



NAME: _____ Department _____

Open Enrollment/Change Form for 2026

BLUE CROSS/BLUE SHIELD Medical Plan

Select the plan you are enrolling into for 2026 or WAIVE coverage

- | | |
|---|---|
| ☐ I will keep my current coverage | ☐ WAIVE Medical Plan Coverage |
| ☐ Plan 1 - PPO No Deductible Single Plan | ☐ Plan 1 - PPO No Deductible Family Plan |
| ☐ Plan 2 - PPO Deductible Single Plan | ☐ Plan 2 - PPO Deductible Family Plan |
| ☐ Plan 3 - HDHP Single Plan/HSA | ☐ Plan 3 - HDHP Family Plan/HSA |

If enrolling, attach enrollment form

Ameritas Dental Plan

- ☐ I will keep my current coverage
- ☐ I am enrolling in the dental plan for Single coverage ☐ Family coverage ☐
- ☐ I am opting out of dental coverage for 2026

If enrolling, attach enrollment form

EyeMed Vision Plan

- ☐ I will keep my current coverage
- ☐ I am enrolling in the vision plan for Single coverage ☐ Family coverage ☐
- ☐ I am opting out of vision coverage for 2026

If enrolling, attach enrollment form

HealthEquity Spending Accounts

- | | |
|--|--|
| ☐ I am enrolling in HealthEquity FSA for 2026 | ☐ I am enrolling in HealthEquity HSA for 2026 |
|--|--|
- If enrolling, attach enrollment form** **If enrolling, attach enrollment form**

Optional Supplemental Coverage

- ☐ Contact Aflac for coverage - see flyer in email

RETURN BY 3:00PM FRIDAY, DECEMBER 5TH - THANK YOU!

Signature: _____ Date: _____



BLUE CROSS BLUE SHIELD MEDICAL PLANS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.NebraskaBlue.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family <u>In-Network</u> : \$0/\$0 <u>Out-of-Network</u> : \$500/\$1,000	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your deductible?	Yes, <u>preventive care</u> , <u>prescription drugs</u> , and <u>provider</u> office services.	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>In-Network</u> : \$1,500/\$3,000 <u>Out-of-Network</u> : \$2,000/\$4,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , <u>balance billed</u> charges, penalties, denial for failure to obtain <u>preauthorization</u> and services this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.NebraskaBlue.com/find-a-doctor or call 1-844-201-0763 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drugs, may require preauthorization. Failure to obtain preauthorization will result in denial of the claim.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	30% <u>coinsurance</u>	Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> . <u>Preauthorization</u> may be required.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	30% <u>coinsurance</u>	Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> . <u>Preauthorization</u> may be required.
	<u>Preventive care/screening/immunization</u>	No charge for federally mandated services.	30% <u>coinsurance</u> . For immunizations for children up to age 7, the <u>deductible</u> does not apply.	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. <u>Preauthorization</u> may be required.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need drugs to treat your illness or condition		For all <u>prescription drugs</u> , out-of-pocket costs shown are per 30-day supply. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for <u>specialty drugs</u>) by paying 3 <u>copay</u> amounts. Home delivery benefits are not available <u>out-of-network</u> . The following cost-shares apply only when obtaining drugs through a pharmacy.		
	Generic drugs	\$8/prescription, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> may be required.
	Preferred brand drugs	\$15/prescription, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> may be required.

