benefits-eligible, salaried Aramark employee, you will automatically receive the company-paid benefits listed below at no cost to you. You do not need to enroll in these benefits. You should, however, designate a beneficiary for basic life and accident insurance using the Benefits Enrollment Website.

Basic Life Insurance*

- The coverage amount is equal to one times your annual salary, up to a maximum of \$500,000.
- For Optional Life Insurance, see page 28.

Basic Accidental Death and Dismemberment (AD&D) Insurance*

- The coverage amount is equal to one times your annual salary, up to a maximum of \$500,000.
- Dismemberment benefits are based on the nature of your loss.
- For Optional Personal Accident Insurance, see page 29.

*Remember to update your beneficiary information by selecting Beneficiaries in the Action Center on the home page of the Benefits Enrollment Website.

Business Travel*

- All-Accident Insurance
 - Bands 0 through 5 – 24-hour accident protection, whether or not you are on company business, up to the greater of \$300,000 or one times your annual salary, up to \$1.5 million.
 - Bands 6 and Higher – Coverage is up to one times your annual salary, up to a maximum of \$200,000, for losses incurred as the result of a covered accident **while traveling on company business**.

If you're unsure of your band, please check with your manager.

Short-Term Disability (STD)

- This benefit pays 100% of your eligible base pay** if you become disabled and are unable to work due to a non-work-related illness or injury.
- Benefits begin after you have been disabled for 10 consecutive business days and will continue for up to 26 weeks (including the 10-day waiting period) for a medically certified disability.

Long-Term Disability (LTD)

- Aramark provides LTD coverage equal to 50% of your eligible monthly base pay,** up to \$10,000 per month, if you are medically disabled due to illness or injury and unable to work for more than 26 weeks.
- LTD benefits are offset by any benefits you receive from a federal or state government disability plan.
- LTD benefits are taxable income and will be provided by New York Life and reported on a W-2 form.
- For Optional LTD, see page 29.

**Eligible base pay may include commissions for Refreshment Services route drivers.



Please be aware that the STD and LTD Plans include a pre-existing condition provision. The pre-existing provision will be reviewed for any medical condition if you become disabled during your first 12 months of coverage and your disability is due to the same or related condition for which you received treatment in the three-month period before your coverage began. Benefits will not be paid to you for the condition for which you received medical treatment, consultation, care, or services, or took prescription medication or had medications prescribed.

EXCEPTION FOR STD: The pre-existing condition provision does not apply to maternity claims.



Automatic Benefits (continued)

Maternity Leave

- To qualify for the Maternity Leave benefit, you must be eligible and enrolled in the Short-Term Disability Plan.
- Aramark offers eligible birth mothers **six weeks** of paid Maternity Leave from the date of delivery.
- No waiting period or pre-existing condition limitation.
- Maternity benefit payment commences on date of delivery.
- If you develop a pre or post pregnancy-related complication that requires you to be away from work longer than the six-week Maternity Leave period, you may be eligible for additional leave under Aramark's STD Plan, subject to the 10 business day waiting period.

Parental Leave

- Aramark provides Parental Leave, which allows new parents to take paid leave to care for their newborn or newly adopted children.
- Eligible employees will receive a maximum of **two weeks** (10 business days) of 100% paid Parental Leave per birth or adoption within a rolling 12-month period.
- Employees are eligible for Parental Leave after 12 months of Aramark service and have met the 1,250 hours worked requirement.
- The parental leave benefit is two weeks following the exhaustion of the STD benefit, or within 12 months following the birth or adoption of the child.

NEW! Digital Exercise Therapy Program

Aramark has partnered with **Hinge Health** to provide access to digital exercise therapy programs. Hinge Health gives you the tools you need to conquer joint and muscle pain, recover from injuries, prepare for surgery, and stay healthy and pain free. These programs are available to employees and family members who are 18+ and enrolled in an Aramark medical plan. Plus, it's simple to sign up for, easy to do from home, and **is completely free!** Here's how it works:

- Get exercise therapy, a personal care team, and education designed to improve your specific situation.
- Simply answer a few questions and you will receive exercises that are right for you based on your pain and fitness level.
- You can do your exercises anytime, anywhere with the Hinge Health app — no need for appointments or travel!

To sign-up, go to www.hingehealth.com/for/aramark. If you have any questions, contact Hinge Health at 1-855-902-2777 or email them at hello@hingehealth.com.



Support for Parents of Children with Developmental Disabilities

Does your child have a developmental disability? As an Aramark employee, you can take advantage of a no-cost benefit that will help your child reach his/her full potential. **Rethink** offers an innovative program that puts clinical best practices at your fingertips.

- Communicate with your child more effectively.
- Teach your child crucial skills.
- Decrease problem behaviors.
- Easily collaborate with your child's care team.
- Get help through Rethink's Parent Support Center.
- Speak with professional behavioral therapists.
- Access a comprehensive online treatment curriculum.
- Learn from over 1,500 simple video-based teaching steps.
- Learn and use proven Applied Behavior Analysis (ABA) strategies.

Visit <http://rethinkbenefits.com/aramark> to register and learn more.



Automatic Benefits (continued)

Healthy Living Tip

Your Employee Assistance Program (EAP) is free, confidential and available 24/7!

Services are available to you and anyone in your household. Whether obtaining counseling for a personal problem, finding quality child or elder care, or locating information on college financial aid, your EAP can help. Call Cigna Behavioral Health toll-free at **1-888-636-6717**. Or visit <http://my.cigna.com> and enter "Aramark" as your Company or Employer ID.

Diabetes Management Program

The **Livongo for Diabetes Program™** is a health benefit fully paid by Aramark that makes living with diabetes easier. If you have diabetes, here are the key benefits:

- **Latest technology.** You'll receive the Livongo connected meter that uploads your blood glucose readings, making log books a thing of the past. You'll also receive personalized tips through the meter and mobile app.
- **Unlimited test strips at no cost.** Get as many test strips and lancets as you need shipped right to your door, with no hidden costs or copays.
- **Coaching anytime and anywhere.** Livongo Coaches are Certified Diabetes Educators who can assist you with nutrition and lifestyle changes.

Visit go.livongo.com. Click "**Join Now**" and use "**Aramark-ESI**" if you have Express Scripts Rx coverage, or "**Aramark-Non-ESI**" if you do not have Express Scripts Rx coverage.

Have questions or need help enrolling? Call **Livongo Member Support** at **1-800-945-4355**.



NOTE: The program is offered to employees who are eligible for standard Aramark medical benefits, as well as dependents with diabetes covered under the Express Scripts Prescription Plan. Employees do **NOT** need to be enrolled in an Aramark medical plan. Part-time and union employees are eligible only if the location extends standard Aramark medical benefits to these employees.



Automatic Benefits (continued)

VSP Vision Savings Pass

SERVICE	REDUCED PRICES AND SAVINGS
WellVision Exam®	<ul style="list-style-type: none">• \$50 with purchase of a complete pair of prescription glasses• 20% off without a purchase• Once every calendar year
Retinal Screening	Guaranteed pricing with WellVision Exam, not to exceed \$39
Lenses	With purchase of a complete pair of prescription glasses: <ul style="list-style-type: none">• Single vision \$40• Lined bifocals \$60• Lined trifocals \$75• Polycarbonate for children \$0
Lens Enhancements	Average savings of 20-25% on lens enhancements such as progressive, scratch-resistant and anti-reflective coatings
Frames	25% savings when a complete pair of prescription glasses is purchased
Sunglasses	20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last WellVision Exam
Contact Lenses	15% savings on contact lens exam (fitting and evaluation)
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

Find a VSP doctor at www.vsp.com or call 1-800-877-7195.



NOTE: For your reference, the Vision Savings Pass Plan Group Number is 12313941.

VSP TruHearing™ Hearing Aid Discount Program

- Savings of up to \$2,400 on a pair of digital hearing aids
- Three provider visits for fittings and adjustments
- 45-day money back guarantee
- Three-year manufacturer's warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid per year
- Access to a national network of more than 4,500 licensed hearing aid professionals
- Deep discounts on replacement batteries shipped directly to your door

Learn more at www.truhearing.com/vsp or call 1-877-372-4040.