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about <u>prescription drug coverage</u> is available at www.nebraskablue.com	Non-preferred brand drugs	\$25/prescription, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> may be required.
	<u>Specialty drugs</u>	Same as any other retail drug	Not covered	Retail and home delivery: 30-day supply maximum. Designated pharmacy may apply. <u>Preauthorization</u> may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$75 <u>copay</u> /visit, then 10% <u>coinsurance</u> , <u>deductible</u> does not apply	Same cost shares as <u>in-network provider</u>	<u>Copay</u> waived if admitted. <u>Preauthorization</u> may be required.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> per transport	Same cost shares as <u>in-network provider</u>	Limitations may apply to air ambulance.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	<u>Copay</u> applies to <u>urgent care</u> facilities. Some <u>urgent care</u> services may be subject to the <u>deductible</u> and <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fee	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15 <u>copay</u> /visit Other Outpatient Services: 10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	Some office services may be subject to <u>deductible</u> and <u>coinsurance</u> . <u>Preauthorization</u> may be required.
	Inpatient services	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Copay</u> may apply for visit to determine pregnancy. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copay</u> , <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. <u>Preauthorization</u> may be required.
	Childbirth/delivery professional services	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	See pregnancy office visits limit. <u>Preauthorization</u> may be required.
	Childbirth/delivery facility services	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	See pregnancy office visits limit. <u>Preauthorization</u> may be required.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Home health aide</u> : 60 days per calendar year. <u>Skilled nursing in the home</u> : Limited to 8 hours per day. <u>Respiratory care</u> : 60 days per calendar year. <u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	Outpatient therapy: \$15 <u>copay</u> /visit Manipulations: \$15 <u>copay</u> /visit Other services: 10% <u>coinsurance</u>	Outpatient therapy: 30% <u>coinsurance</u> Manipulations: 30% <u>coinsurance</u> Other services: 30% <u>coinsurance</u>	<u>Outpatient physical, occupational, speech, physiotherapy</u> : Combined 60 session limit per calendar year. <u>Manipulations and adjustments</u> : Combined 20 session limit per calendar year. <u>Outpatient cardiac rehabilitation</u> : Combined 18 session limit per diagnosis. <u>Outpatient pulmonary rehabilitation</u> : Combined 18 session limit per diagnosis for certain diagnoses and criteria. <u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	Outpatient therapy: \$15 <u>copay</u> /visit Other services: 10% <u>coinsurance</u>	Outpatient therapy: 30% <u>coinsurance</u> Other services: 30% <u>coinsurance</u>	See the <u>Rehabilitation services</u> and <i>If you have a hospital stay</i> sections. Educational services are not covered. <u>Preauthorization</u> may be required.

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<i>In the home:</i> See the <u>Home health care</u> section. <u>Skilled nursing care</u> : Limited to 60 days per calendar year. <u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	Rental or purchase, whichever is least costly. <u>Preauthorization</u> may be required.
	<u>Hospice services</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u>	30% <u>coinsurance</u>	Visual acuity tests are covered under the <u>preventive services</u> benefit. Eye exam limited to 1 per calendar year. Pediatric vision services are limited to covered persons up to age 19. Additional vision services may be available when <u>medically necessary</u> . <u>Preauthorization</u> may be required.
	Children's glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
	Children's dental check-up	<u>Preventive</u> , Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	<u>Preventive</u> , Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	No coverage for dental check-up.

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|------------------------|--------------------------|------------------------|
| • Acupuncture | • Dental care (children) | • Long-term care |
| • Bariatric surgery | • Glasses (children) | • Private-duty nursing |
| • Cosmetic surgery | • Infertility treatment | • Weight loss programs |
| • Dental care (adults) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---------------------|--|---------------------|
| • Chiropractic care | • Non-emergency care when traveling outside the US | • Routine foot care |
| • Hearing aids | • Routine eye care (adults) | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or your employer's human resources department. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Nebraska at 1-844-201-0763 or visit www.NebraskaBlue.com, the Nebraska Department of Insurance at 1-877-564-7323 or www.doi.ne.gov, for group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, your employer's human resources or employee benefits department.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Language Access Services:

Para obtener asistencia en Español, llame al 1-844-201-0763.

如果需要中文的帮助, 请拨打这个号码 1-844-201-0763.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-201-0763.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-201-0763.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copay</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$1,100
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$60
The total Peg would pay is	\$1,250

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copay</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$50
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$70
The total Joe would pay is	\$520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copay</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$0
The total Mia would pay is	\$400

The plan would be responsible for the other costs of the EXAMPLE covered services.



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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family In-Network: \$500/\$1,000 Out-of-Network: \$1,000/\$2,000	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your deductible?	Yes, <u>preventive care</u> , <u>prescription drugs</u> , and <u>provider</u> office services.	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$1,500/\$3,000 Out-of-Network: \$4,000/\$8,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance billed</u> charges, penalties, denial for failure to obtain <u>preauthorization</u> and services this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.NebraskaBlue.com/find-a-doctor or call 1-844-201-0763 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drugs, may require preauthorization. Failure to obtain preauthorization will result in denial of the claim.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	30% <u>coinsurance</u>	Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> . <u>Preauthorization</u> may be required.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	30% <u>coinsurance</u>	Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> . <u>Preauthorization</u> may be required.
	<u>Preventive care/screening/immunization</u>	No charge for federally mandated services.	30% <u>coinsurance</u> . For immunizations for children up to age 7, the <u>deductible</u> does not apply.	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. <u>Preauthorization</u> may be required.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need drugs to treat your illness or condition	For all <u>prescription drugs</u> , out-of-pocket costs shown are per 30-day supply. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for <u>specialty drugs</u>) by paying 3 <u>copay</u> amounts. Home delivery benefits are not available <u>out-of-network</u> . The following cost-shares apply only when obtaining drugs through a pharmacy.			
	Generic drugs	\$10/prescription, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> may be required.
	Preferred brand drugs	\$25/prescription, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> may be required.
	Non-preferred brand drugs	\$40/prescription, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply plus 25% penalty	<u>Preauthorization</u> may be required.
More information about <u>prescription drug coverage</u> is available at www.nebraskablue.com				

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	Same as any other retail drug	Not covered	Retail and home delivery: 30-day supply maximum. Designated pharmacy may apply. <u>Preauthorization</u> may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	Same cost shares as in-network provider	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	Same cost shares as in-network provider	Limitations may apply to air ambulance.
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15 <u>copay</u> /visit Other Outpatient Services: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Some office services may be subject to <u>deductible</u> and <u>coinsurance</u> . <u>Preauthorization</u> may be required.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Copay</u> may apply for visit to determine pregnancy. <u>Cost sharing</u> does not apply to certain preventive services. Depending on the type of services, <u>copay</u> , <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. <u>Preauthorization</u> may be required.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	See pregnancy office visits limit. <u>Preauthorization</u> may be required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	See pregnancy office visits limit. <u>Preauthorization</u> may be required.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Home health aide</u> : 60 days per calendar year. <u>Skilled nursing in the home</u> : Limited to 8 hours per day. <u>Respiratory care</u> : 60 days per calendar year. <u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	Outpatient therapy: 10% <u>coinsurance</u> Manipulations: 10% <u>coinsurance</u> Other services: 10% <u>coinsurance</u>	Outpatient therapy: 30% <u>coinsurance</u> Manipulations: 30% <u>coinsurance</u> Other services: 30% <u>coinsurance</u>	<u>Outpatient physical, occupational, speech, physiotherapy</u> : Combined 60 session limit per calendar year. <u>Manipulations and adjustments</u> : Combined 20 session limit per calendar year. <u>Outpatient cardiac rehabilitation</u> : Combined 18 session limit per diagnosis. <u>Outpatient pulmonary rehabilitation</u> : Combined 18 session limit per diagnosis for certain diagnoses and criteria. <u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	Outpatient therapy: 10% <u>coinsurance</u> Other services: 10% <u>coinsurance</u>	Outpatient therapy: 30% <u>coinsurance</u> Other services: 30% <u>coinsurance</u>	See the <u>Rehabilitation services</u> and <i>If you have a hospital stay</i> sections. Educational services are not covered. <u>Preauthorization</u> may be required.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<i>In the home</i> : See the <u>Home health care</u> section. <u>Skilled nursing care</u> : Limited to 60 days per calendar year. <u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Rental or purchase, whichever is least costly. <u>Preauthorization</u> may be required.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Visual acuity tests are covered under the <u>preventive services</u> benefit. No coverage for eye exams.
	Children's glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
	Children's dental check-up	<u>Preventive</u> , Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	<u>Preventive</u> , Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adults)
- Dental care (children)
- Glasses (children)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adults)
- Routine eye care (children)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the US
- Routine foot care

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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Nebraska at 1-844-201-0763 or visit www.NebraskaBlue.com, the Nebraska Department of Insurance at 1-877-564-7323 or www.doi.ne.gov, for group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, your employer's human resources or employee benefits department.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-844-201-0763.