As an Aramark employee, you and your dependents are automatically eligible for discounts on certain vision and hearing services and products through the VSP Vision Savings Pass and TruHearing Hearing Aid Discount Program. **You do not need to be enrolled in the vision plan in order to receive these discounts.**

When you go to a VSP doctor, identify yourself as a VSP member through Aramark. The VSP Vision Savings Pass can be used as often as you like throughout the year.



Optional Benefits

The benefits listed below require you to enroll if you want to participate. Enrollment in any of these benefits is entirely voluntary.

- Medical (including prescription drug)
- Dental
- Vision
- Optional Life Insurance*
- Spouse Optional Life Insurance*
- Dependent Optional Life Insurance*
- Personal Accident Insurance (PAI)
- Optional Long-Term Disability (LTD) Insurance*
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Savings Account (if enrolling in a Bronze Plus Medical Plan)
- Supplemental Benefits (offered at group or discounted rates):
 - Accident Insurance
 - Hospital Indemnity Insurance
 - Critical Illness Insurance
 - Universal Life Insurance
 - Legal Services
 - Identity Theft Protection
 - Auto and Home Insurance
 - Pet Insurance
 - Working Advantage Discounts

For more information on eligibility and the benefits available, go to www.aramarksupplementalplans.com.

*May be subject to Evidence of Insurability. Review eligibility requirements.

Mental Wellbeing Resources

Employees, spouses and dependents **enrolled** in an Aramark national medical plan are eligible for these benefits.

Universal Telehealth

- Teladoc is our sole telehealth vendor. Through telehealth, you can access care 24 hours a day/365 days per year without leaving the house, including mental health care.
- You can speak to or video consult with a physician to diagnose conditions, recommend treatment and write a prescription. Their mental health professionals can help you address stress, anxiety and other conditions with therapy, counseling and treatment.
- To enroll, call Quantum Health at **1-855-497-1241** or call Teladoc at **1-800-835-2362** or www.teladoc.com.



Digital Therapeutics for Insomnia and Anxiety

- We have partnered with Big Health and Express Scripts (ESI) to bring mental health digital therapeutics to your fingertips.
- **Sleepio**'s customized, science-backed sleep improvement program can help you get a better night's sleep and wake up energized.
- **Daylight** is a clinically proven app that addresses the underlying causes of your anxiety and teaches you techniques you can practice in as little as a few minutes a day.



Medical Coverage

	BRONZE PLUS PLAN	SILVER PLAN AND GOLD PLAN
Type of plan	High-deductible plan that covers in- or out-of-network care.	PPO plans that cover in- or out-of-network care.
Pay now or pay later? NOTE: See the deductible and out-of-pocket maximums on page 12.	Lower paycheck deductions; higher deductibles and out-of-pocket maximum.	Silver Plan has moderate paycheck deductions; moderate deductibles and out-of-pocket maximum. Gold Plan has higher paycheck deductions; lower deductibles and out-of-pocket maximum.
Does it offer access to a Health Savings Account (HSA)? See how an HSA can save you money on page 31.	Yes	No
How are in-network prescription drugs covered? NOTE: Your prescription drug coverage will be provided by the Pharmacy Benefit Manager (PBM). See how this may affect you on page 21.	You pay the full cost until you reach the deductible and then you pay coinsurance until you reach the out-of-pocket maximum and then you pay nothing.	You pay a copay for all in-network prescription drugs until you reach the out-of-pocket maximum and then you pay nothing.

Consider The Total Cost To You

When you enroll, you'll be able to see which carrier offers the lowest cost to you for each coverage level. You'll also be able to see the contribution amount from Aramark.

You'll have to consider what you'll pay throughout the year (e.g., copays and deductibles) when you need care. Make sure to take your total healthcare costs into consideration by choosing the coverage level and insurance carrier that offers the right balance for you and your family.

Need Assistance?

Use the "Medical Plan Comparison" tool on the Benefits Enrollment Website.

Is a Primary Care Physician Required?

You must designate a primary care physician if you choose Kaiser Permanente as your insurance carrier.

Affordability Under Health Care Reform

Under the Affordable Care Act (Health Care Reform), a low-cost medical plan option must be made available to employees at certain income levels. **Aramark complies with this requirement by providing affordable pricing to eligible employees through the Bronze Plus Plan, Employee Only coverage.**



NOTE: Are you selecting Kaiser, Geisinger or UPMC? Your plans might be a little different depending upon the medical carrier you choose. Refer to page 34 for carrier website and contact information.



Medical Coverage (continued)

Annual Deductible

- A deductible is what you pay out of pocket before your insurance starts paying its share of your costs. But how the deductible works depends on the coverage level you choose.
- The Bronze Plus Plan** coverage level has a true family deductible. This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no individual deductible in these plans when you have family coverage. (Exception: If you live in California and are covered by Kaiser Permanente, the Bronze Plus Plan coverage level has a traditional deductible.)
 - The Silver Plan and Gold Plan** have a traditional deductible. For example, in the Gold Plan, once a covered family member meets the \$750 individual deductible, your insurance will begin paying benefits for that family member. Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

	BRONZE PLUS PLAN*	SILVER PLAN	GOLD PLAN
Annual Deductible (individual / family)	In-network: \$2,250 / \$4,500	In-network: \$1,500 / \$3,000	In-network: \$750 / \$1,500
	Out-of-network: \$2,250 / \$4,500	Out-of-network: \$3,000 / \$6,000	Out-of-network: \$1,500 / \$3,000
*Entire in- or out-of-network family deductible must be met before the plan will pay benefits for any covered family member.			

Copays and amounts taken out of your paycheck for health coverage do not apply toward the annual deductible.

Annual Out-of-Pocket Maximum

- The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a calendar year for healthcare costs. It doesn't include amounts taken out of your paycheck for health coverage or certain copays under the Silver Plan and Gold Plan.
- Here's how the out-of-pocket maximum works if you have family coverage:

- The Bronze Plus Plan** has a true family out-of-pocket maximum. This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no individual out-of-pocket maximum in these plans when you have family coverage. (Exception: If you live in California and are covered by Kaiser Permanente, the Bronze Plus Plan coverage level has a traditional out-of-pocket maximum.)
- The Silver Plan and Gold Plan** have a traditional out-of-pocket maximum. Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

	BRONZE PLUS PLAN*	SILVER PLAN	GOLD PLAN
Annual Out-of-Pocket Maximum (individual / family)	In-network: \$4,000 / \$8,000	In-network: \$6,000 / \$12,000	In-network: \$4,000 / \$8,000
	Out-of-network: \$10,000 / \$20,000	Out-of-network: \$12,000 / \$24,000	Out-of-network: \$8,000 / \$16,000
*Entire in- or out-of-network family out-of-pocket maximum must be met before the plan will pay 100% of covered plan benefits for any covered family member.			

The charts above may not take into account how each plan covers any state-mandated benefits, its plan administration capabilities or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit or need additional information, contact Quantum Health.

Unlimited Lifetime Maximum Benefit

All Plans pay unlimited lifetime benefits with no maximum either in-network or out-of-network.

Keep In Mind

- Out-of-network charges will not count toward your in-network annual deductible or out-of-pocket maximum. The same goes for in-network charges—they will not count toward your out-of-network annual deductible or out-of-pocket maximum.
- Some insurance carriers in CA, CO, D.C., GA, HI, MD, OR, VA and WA do not cover out-of-network benefits at all.



Medical Coverage (continued)

The following plan designs apply to Aetna and Independence Blue Cross. Kaiser, Geisinger and UPMC have some plan variations. Please see page 19 for more information.

Check The Details

This is intended to be a summary of the most common covered services offered across insurance carriers. While we have made every attempt to ensure the accuracy of the information in these charts, if there is any discrepancy between this information and the official plan contracts and documents, the plan contracts and documents will rule.

To see a comparison of each plan's details when you enroll online, select the **Medical Plan Comparison** link at the bottom of the **Home page**.