如果需要中文的帮助, 请拨打这个号码 1-844-201-0763.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-201-0763.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-201-0763.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copay</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$60
The total Peg would pay is	\$1,540

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copay</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$70
The total Joe would pay is	\$1,070

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copay</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$0
The total Mia would pay is	\$770

The plan would be responsible for the other costs of the EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.NebraskaBlue.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family In-Network: \$3,400/\$6,800 Out-of-Network: \$5,400/\$10,800	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your deductible?	Yes, <u>preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$5,000/\$10,000 Out-of-Network: \$10,000/\$20,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance billed</u> charges, penalties, denial for failure to obtain <u>preauthorization</u> and services this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.NebraskaBlue.com/find-a-doctor or call 1-844-201-0763 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drugs, may require preauthorization. Failure to obtain preauthorization will result in denial of the claim.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Preventive care/screening/immunization</u>	No charge for federally mandated services.	30% <u>coinsurance</u> . For immunizations for children up to age 7, the <u>deductible</u> does not apply.	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. <u>Preauthorization</u> may be required.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need drugs to treat your illness or condition	For all <u>prescription drugs</u> , out-of-pocket costs shown are per 30-day supply. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for <u>specialty drugs</u>) by paying 3 <u>copay</u> amounts. Home delivery benefits are not available <u>out-of-network</u> . The following cost-shares apply only when obtaining drugs through a pharmacy.			
	Generic drugs	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Preferred brand drugs	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Non-preferred brand drugs	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
More information about <u>prescription drug coverage</u> is available at www.nebraskablue.com				

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not covered	Retail and home delivery: 30-day supply maximum. Designated pharmacy may apply. <u>Preauthorization</u> may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	Same cost shares as in-network provider	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Same cost shares as in-network provider	Limitations may apply to air ambulance.
	<u>Urgent care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fee	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. <u>Preauthorization</u> may be required.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	See pregnancy office visits limit. <u>Preauthorization</u> may be required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	See pregnancy office visits limit. <u>Preauthorization</u> may be required.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Home health aide</u> : 60 days per calendar year. <u>Skilled nursing in the home</u> : Limited to 8 hours per day. <u>Respiratory care</u> : 60 days per calendar year. <u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	Outpatient therapy: 20% <u>coinsurance</u> Manipulations: 20% <u>coinsurance</u> Other services: 20% <u>coinsurance</u>	Outpatient therapy: 30% <u>coinsurance</u> Manipulations: 30% <u>coinsurance</u> Other services: 30% <u>coinsurance</u>	<u>Outpatient physical, occupational, speech, physiotherapy</u> : Combined 60 session limit per calendar year. <u>Manipulations and adjustments</u> : Combined 20 session limit per calendar year. <u>Outpatient cardiac rehabilitation</u> : Combined 18 session limit per diagnosis. <u>Outpatient pulmonary rehabilitation</u> : Combined 18 session limit per diagnosis for certain diagnoses and criteria. <u>Preauthorization</u> may be required.
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	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Rental or purchase, whichever is least costly. <u>Preauthorization</u> may be required.
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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Visual acuity tests are covered under the <u>preventive services</u> benefit. No coverage for eye exams.
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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
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- Dental care (adults)
- Dental care (children)
- Glasses (children)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adults)
- Routine eye care (children)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-844-201-0763.

如果需要中文的帮助, 请拨打这个号码 1-844-201-0763.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-201-0763.

Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-844-201-0763.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,600
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$60
The total Peg would pay is	\$5,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$70
The total Joe would pay is	\$3,570

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or <u>exclusions</u>	\$0
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of the EXAMPLE covered services.