Medical Benefits Summary

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Preventive Care – For a list of preventive care services required to be covered by all health plans, visit https://www.healthcare.gov/preventive-care-benefits .			
Annual physical exam, well-child exams, well-woman exam including Pap smear, mammogram, bone-density screening, other cancer screenings, immunizations	In-network: 100% covered, no deductible Out-of-network: 60% covered after deductible	In-network: 100% covered, no deductible Out-of-network: 50% covered after deductible	In-network: 100% covered, no deductible Out-of-network: 60% covered after deductible
Doctor's Office Visits			
Primary Doctor's Office Visit	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: You pay \$30 for PCP visit. Out-of-network: 50% covered after deductible	In-network: You pay \$25 for PCP visit. Out-of-network: 60% covered after deductible
Specialist Doctor's Office Visit	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: You pay \$50 for specialist visit. Out-of-network: 50% covered after deductible	In-network: You pay \$40 for specialist visit. Out-of-network: 60% covered after deductible
Inpatient Hospital Care			
Hospital Semi-Private Room and Board	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Inpatient Physician and Surgeon Services	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Inpatient Lab and X-ray	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible

Medical Coverage (continued)

Medical Benefits Summary (continued)

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Outpatient Care			
Outpatient Surgery <i>In a freestanding surgical facility or hospital</i>	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Outpatient Lab and X-ray	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Emergency Room – if not admitted <i>Must be a true emergency</i>	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible	In-network: \$150 copay per visit, then 70% covered after deductible Out-of-network: \$150 copay per visit, then 70% covered after deductible	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible
Urgent Care Center	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Ambulance	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible	In-network: 70% covered after deductible Out-of-network: 70% covered after deductible	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible
Durable Medical Equipment <i>Carrier guidelines apply</i>	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible

Medical Coverage (continued)

Medical Benefits Summary (continued)

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Alternative Care			
Prescribed Care in Non-Custodial Skilled Nursing Facility <i>120-day annual maximum</i>	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Non-Custodial Home Health Care <i>120-visit annual limit</i>	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Hospice Care	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Transgender Services*			
Gender Assignment / Reassignment Surgery	In-network: 80% covered after deductible** Out-of-network: 60% covered after deductible**	In-network: 70% covered after deductible** Out-of-network: 50% covered after deductible**	In-network: 80% covered after deductible** Out-of-network: 60% covered after deductible**
Gender Assignment / Reassignment Counseling	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: \$30 copay Out-of-network: 50% covered after deductible	In-network: \$25 copay Out-of-network: 60% covered after deductible
Hormone Replacement Therapy	In-network: Covered according to the formulary and the appropriate prescription drug tier Out-of-network: Covered according to the formulary and the appropriate prescription drug tier	In-network: Covered according to the formulary and the appropriate prescription drug tier Out-of-network: Covered according to the formulary and the appropriate prescription drug tier	In-network: Covered according to the formulary and the appropriate prescription drug tier Out-of-network: Covered according to the formulary and the appropriate prescription drug tier
Cosmetic Surgery	In-network: Not covered Out-of-network: Not covered	In-network: Not covered Out-of-network: Not covered	In-network: Not covered Out-of-network: Not covered
Reversal of Gender Reassignment Surgery	In-network: Not covered Out-of-network: Not covered	In-network: Not covered Out-of-network: Not covered	In-network: Not covered Out-of-network: Not covered

*Benefits vary by insurance carrier due to state mandates or administrative limitations.

**Carrier guidelines may apply.

Medical Coverage (continued)

Medical Benefits Summary (continued)

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Family Planning/Maternity Services			
Fertility Services <i>Subject to state mandate, benefit may be limited to \$15,000 medical and \$5,000 prescription lifetime maximum for all fertility treatments (combined in and out-of-network)</i>	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: Cost share based on place of service Out-of-network: 60% covered after deductible
Office Visits, Pre- and Post-Natal	In-network: 80% covered after deductible for first PCP visit (others covered under global maternity fee) Out-of-network: 60% covered after deductible for first PCP visit (others covered under global maternity fee)	In-network: \$30 copay for first PCP visit \$50 copay for first specialist visit (others covered under global maternity fee) Out-of-network: 50% covered after deductible for first PCP visit (others covered under global maternity fee)	In-network: \$25 copay for first PCP visit \$40 copay for first specialist visit (others covered under global maternity fee) Out-of-network: 60% covered after deductible for first PCP visit (others covered under global maternity fee)
In-Hospital Delivery	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Newborn Nursery	In-network: Preventive services covered at 100%, deductible waived; additional cost shares apply for non-routine services and/or when a length of stay exceeds the standard range for a normal delivery. Out-of-network: 60% covered after deductible	In-network: Preventive services covered at 100%, deductible waived; additional cost shares apply for non-routine services and/or when a length of stay exceeds the standard range for a normal delivery. Out-of-network: 50% covered after deductible	In-network: Preventive services covered at 100%, deductible waived; additional cost shares apply for non-routine services and/or when a length of stay exceeds the standard range for a normal delivery. Out-of-network: 60% covered after deductible



Medical Coverage (continued)

Medical Benefits Summary (continued)

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Alternative Treatment			
Acupuncture	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Chiropractic <i>20 visit annual maximum</i>	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible

Medical Therapy – 60 visits/days combined annual maximum for Physical, Speech and Occupational Therapy

Outpatient Physical Therapy	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Outpatient Speech Therapy	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Outpatient Occupational Therapy	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible

Medical Coverage (continued)

Medical Benefits Summary (continued)

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Mental Health and Substance Abuse Treatment			
Mental Health Inpatient	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Mental Health Outpatient	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: Office Visit: You pay \$30 per visit Facility Visit: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: Office Visit: You pay \$25 per visit Facility Visit: 80% covered after deductible Out-of-network: 60% covered after deductible
Substance Abuse Inpatient	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible
Substance Abuse Outpatient	In-network: 80% covered after deductible Out-of-network: 60% covered after deductible	In-network: Office Visit: You pay \$30 per visit Facility Visit: 70% covered after deductible Out-of-network: 50% covered after deductible	In-network: Office Visit: You pay \$25 per visit Facility Visit: 80% covered after deductible Out-of-network: 60% covered after deductible

Medical Travel Benefit

- All employees enrolled in an Aramark medical plan are eligible for reimbursement up to \$1,500 per occurrence for any covered medical service if an in-network provider is not available within 100 miles of their home residence.
- Per IRS regulation, lodging reimbursement is limited to \$50/night per patient up to maximum of \$100/night (including travel companion).
- For more information, to check whether there is an in-network provider within 100 miles, or to file a claim for reimbursement, contact Quantum Health at **1-855-497-1241**.

Medical Variations

The plan information on the preceding pages does not apply to Kaiser, Geisinger or UPMC plans which have variations. **If you live in Texas or Illinois, you have a fourth medical plan option in addition to the Bronze Plus, Silver and Gold plans outlined in this guide.** This information also does not pertain to Next Level Hospitality medical plans or the Flowers Sanitation Bronze Choice plan. For more information on your plan, see the contact information on page 34. To see a comparison of each plan's details, when you enroll online, select the Medical Plan Comparison link on the Home page.

Summary Health Benefits Information

To help you make an informed choice, you should also check out the Summary of Benefits and Coverage (SBC). The SBCs summarize important information about all your health coverage options in a standard format to help you compare them. These SBCs are required by the Health Care Reform law. SBCs will be available when you enroll for medical benefits on the Benefits Enrollment Website. A paper copy is also available upon request, free of charge, by calling **1-855-528-BENE (2363)**.

SBC Language Assistance

- Spanish (Español): Para obtener asistencia en Español, llame al **1-855-528-BENE (2363)**.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-855-528-BENE (2363)**.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-855-528-BENE (2363)**.

Medical/Prescription Drug Coverage Insurance Carriers

Things to Consider

When deciding which insurance carrier to choose, try the **Medical Plan Comparison** tool. It will help you assess the carriers that may be the best fit based on your needs. As a reminder, be sure to consider:

- Cost per paycheck
 - Each carrier will offer its own price for each coverage option. Just like shopping for a flight on a travel website, you'll be able to see all of those prices in one place. That makes it easy to see which carrier is offering you the best deal. The benefits provided under a coverage option will be very similar across carriers, but there could be some differences (for example, inpatient hospital coverage or infertility benefits). You can compare the details when you enroll online or, call the carriers directly (or contact Quantum Health for Aetna and IBC).
- Network

If you want to keep seeing your current doctors, choose an insurance carrier whose network includes your preferred providers (e.g., doctors, specialists, hospitals). To see whether your doctor participates:

 - Before enrollment, check out the insurance carrier website or contact the carrier directly (or contact Quantum Health for Aetna and IBC), to verify your providers are in-network (contacts listed on page 34).

Important: Even if you can keep your current insurance carrier, the provider network could be different and can change from year to year, so *always* check the provider networks before making a decision.
- Prescription drug coverage
 - If you select coverage with Aetna or IBC, your prescription drug coverage will be provided through **Express Scripts (ESI)**. You will receive a separate ID card for your prescription drug coverage from **ESI** if you are newly enrolling with Aetna or IBC. (If you are currently enrolled, hold onto your **ESI** card).
 - If you select coverage with a medical carrier other than Aetna or IBC, your prescription drug coverage will continue to be managed by the insurance carrier.
 - You need to make sure you're comfortable with how ESI or your medical insurance carrier will cover any medications you and your covered family members need. To find out more, see page 21.
- Lifestyle and Wellness Support
 - Quantum Health offers their own condition management and coaching programs for employees that select Aramark health benefits. These could include a 24-hour nurse line, healthy lifestyle coaching, pregnancy support, transition of care, assistance with finding a physician, assistance with claims and more. Browse their sites now to learn about their tools and other considerations that could influence your decision.



NOTE: Are you selecting Kaiser, Geisinger or UPMC? Your plans might be a little different depending upon the medical carrier you choose. Refer to page 34 for carrier website and contact information.



[Back to Main Menu](#)

Medical/Prescription Drug Coverage Insurance Carriers

(continued)



ID Cards

- Aetna and Independence Blue Cross participants will receive a new medical ID card from your carrier's Third-Party Administrator (Aetna: Meritain; Independence Blue Cross: Independence Administrators) co-branded with Quantum Health.
- If you newly enroll in medical coverage with Kaiser (except California and Hawaii), Geisinger Health Plan or UPMC, you will receive a new medical ID card from your insurance carrier.
 - New ID cards will NOT be issued if you are already enrolled. Hold onto your card.
- Prescription cards from ESI are only mailed to new participants. Hold onto your card.
- ID cards are not issued or needed for Dental and Vision plans. Simply tell your doctor you have Delta Dental (Plan Group #: 2497) or VSP (Plan Group #: 12221565) coverage through Aramark.

Smoker Premium

If you enroll in any Aramark Medical Plan for 2025, you must answer the smoking question(s) on the Benefits Enrollment Website for you and your enrolled spouse/domestic partner. Premiums for smokers are higher than for non-smokers—smokers pay an additional \$10 per week per person (maximum additional \$20 weekly for employee plus spouse). The higher premium applies if you indicate smoker status. Your response to the smoker question remains in effect throughout all of 2025; it cannot be changed once Annual Enrollment closes. However, you can avoid the premium by participating in the smoking cessation program described below. The increase in premium will appear on your pay statement as "ESMKPREM" (for employee) and "SSMKPREM" (for spouse/domestic partner). If applicable, your smoking status certification from 2024 will roll over to 2025. However, it is important to review your election in case your circumstances have changed.

Aramark considers a smoker as someone who has used cigarettes, electronic nicotine delivery systems (ENDS), cigars, pipes, chewing tobacco, snuff products or any form of smokeless tobacco (i.e. "chew") in the past 12 months.



NOTE: Premiums are deducted on a pre-tax basis and generally cannot be stopped mid-year.

Healthy Living Tip

Stop smoking today! We can help. If you are a smoker, we offer a voluntary smoking cessation program through the American Cancer Society. You are not required to participate in the program, but you will receive the lower non-smoker premiums if you complete it. The program offers free telephone counseling and support and nicotine replacement therapy (e.g., patches, gum, lozenges). Prescription medications (e.g., Chantix, Zyban, Nicotrol Inhaler, nasal sprays) are covered under the terms of your insurance carrier. For free confidential help, call **1-866-QUIT-4-LIFE (1-866-784-8454)** or go to www.quitnow.net/Aramark.

What Is the Women's Health and Cancer Rights Act of 1998?

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.



Prescription Drug Coverage

Your Medical Insurance Carrier Choice Matters

Express Scripts (ESI) is a Pharmacy Benefit Manager (PBM). Employees who enroll with Aetna or Independence Blue Cross will have their pharmacy benefits managed by ESI.

A PBM provides administrative services in processing and analyzing prescription drug claims, contracts with a network of pharmacies, maintains programs to ensure patient compliance and develops and manages formularies and prior authorization programs.



NOTE: If you are enrolling with a regional carrier, such as Kaiser, Geisinger or UPMC, contact your carrier. See contact information on page 34.

Things to Consider

If you or a family member regularly takes medication, it is strongly recommended that you check your formulary at www.express-scripts.com/aramark.

Here's a list of questions to consider:

- **Is my drug on the formulary?** A formulary is a list of generic and brand-name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't on the formulary, you'll pay more for it.
- **How much will my drug cost?** The cost of your prescription depends on how your medication is classified by your Pharmacy Benefit Manager (PBM)—either Tier 1, Tier 2 or Tier 3. The higher the tier, the more you'll pay. While generics will cost less most of the time, insurance carriers can classify higher- cost generics as Tier 2 or Tier 3 drugs, which means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can also find this information on the carrier sites (see page 34).
- **Will my doctor have to provide prior authorization before my prescription can be approved?** In some instances, your doctor will need to provide approval before your medication can be filled. This may apply for costly medications.
- **Will I have a step therapy program?** If this applies to one of your medications, you'll need to try using the most cost-effective drug first— usually the generic. A more expensive drug will only be covered if the first drug isn't effective in treating your condition.
- **Will I have to pay more if I choose a brand- name drug?** Maybe. Some PBMs will require you to pay the Tier 2 copay or coinsurance plus the cost difference between brand-name and generic drugs if you choose a brand-name when a generic is available.
- **Is my drug considered “preventive” (covered 100%)?** The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you fill them in-network—but each PBM determines which drugs it considers “preventive.” If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.
- **Are there any quantity limits?** Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.
- **Will I receive an ID card?** If you enroll in a medical plan with Aetna, or Independence Blue Cross, you will receive an ID card and welcome kit from Express Scripts (ESI).
- **Are the pharmacies easy to access?** Each PBM has a network of participating pharmacies.
- **How do I take advantage of mail order service?** You'll need a new 90-day prescription from your doctor. And, because mail order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime. If your PBM is ESI, you can also get a 90-day supply at CVS or Walgreens.



Contact ESI

- Phone: **1-855-307-4586**
- Pre-enrollment Website (check your formulary here): www.express-scripts.com/aramark
- Post-enrollment Website: www.express-scripts.com



Prescription Drug Coverage (continued)

Prescription Drug Benefits Summary

The coverage level you choose will affect your prescription drug coverage. See how on the previous page.