DENTAL PLAN

Dental Plan Benefits

Networks: Classic & Plus

Type 1 Preventive No Waiting Period	100%	Routine Exam (2 per Benefit Period) Bitewing X-rays (2 per Benefit Period) Cleaning (4 per Benefit Period) Fluoride for Children 18 and under (1 per Benefit Period) Sealants 18 and under (1 in 3 years 1st and 2nd permanent molars)
Type 2 Basic No Waiting Period	80%	Surgical Extractions Simple Extractions Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Periodontics (nonsurgical) Endodontics (surgical) Periodontics (surgical)
Type 3 Major No Waiting Period	50%	Crowns (1 in 5 years per tooth) Prosthodontics (Bridges, Dentures) (1 in 5 years) Implants (1 in 5 years)

Deductible

Type 1	\$0
Type 2 and 3	\$50 per person, per calendar year
Family Maximum	\$150 per Calendar Year

Benefit Year Maximum

Type 1, 2, and 3 (per person, per calendar year)	\$1,500
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Orthodontia Benefits (adult ortho included)

No waiting period	
Plan Benefit	50%
Lifetime Deductible	\$0
Lifetime Maximum (per person)	\$1,500

Claims Allowance

Type 1, 2 and 3	90th U&C
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In network allowance is discounted fee

Open Enrollment

If you do not elect to participate when initially eligible, you may elect to participate at the policyholder's next enrollment period, which normally coincides with the policy anniversary date.

Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When you visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at Ameritas.com.



The Ameritas Dental Network is one of the nation's largest.

Network providers have agreed to charge **25-50% less** than their regular rates which can lower your out-of-pocket costs.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

Member Savings

Prescription savings

Just for participating in our dental, vision or hearing care plans, members can save big on prescription medications through one of the world's largest retailers. **No additional cost. Only savings.**

Extra Value

Our plan members, their covered dependents can **save on prescription medications at over 60,000 pharmacies across the nation** including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

Participating pharmacies will give Ameritas plan members their normal health care pharmacy benefit, or the prescription discount, whichever saves them more. Even if the employees already have health insurance pharmacy benefits, they are welcome to check out this Rx discount.

Find a pharmacy near you – <http://www.emsmed.com/vendors/pharmacy.aspx>

Look up a price – <http://www.emsmed.com/vendors/rxpricing.aspx?groupid=Ameritas>

Rx Savings

Members can receive up to 65% savings on generic prescriptions, and overall average savings of 40% across brand name and generic prescription combined.



Save on frames and lenses

Save up to 30% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. This is available to you without any additional cost to your plan premium.

You may receive savings on the following vision care products at Walmart Vision Centers:



- **top quality frames** for the entire family including today's most popular brands.



- **wide selection of lens options**; all lenses come with scratch resistant coating for no additional charge.



- **safety eyewear.**

Guarantees

Walmart Vision Centers stand behind their products and workmanship by offering:

- 60-day frame and lens satisfaction guarantee.
- 12-month replacement guarantee on broken or damaged frames or lenses.
- lifetime adjustments and cleanings.

Customer Service

Customer Connections **800-487-5553** www.Ameritas.com

Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.



VISION PLAN

Got questions? We've got answers.

HOW DO I USE MY BENEFITS?

It's a lot easier than other kinds of benefits you might have. Just choose an in-network eye doctor from the Enhanced Provider Search on eyemed.com, schedule your visit, and go in for care or eyewear. You don't even need your ID card if you don't have it – just give them your name. When you stay in-network, we'll handle all the paperwork.

CAN I VIEW MY EYEMED BENEFITS ONLINE?

Yes, you can view your benefits and do a lot more on our secure member portal – such as print an ID card, check the status of a claim, locate a provider and download an Explanation of Benefits.

HOW DO I GET ON-THE-GO ACCESS?

Download the EyeMed Members App (App Store or Google Play) to get the same features, plus the ability to save a vision prescription, set an eye exam reminder or save your ID card to your wallet (iOS only).

HOW DO I SUBMIT A CLAIM?

When you see one of our in-network providers, we take care of all the paperwork. If you visit an out-of-network provider AND have out-of-network benefits as part of your plan, you'll need to pay during the visit and submit a claim form online for reimbursement. Remember to upload an itemized paid receipt with your name included.

WILL I GET AN ID CARD? HOW DO I ORDER REPLACEMENTS OR EXTRA CARDS?