	BRONZE PLUS PLAN	SILVER PLAN	GOLD PLAN
Annual Prescription Drug Deductible	All prescription drugs (except those classified as preventive) are subject to the annual medical deductible (see page 12).	None	None
Retail Tier 1: Lowest Cost Options (30-day supply)	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible	In-network: You pay \$15 Out-of-network: You pay \$15	In-network: You pay \$12 Out-of-network: You pay \$12
Retail Tier 2: Moderate Cost Options (30-day supply)	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible	In-network: You pay \$50 Out-of-network: You pay \$50	In-network: You pay \$40 Out-of-network: You pay \$40
Retail Tier 3: Highest Cost Options (30-day supply)	In-network: 80% covered after deductible Out-of-network: 80% covered after deductible	In-network: You pay \$70 Out-of-network: You pay \$70	In-network: You pay \$70 Out-of-network: You pay \$70
Mail Order Tier 1: Lowest Cost Options (90-day supply)	In-network: 80% covered after deductible Out-of-network: Not covered	In-network: You pay \$37.50 Out-of-network: Not covered	In-network: You pay \$30 Out-of-network: Not covered
Mail Order Tier 2: Moderate Cost Options (90-day supply)	In-network: 80% covered after deductible Out-of-network: Not covered	In-network: You pay \$125 Out-of-network: Not covered	In-network: You pay \$100 Out-of-network: Not covered
Mail Order Tier 3: Highest Cost Options (90-day supply)	In-network: 80% covered after deductible Out-of-network: Not covered	In-network: You pay \$175 Out-of-network: Not covered	In-network: You pay \$175 Out-of-network: Not covered



NOTE: Specialty drug copays will mirror the channel where it is obtained and must be obtained directly from the specialty pharmacy after one fill at a retail pharmacy. Specialty drugs are not covered out-of-network.



Medicare Part D Creditable Coverage Notice

The Medicare Part D Notice in this section applies to those Aramark employees who are currently eligible for Medicare or will become eligible in the next 12 months. It concerns your current Aramark prescription drug coverage and the prescription drug coverage through Medicare. Please read it carefully. Important highlights of this notice are:

- Medicare prescription drug coverage is available to those eligible for Medicare.
- Aramark's prescription drug coverage is creditable coverage. This means Aramark offers prescription drug benefits to all plan participants equal to or better than the standard Medicare prescription drug coverage.

Your Prescription Drug Coverage Options

If you qualify for Medicare prescription drug benefits while covered by an Aramark medical plan, you have the option of continuing your existing prescription drug coverage through Aramark or enrolling in the Medicare prescription drug coverage.

- Because your existing coverage is credible coverage, you can keep the coverage and not pay a higher premium (a penalty) if you later decide to 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 credible 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.
- If you decide to join a Medicare drug plan, your current Aramark coverage will not be affected. However, if you decide to join a Medicare drug plan and drop your current Aramark coverage, be aware that you and your dependents will be able to get this coverage back as long as you meet the eligibility requirements at the next annual enrollment period or if you experience a qualifying life event mid-year.



NOTE: If you are enrolled in Aramark's prescription drug coverage and also enrolled in Medicare Part D, you must present your Aramark prescription drug card when filling prescriptions

Keep in mind that because your Aramark prescription drug coverage meets the Social Security creditable coverage requirements, if you choose to enroll later in a Medicare prescription drug plan during the October 15 to December 7 annual Medicare drug enrollment period, you may do so without having to pay a higher premium.

However, if you drop your Aramark medical and prescription drug coverage and go without creditable coverage for 63 continuous days or more before enrolling in Medicare prescription drug coverage, you could be subject to paying higher premiums for Medicare coverage.

Limited Income Assistance

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this additional help is available from the Social Security Administration.

For information about this extra help, see the contact information below.

For More Information About This Medicare Part D Notice

If you need further information, contact:

- Social Security Administration at **1-800-772-1213** or www.socialsecurity.gov
- Medicare at **1-800-MEDICARE (1-800-633-4227)** or www.medicare.gov or
- Aramark Benefits Center at **1-855-528-BENE (2363)**.

You may receive this notice at other times in the future, such as when coverage changes. You may also request a copy of this notice by calling the Aramark Benefits Center.



Preventive Care

Preventive Care Covered at 100% In-Network

Good preventive care today is an important key to good health tomorrow. Regardless of your age, gender, line of work—or whether you are in excellent health or dealing with a chronic condition—preventive care can help you head off health problems before they occur or minimize complications from existing conditions.

The Bronze Plus, Silver and Gold Plans all cover preventive healthcare at 100% in-network.

This means:

- no copay;
- no deductible; and
- no coinsurance.

What are the preventive care services that are covered at 100% in-network?

They are services recommended by nationally recognized authorities such as the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

For a complete list of recommended preventive care services, call the insurance carrier that administers your plan, or visit <https://www.healthcare.gov/preventive-care-benefits>.

A note about how your doctor or provider bills for a preventive service:

- In order to be covered at 100%, your medical provider must bill the insurance company for the service as preventive care.
- If the service is billed as treatment for illness or injury or to make a diagnosis, then you will be subject to the applicable copay, deductible and/ or coinsurance.
- If preventive care is not the primary purpose for an office visit, you will pay the applicable copay, deductible and/or coinsurance under your plan.

Example #1:

You receive a mammogram. If the test is part of your annual routine care, it's considered preventive and is covered at 100%. If your doctor recommends the test because you have a lump that he or she wants investigated further, then it's considered diagnostic and would be subject to the applicable copay, deductible and/or coinsurance under your plan.

Example #2:

You visit your doctor for an ear infection but also have a preventive blood pressure check while there. You will still be required to pay the applicable copay, deductible and/or coinsurance for the office visit because the primary purpose of your visit was to be treated for an illness.



Dental Plan

To help you manage dental costs while encouraging good dental care, Aramark offers the Delta Dental PPO Plus Premier Plan, which is a fully insured program administered by Delta Dental.

The Delta Dental PPO Plus Premier Plan offers you the choice of using any dental provider, but plan benefits are greatest when you use participating dentists. For a list of participating dentists call Delta Dental at **1-800-932-0783** or visit www.deltadentalins.com. Search for providers under Delta Dental PPO (for the greatest savings) and/or Delta Dental Premier® Plans (for the largest access).



Dental Benefits Summary

DESCRIPTION	PARTICIPATING DENTISTS	NON-PARTICIPATING DENTISTS*
Calendar Year Deductible	\$25 per person	\$50 per person
Calendar Year Maximum Benefit	\$1,800 per person	
Patient Payment Amount	Any applicable deductibles, coinsurance amounts and amounts above the plan maximums	Any applicable deductibles, coinsurance amounts and amounts above the plan maximums, and the difference between Delta Dental's payment and the dentist's charge (unlimited)
	Coinsurance (plan pays % / you pay %):	
Diagnostic Services (No deductible)	Plan pays 100%	80% / 20%
Preventive Services (No deductible)	Plan pays 100%	80% / 20%
Basic Services	80% / 20%	80% / 20%
Major Services	50% / 50%	50% / 50%
Oral Surgery	80% / 20%	80% / 20%
Endodontic	80% / 20%	80% / 20%
Periodontic	80% / 20%	80% / 20%
Prosthodontic	50% / 50%	50% / 50%
Orthodontic	Plan pays 50% (\$2,500 lifetime maximum per person). The amount paid by you does not apply toward the deductible.	
TMJ	Plan pays 50% (\$750 lifetime maximum per person)	

*Subject to Maximum Plan Allowance (MPA).



NOTE: ID cards are not issued or needed for the Dental Plan. For your reference, the Dental Plan Group Number is 2497.

Vision Plan

If you enroll in Aramark’s vision plan offered through VSP, you are eligible to receive eye care benefits every calendar year for eye exams and eyeglasses or contact lenses. Additionally, discounts are available on services and procedures such as laser vision correction.

VSP is also offering an enhanced Vision Plan option – Vision Service Plan – Plus. Enrollees will pay a higher rate to choose one of the following: increased frame allowance, increased contact lens allowance, full progressive lens, full anti-reflective coating or full photochromic/light adaptive lenses. Employees who elect the enhanced plan at Annual Enrollment can choose their upgrade option at time of service. Cost will be provided on the Benefits Enrollment Website.

You can save money by visiting VSP doctors nationwide for all your routine eyecare needs. And there are no claim forms to complete. For a list of participating doctors near you, call VSP at **1-800-877-7195** or visit www.vsp.com. Search for providers in your network by going to www.vsp.com/eye-doctor. Reduced reimbursement is also available for services from non-VSP doctors.

Search for providers in your network by selecting VSP Choice. Reduced reimbursement is also available for services from non-VSP doctors.

In addition to the private practice providers in the VSP network, VSP's Retail Chain Affiliate Partners have more than 1,000 optical stores for your convenience. These stores include Costco Optical, Visionworks, Wisconsin Vision, Heartland Vision and Rx Optical. You'll receive equivalent benefits at these locations to those listed below, except where noted.

Vision Service Plan – Core and Vision Service Plan – Plus Benefits Summary

This is a summary. Please see the 2025 Vision Plan Comparison on the Benefits Enrollment Website for details.

BENEFIT	COVERAGE/COPAY WITH VSP NETWORK DOCTOR*
Calendar Year Deductible	None
Patient Payment Amount	Any applicable copays and amounts above the plan's network allowance
WellVision Examination (Annual)	Plan pays 100% after \$10 copay
Prescription Glasses (Annual)	
• Frames	<ul style="list-style-type: none">• \$150 for most frames; \$170 for featured brands• 20% savings on the amount over your allowance• \$80 Costco allowance
• Lenses	<ul style="list-style-type: none">• Single vision, lined bifocal and lined trifocal lenses• Impact-resistant lenses for dependent children
• Lens Enhancements	<ul style="list-style-type: none">• Standard progressive lenses: \$0• Premium progressive lenses: \$95-\$105• Custom progressive lenses: \$150-\$175• Average savings of 20-25% on other lens enhancements
Contacts (Annual; in lieu of prescription glasses)	<ul style="list-style-type: none">• \$150 allowance for contacts; copay does not apply• Contact lens fitting and evaluation: \$60

*Get the most out of your benefits and greater savings with a VSP network doctor. Call VSP Member Services for out-of-network plan details



NOTE: ID cards are not issued or needed for the Vision Plan. For your reference, the VSP Group Number is 12221565.



Vision Plan (continued)

BENEFIT	COVERAGE/COPAY WITH VSP NETWORK DOCTOR*
Diabetic Eyecare Program™ (As needed)	<ul style="list-style-type: none">• \$20 per exam• Ask your VSP doctor for details
Extra Savings and Discounts	See the 2025 Vision Plan Comparison on the Benefits Enrollment Website for information about discounts on: <ul style="list-style-type: none">• Glasses and Sunglasses: Visit vsp.com/specialoffers for details.• Routine retinal screenings• Laser vision correction
Diabetic Eyecare Program™ (As needed)	<ul style="list-style-type: none">• \$20 per exam• Ask your VSP doctor for details

*Get the most out of your benefits and greater savings with a VSP network doctor. Call VSP Member Services for out-of-network plan details



Vision Service Plan – Plus Additional Features and Savings

With VSP EasyOptions, each member on your plan can personalize their benefit with ease. Choose one of these upgrades at the time of service:

- An additional \$100 frame allowance, or
- Fully covered premium or custom progressive lenses, or
- Fully covered anti-reflective lenses, or
- Fully covered photochromic lenses, or
- An additional \$50 contact lens allowance.

Life Insurance and Disability Coverage

Employee Optional Life Insurance

To help protect your family's financial security, Aramark offers, at your expense, Employee Optional Term Life Insurance. (This optional coverage is in addition to the company-paid Basic Life and Basic AD&D coverage, which is one times your annual salary up to a maximum of \$500,000.) As shown on the Benefits Enrollment Website, **you may elect optional term life coverage of up to five times your annual salary, up to a maximum benefit of \$1.5 million.**

Rates listed on the Benefits Enrollment Website are calculated based on your age as of **January 1, 2025**. Your coverage amount will increase or decrease in conjunction with changes in your salary. Evidence of Insurability is required if enrolling in Optional Life Insurance for the first time or increasing your current level of coverage.

Spouse/Qualified Domestic Partner Optional Life Insurance

You may purchase Optional Life Insurance coverage for your spouse (or eligible domestic partner) in \$10,000 increments, up to a maximum of \$100,000. Rates are listed on the Benefits Enrollment Website.

If your spouse is under age 75 on the effective date of insurance, Spouse/Qualified Domestic Partner Optional Life Insurance will end at the end of the month in which your spouse attains age 75. If your spouse is 75 or older on the effective date of insurance, they would not qualify for Spouse/Qualified Domestic Partner Optional Life Insurance.

You must provide your spouse's/qualified domestic partner's date of birth and Social Security number prior to enrolling him or her. If your domestic partner is not registered under the laws of any local or state government entity, please complete the required domestic partner affidavit when electing coverage for a domestic partner. Failure to complete this affidavit will result in a denial of benefits.

Evidence of Insurability Requirements

For 2025, Evidence of Insurability is required if enrolling in Optional Life Insurance for you or your spouse for the first time or increasing your current coverage.

Dependent Child Optional Life Insurance

You may enroll your dependent children in dependent optional life. Amounts available are \$5,000, \$10,000 or \$15,000. Rates vary by the amount of coverage you select but are the same no matter how many children you are enrolling. **Eligible dependent children include your children who are 15 days or older up to age 19, or up to age 25 if a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.** Your dependent children must be listed on the Benefits Enrollment Website to be covered. Rates are listed on the Benefits Enrollment Website.

Important

Your dependents must meet the requirements below. If they do not meet these requirements on the day coverage is due to begin, it will become effective on the day they meet the requirements.

On the date Dependent Life Insurance is scheduled to take effect, the dependent spouse or child must **NOT** be:

- confined at home under a physician's care
- receiving or applying to receive disability benefits from any source, or
- hospitalized

If the dependent does not meet this requirement on such date, insurance for the dependent will take effect on the date he or she is no longer:

- confined
- receiving or applying to receive disability benefits from any source, or
- hospitalized



NOTE: You do not need to enroll yourself in Optional Life Insurance in order to enroll your spouse/domestic partner or children. However, you must be actively at work in order for the new or increased coverage to take effect. See Evidence of Insurability Requirements above.

Non-Smoker/Smoker Rates for Employee Optional Life Insurance

Two sets of Optional Life Insurance premium rates will appear on the Benefits Enrollment Website: Non-Smoker and Smoker. When you enroll for Employee Optional Life Insurance coverage, you must indicate your smoking status on the Benefits Enrollment Website by selecting the rate that corresponds to your smoking status. If you previously enrolled for Optional Life Insurance coverage, your smoker status will be reflected on the Benefits Enrollment Website. If your status has changed, you should indicate that change during Annual Enrollment.

Aramark considers a smoker as someone who has used cigarettes, electronic nicotine delivery systems (ENDS), cigars, pipes, chewing tobacco, snuff products or any form of smokeless tobacco (i.e., "chew") in the past 12 months. If your smoking status changes (e.g., you quit smoking), you may update your status only during Annual Enrollment.



NOTE: Non-Smoker/Smoker rates do not apply to the grandfathered Optional Life plans (offered pre-1996), Spouse/Qualified Domestic Partner Optional Life Insurance or Dependent Child Optional Life Insurance.



Life Insurance and Disability Coverage (continued)

Personal Accident Insurance (PAI)

In addition to the employer-paid Basic AD&D coverage, you have the option to elect additional voluntary accidental death & dismemberment coverage for yourself, spouse/domestic partner and dependent children. This is not an All Accident policy. The policy limits coverage to Accidental Death & Dismemberment claims only.

Eligible dependent children include your children up to age 19, or up to age 25 if a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

You may elect coverage for yourself from a minimum of \$100,000 to a maximum of 10 times your annual base salary (not to exceed \$500,000).

Coverage options and rates are listed on the Benefits Enrollment Website. Premiums are paid on an after-tax basis.

If you elect coverage for your spouse or domestic partner, the coverage is equal to 60% of the amount you choose for yourself.

If you elect coverage for your dependent children, the coverage is equal to 20% of the amount you choose for yourself, up to a maximum coverage amount of \$50,000.



NOTE: Eligibility rules for dependents are the same as those on the previous page.