We send 2 ID cards in the subscriber's name when you join EyeMed, but you don't have to have it when you visit your eye doctor. If you lose your card or need extras for your family, you can print a replacement on the member portal. Or to pull up a digital version anytime, anywhere, download the EyeMed Members App through the App Store or Google Play.

HOW DO I FIND AN EYE DOCTOR IN YOUR NETWORK?

Our Enhanced Provider Search on eyemed.com has more than 100,000 network providers to choose from. You can filter your search to find ones near you that have the frame brands, hours and services you want most.



eye
Med

DOES EYEMED OFFER ANY ADDITIONAL DISCOUNTS?

We sure do. At participating in-network providers, members get extra savings like 40% off complete additional pair of eyeglasses or 20% off non-prescription sunglasses and accessories. (These discounts are for in-network providers only. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Additional limitations and exclusions may apply. Log in to member portal for full details.)

Don't like wearing glasses or contacts? No problem. We also offer discounts on LASIK laser vision correction. Learn more about LASIK or call 1.800.988.4221 to find a US Laser Network provider.

HOW CAN I SEE INFORMATION ABOUT MY DEPENDENTS?

If they're under the age of 18, their information will be listed with yours on the member portal. But, due to privacy rules, dependents 18 or older won't be listed there. They'll need to register for their own account.

DOES EYEMED SELL INDIVIDUAL INSURANCE PLANS?

You bet. Visit eyemed.com to see if an individual plan is offered in your state.

CAN I USE MY BENEFITS ONLINE?

Absolutely. Apply EyeMed benefits in your shopping cart at many popular online eyewear stores, with free shipping, free returns and no paperwork. Visit any of our online network options:

- lenscrafters.com
- glasses.com
- targetoptical.com
- contactsdirect.com
- ray-ban.com

CAN I USE FSA FUNDS AFTER MY EYEMED BENEFIT IS APPLIED?

Sure. A Flexible Spending Account (FSA) is great for paying for a variety of health-related out-of-pocket expenses, including vision care. You can use FSA money for the eye exam copay, prescription glasses or contact lenses, supplies such as contact lens solution, even LASIK surgery. Vision care out-of-pocket costs are also eligible for Health Savings Account reimbursement, though these expenses don't count toward your annual deductible.

I DON'T WEAR GLASSES AND CAN SEE FINE. WHY DO I NEED AN EYE EXAM?

Getting an eye exam isn't just about needing glasses. It's also about your health. An eye exam can detect eye health problems like glaucoma or cataracts, but it may also help identify signs of serious diseases, like high blood pressure, diabetes and high cholesterol – just to name a few.¹ We talk about the vision/health link a lot at eyesiteonwellness.com.



AT WHAT AGE SHOULD MY CHILD FIRST VISIT THE EYE DOCTOR?

The American Optometric Association recommends a first eye exam with an optometrist or ophthalmologist between 6 months and 1 year of age.² The doctor may check for things like nearsightedness, farsightedness, astigmatism, amblyopia (or “lazy eye”), proper eye movement and eye alignment, and how the eye reacts to light and darkness. They also recommend an exam between the ages of 3 and 5, and every year after that. During these exams, many doctors may do a comprehensive eye exam and vision screening tests, depending on the child’s vision needs. To learn more about your child’s vision, visit eyesiteonwellness.com.

MY CHILD GETS A VISION SCREENING AT SCHOOL. IS THERE STILL A NEED FOR AN EYE EXAM?

A vision screening does not take the place of an eye exam. Generally, they check a child’s ability to see far away and check for color blindness, but a comprehensive eye exam evaluates the entire structure of the eye and also allow the doctor to view nerves and blood vessels, providing a glimpse into a child’s overall health. Eye doctors may also check for farsightedness, which is more common in younger children.³

HOW OFTEN SHOULD I GET AN EYE EXAM?

Vision changes can happen slowly – you may not even notice it. Annual eye exams are a good rule of thumb unless your doctor suggests more frequent checks; we suggest making it part of your regular preventive care routine.



¹ 5 Health Problems Eye Exams Can Detect,” YourSightMatters.com, March, 2016.