Optional Long-Term Disability (LTD)

- In addition to the employer-paid LTD benefit, you may elect to increase the amount of LTD coverage by 20% on an optional basis. You must enroll if you wish to have this additional coverage.
- If you choose the additional LTD coverage, you can choose benefits equal to a total of 60% or 70% of your eligible monthly base pay,* up to a maximum benefit of \$15,000 per month while you remain medically certified as disabled.
- Your cost for the additional LTD coverage is listed on the Benefits Enrollment Website. Your benefit amount and your cost for coverage may change during the year to reflect changes in your pay.
- If you do not elect the additional LTD benefit when you are first eligible, you may enroll during subsequent Annual Enrollment periods or upon a qualified life status change. But you will be required to provide **Evidence of Insurability** to the carrier for approval. Employees must be actively at work to enroll in the LTD Plan.

The LTD Plan includes a pre-existing condition provision. The disability plan has a pre-existing provision that will be reviewed for any medical condition if you become disabled during your first 12 months of coverage and your disability is due to the same or related condition for which you received treatment in the three-month period before your coverage began. Benefits will not be paid to you for the condition for which you received medical treatment, consultation, care, or services, or took prescription medication or had medications prescribed.

*Eligible base pay may include commissions for Refreshment Services route drivers.

Keep Your Beneficiary Information Up-to-Date!

If you're a current or new employee, you must designate a beneficiary for life insurance coverage.

When you enroll for benefits, you will be prompted to complete a beneficiary designation form on the Benefits Enrollment Website.

If you wish to update an existing beneficiary designation (or if there is no named beneficiary on file) for Basic Life, Employee Optional Life, Basic AD&D or All Accident Insurance (PAI), you may do so on the Benefits Enrollment Website.

If there is no named beneficiary on file, benefits will be paid to your survivors in the order listed below:

1. Spouse / Domestic Partner
2. Child(ren)
3. Parent(s)
4. Sibling(s)



Flexible Spending Accounts (FSAs)

FSAs are administered by HealthEquity. Go to www.healthequity.com/wageworks, select **LOG IN/REGISTER** and then **Employee Registration**. You'll need to answer a few simple questions and create a username and password. You will also receive a welcome packet with your HealthEquity® Visa® Healthcare Card in the mail.



NOTE: If you participated in an Aramark FSA in 2024 and you wish to do so again in 2025, you must re-enroll and indicate the amount you wish to contribute in 2025—even if it is the same amount you elected for 2024.

Estimate and Manage Your Money Carefully

- **Use It or Lose It** — FSAs require that you estimate your average spending level in advance. Make sure to estimate carefully, because if you overestimate and do not use all the money in your account, the balance is forfeited. Due to IRS rules, you will lose any money you do not claim by March 31, 2026, for expenses incurred from January 1, 2025, through December 31, 2025.
- **Online Tools** — once you're participating in an FSA, you can track your account online at www.healthequity.com/wageworks.

Health Care Spending Account

- You may deposit a minimum of \$50 up to a maximum of \$3,300 (2024 projection for 2025) per year into a Health Care FSA.
 - You can use this pre-tax money to pay deductibles, copays and certain other out-of-pocket healthcare expenses not covered by any medical, dental or vision coverage you, your spouse or your children may have. Exception: If you have an HSA, your Health Care FSA can be used only for non-medical expenses, such as vision and dental. For a list of eligible and ineligible expenses, go to www.irs.gov/publications/p502.
 - Contributions made during 2025 can be used only to pay expenses incurred from January 1, 2025, through December 31, 2025.
 - There are very limited circumstances under which expenses incurred on behalf of a domestic partner or a domestic partner's dependent are eligible for reimbursement under the IRS's FSA rules.
- HealthEquity® Visa® Healthcare Card. Your debit card from HealthEquity is connected to your FSA.
 - Use it to pay for any eligible medical, dental, vision and pharmacy expenses.
 - Use it to pay by phone or through the web, or at any eligible provider or merchant that accepts Visa.
 - Shop only at general merchandise stores or pharmacies that have an IRS-approved inventory system in place. Visit www.sigis.com for the most updated list of approved merchants. The healthcare card will not work at a non-certified merchant.
 - Use it for eligible dependent care expenses.
 - You will not have to pay with cash, write checks, or submit claim forms.
- In compliance with Health Care Reform, over-the-counter medicines are not eligible for reimbursement from a Health Care FSA unless you have a prescription (does not apply to insulin without a prescription). For a list of eligible and ineligible over-the-counter items, go to www.irs.gov/publications/p502.

Dependent Care Spending Account

- You may deposit a minimum of \$50 up to a maximum of \$5,000 per year into the Dependent Care FSA. The most you can receive in reimbursement on a tax-free basis is \$2,500 if you are married and file your taxes separately. You should limit your contribution if you plan to file taxes separately for 2025.
 - During the year, you can use the pre-tax money in this account to pay for certain dependent care expenses (e.g., day care) while you (and your spouse or domestic partner) are working or attending school full time.
 - Eligible expenses (e.g., day care) include those incurred for the care of a dependent child under age 13 and may also include expenses for the care of a spouse or adult dependent who is physically or mentally incapable of caring for himself or herself. Medical expenses for dependents are not eligible for reimbursement under the Dependent Care FSA. In addition, supplies, transportation, food expenses, overnight camp and private school tuition do not qualify for reimbursement from the Dependent Care FSA.
 - For a list of eligible and ineligible expenses, go to www.irs.gov/pub503.



NOTE: Employees whose earnings exceed an IRS threshold may be subject to a limit on annual contributions to Dependent Care Spending Accounts. The limit is \$2,000; however, it may be further reduced depending upon plan enrollment. If you are subject to this limit, it will be reflected on the Benefits Enrollment Website.



Health Savings Account (HSA)

Special Option for Bronze Plus Plan Medical Plan Participants

If you enroll in the Bronze Plus Plan, your payroll deductions will be the lowest of all the plans—but your deductible and certain out-of-pocket costs will be highest. So, a special option exists for Bronze Plus Plan enrollees: the Health Savings Account (HSA). The HSA lets you have additional pre-tax payroll deductions taken and set aside in your HSA account, which you can use to pay for medical, dental and vision out-of-pocket expenses such as your deductibles, copays and coinsurance.

- You can decide during enrollment whether to enroll in an HSA and how much money you want to save.
- You can change the amount you save at any time throughout the year.
- For 2025, you can save up to \$4,300 if you're covering just yourself under the Bronze Plus Plan, or up to \$8,550 if you're also covering other members of your family.
- If you are age 55 or older, an additional \$1,000 per year may be contributed.

Your money earns tax-free interest and you pay no taxes when you spend the money on eligible healthcare expenses.

Best of all, any unused HSA money carries over year-to-year. Just like a bank account, you own your HSA, so it's yours to keep even if you later change medical plans, leave the company or retire.

Using Your HSA

There are two ways to use your HSA:

1. Use **your HSA debit card**—just swipe it when you're ready to pay for qualified medical expenses and the funds will be taken directly from your account. Just make sure you have enough money in your HSA to cover the expense.
2. **Pay out of pocket**—if you prefer, you can pay for your expenses up front and reimburse yourself electronically from your HSA.

You can **find** a complete list of eligible expenses at www.irs.gov/publications/p502. Keep careful records of your expenses, including receipts, in case you ever need to provide proof of how your HSA funds were spent. If you use money from your HSA to pay for non-qualified medical expenses, you'll pay taxes on that money and pay an additional 20% penalty tax if you're under age 65.

After you enroll, you'll receive a Welcome Letter with your HSA account number and instructions on how to access additional information.

HSA Investment Option

Employees who maintain a minimum balance of \$2,000 in their HSA have an option to invest their funds in excess of \$2,000 in a HealthEquity investment account. HealthEquity's Advisor™ tool assists you in selecting mutual funds based on your personal risk preferences.

For more information about the HealthEquity Advisor™ investment account:

- Log on to www.my.healthequity.com
- Select **Investments** from the **My Account** tab.
- Indicate whether you want to receive investment advice through **Advisor™** or make your own investment choice.

Or, call **1-866-346-5800**.

Important: Funds in an HSA are held at various eligible institutions, such as a federally insured bank, credit union, or similar financial institution as listed in the custodial agreement and also listed on the member's monthly account statement.

Investments in securities through HealthEquity Advisors, LLC™ are not FDIC insured, have no bank guarantee and may lose value.

Please consult with your financial and/or tax advisor before taking any action in an investment account.



Health Savings Account (HSA) (continued)

What are the Differences Between an HSA and a Health Care FSA?

	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)
For which plan participants?	Bronze Plus Plan only	Silver Plan, Gold Plan, Bronze Plus Plan (limited scope dental and vision expenses only so you can remain HSA-eligible)
For what types of expenses?	Medical/Pharmacy, Dental, Vision	Medical/Pharmacy (if you have not enrolled for an HSA under the Bronze Plus Plan), Dental and Vision
Unused funds carry over year to year?	Yes	No, claims must be submitted by March 31 of the following year.
Do I own the account?	Yes, you can take it with you if you change medical plans or leave the company.	No, unused funds are forfeited.
Maximum annual contribution?	\$4,300 for Employee Only; \$8,550 if you cover family members*	\$3,300 (2024 projection for 2025)
Can I change my contribution after I enroll?	Yes	No

*If you are age 55 or over, you may contribute an additional \$1,000.

Special HSA Rules

- To be eligible to contribute to an HSA, you must enroll in a Bronze Plus Plan. If you're covered by another medical plan, it must also be a high-deductible medical plan for you to be eligible for an HSA. For example, if you're also enrolled in your spouse's plan, that plan must be a high-deductible medical plan, too. And you can't be covered by your spouse's health care FSA unless it is limited scope.
- You can't contribute to an HSA if:
 - You're enrolled in Medicare Part A or B or a veteran's medical plan.
 - You're claimed as a dependent on someone else's federal tax return.
 - You or your spouse currently participate (or previously participated within the current plan year) in a general purpose (i.e., not limited scope) Health Care Flexible Spending Account (Health Care FSA).
- Although you can enroll your children up to age 26 in your medical coverage, you can't always use money from your HSA to pay their healthcare expenses. For children above age 18 (or under age 24 if they are full-time students), you can only use HSA money for their expenses if the child lives with you for more than six months during the year, you provide more than one-half of their support and the child is not otherwise ineligible for tax-free HSA reimbursements.
- You can't have an HSA and use a general purpose Health Care FSA for medical expenses at the same time. In this situation, your FSA will be considered a limited scope Health Care FSA and you'll be able to use it only to pay for qualified dental and vision expenses. Remember, your HSA can be used for medical, dental and vision expenses. If you currently have money in a Health Care FSA and you want to contribute to an HSA in the next plan year, use the Health Care FSA money by December 31.



After Enrolling

Print or Save Your Election Confirmation. When you've finished enrolling, be sure to print your elections or save to your computer. You can always view later by logging in to the Benefits Enrollment Website and going to **Health & Insurance > Current Elections**. You can print or save from this screen.



NOTE: By submitting your enrollment on the Benefits Enrollment Website, you are authorizing the applicable payroll deductions for the programs/plans that require you to make a contribution for coverage, including any premiums related to smoker status and/or a working spouse/domestic partner (if applicable).

In the event your wages in any pay period are insufficient to cover the entire amount of the insurance premium deductions, you authorize Aramark to deduct any remaining unpaid insurance premium amounts in future pay periods until paid in full.

You also are consenting to the release of necessary healthcare information from your providers to the insurance companies as it relates to the management and processing of any claims. You also authorize Aramark to permit its Business Employees and Disability Administrators to share information related to your benefit claims or those of your dependent(s) for the purpose of case management and statistical analysis and to use your personal information for administration and payroll purposes.

All data will be handled in accordance with state and federal regulations to protect privacy. Aramark will not have direct access to individual claims information but will receive aggregated claims data from Business Associates or Disability Administrators.



Key Contacts

	CONTACT	INFORMATION
Health & Wellness	Quantum Health Care Coordinators* Medical Benefits	Phone: 1-855-497-1241 Website: https://aramarktakecare.com
	Geisinger Medical Benefits	Phone: 1-800-447-4000 Website: https://www.geisinger.org/health-plan
	Kaiser Permanente Medical Benefits	Phone: CA: 1-800-464-4000 CO: 1-303-338-3800 DC, MD, VA: 1-800-777-7902 GA: 1-888-865-5813 HI: 1-800-966-5955 NW (OR and Southern WA): 1-800-813-2000 WA: 1-888-901-4636 Website (WA Regions): https://wa.kaiserpermanente.org Website (All Other Regions): www.kp.org
	UPMC Medical Benefits	Phone: 1-888-876-2756 Website: www.upmchealthplan.com
	Teladoc* Telehealth Benefits	Phone: 1-800-835-2362 (or call Quantum Health at 1-855-497-1241) Website: www.teladoc.com
	Express Scripts* Prescription Drug Benefits	Phone: 1-855-307-4586 Website: www.express-scripts.com/aramark : Pre-enrollment site (check your formulary here) Post-enrollment site: www.express-scripts.com
	Delta Dental Dental Benefits	Phone: 1-800-932-0783 Website: www.deltadentalins.com
	VSP Plan Vision Benefits	Phone: 1-800-877-7195 Website: www.vsp.com
	Vision Savings Pass Vision Benefits	Phone: 1-800-877-7195 Website: www.vsp.com
	VSP TruHearing Hearing Aid Discount Program Hearing Aid Benefits	Phone: 1-877-372-4040 Website: www.truhearing.com/vsp
	HealthEquity Flexible Spending Account (FSA)	Phone: 1-877-924-3967 Website: www.healthequity.com/wageworks
	HealthEquity Health Savings Account (HSA)	Phone: 1-877-924-3967 Website: www.healthequity.com/hsa
	Cigna Behavioral Health Employee Assistance Program (EAP)	Phone: 1-888-636-6717 Website: http://my.cigna.com
	Livongo Diabetes Management Program	Phone: 1-800-945-4355 Website: go.livongo.com
Work/Life	Aramark Benefits Center Life and Accident	Phone: 1-855-528-BENE (2363) Website: https://aramark365.sharepoint.com/sites/Benefits
	Sedgwick Short-Term Disability FMLA/Parental Leave/ADAAA Accommodation	Phone: 1-855-560-4048 Website: https://claimlookup.com
	New York Life Long Term Disability	Phone: 1-800-362-4462
	Fidelity Investment Services Retirement Benefits	Phone: 1-877-236-9472 Website: www.401k.com
Other	Mercer Supplemental Benefits	Phone: 1-800-642-5746 Website: www.aramarksupplementalplans.com
	Aramark Benefits Center Questions on Benefits Enrollment & Payroll Deductions	Phone: 1-855-528-BENE (2363) Website: https://aramark365.sharepoint.com/sites/Benefits
	Quantum Health Care Coordinators* Questions on all other Health Care Needs	Phone: 1-855-497-1241 Website: https://aramarktakecare.com

*For Aetna and Independence Blue Cross Participants. Kaiser, Geisinger and UPMC participants should contact their carrier directly.

This is a brief summary of the Aramark Benefits Program for Salaried employees and serves as the SMM. The Guide describes certain key features of the Program but does not provide detailed information. While we have made every attempt to ensure the accuracy of the information in this Guide, if there is any discrepancy between this Guide and the official plan contracts and documents, the plan contracts and documents will rule. In addition, this Guide does not constitute or imply a contract of employment, nor does it guarantee the continuation of this benefit program. Aramark reserves the right to change, amend or terminate its plans at any time for any reason.



NOTE: If you live in Texas or Illinois, you have a fourth medical plan option in addition to the Bronze Plus, Silver and Gold plans outlined in this guide. This Enrollment Guide does not apply to Next Level Hospitality employees and does not contain details on the Bronze Choice plan for Flowers Sanitation employees. Please review the Medical Plan Options Guides, FAQs, SPDs and other information on the Benefits Enrollment Website for your specific plans.



Back to Main Menu