² Recommended eye examination frequency for pediatric patients and adults,” American Optometric Association, <https://www.aoa.org/patients-and-public/caring-for-your-vision/comprehensive-eye-and-vision-examination/recommended-examination-frequency-for-pediatric-patients-and-adults>. Accessed January 2019.

³ All About Vision, “Vision Problems of Preschool Children,” Oct. 26, 2017, <http://www.allaboutvision.com/parents/preschool.htm>



FLEXIBLE SPENDING ACCOUNTS (FSA) & HEALTH SAVINGS ACCOUNTS (HSA)

Flexible Spending Account

A healthcare FSA lets you use tax-free money to pay for eligible medical, dental, and vision expenses.¹ So you spend less on the healthcare you need. FSA paycheck deductions are tax-free too, which helps reduce your taxable income. The more you contribute, the more you save.

- ✓ Access annual contribution amount on day one.
- ✓ Pay for your spouse and dependents too.
- ✓ Plan ahead because FSA funds eventually expire.

Less tax. More paycheck.

Get \$20 tax savings for every \$100 you contribute.²

FSA

Tax-free

No FSA

Taxed

FSA Contribution Limit³

\$3,400



**See how much
you can save.**

HealthEquity.com/Learn/FSA

**Scan to download the
HealthEquity mobile app.**



Already enrolled?
Set up your account
directly in the app.
No need to go online.

**Spend tax-free on
eligible expenses.**

- Medical
- Dental
- Vision
- Rx and OTC

Discover more: HealthEquity.com/QME

¹FSAs are never taxed at a federal income tax level when used appropriately for eligible healthcare expenses. Also, most states recognize FSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | ²The example is for illustrative purposes only. Estimated savings are based on a maximum annual contribution and an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your contribution amount and taxable income and tax status. | ³Contribution limit is accurate as of 10/09/25. Each fall the IRS updates the FSA contribution limits. For the latest information, please visit: HealthEquity.com/Learn | HealthEquity does not provide legal, tax or financial advice.

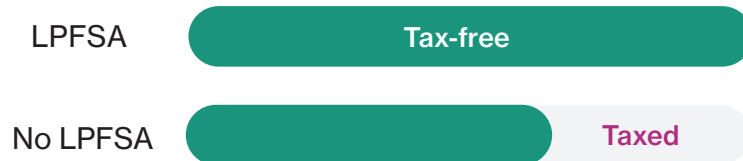
Limited Purpose Flexible Spending Account

An LPFSA lets you use tax-free money to pay for eligible dental and vision expenses.¹ So you spend less on what you need. It also makes a great companion to a Health Savings Account (HSA). Use your LPFSA for dental and vision expenses and keep your HSA growing tax-free for other future healthcare needs.

- ✓ Access annual contribution amount on day one.
- ✓ Pay for your spouse and dependents too.
- ✓ Plan ahead because LPFSA funds eventually expire.

Less tax. More paycheck.

Get \$20 tax savings for every \$100 you contribute.²



LPFSA Contribution Limit³
\$3,400



**See how much
you can save.**

HealthEquity.com/Learn/LPFSA

**Scan to download the
HealthEquity mobile app.**



Already enrolled?
Set up your account
directly in the app.
No need to go online.

**Spend tax-free on
eligible expenses.**

- Vision
- Dental
- Contacts
- Orthodontia

Discover more: HealthEquity.com/QME

¹LPFSAs are never taxed at a federal income tax level when used appropriately for eligible dental and vision expenses. Also, most states recognize LPFSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | ²The example is for illustrative purposes only. Estimated savings are based on a maximum annual contribution and an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your contribution amount and taxable income and tax status. | ³Contribution limit is accurate as of 10/09/2025. Each fall the IRS updates the LPFSA contribution limits. For the latest information, please visit: HealthEquity.com/Learn | HealthEquity does not provide legal, tax or financial advice.

Dependent Care Flexible Spending Account

A DCFSA lets you use tax-free money to pay for eligible dependent care expenses.¹ A qualifying 'dependent' may be a child under age 13, a disabled spouse, or an older parent in eldercare. DCFSA paycheck deductions are tax-free too, which helps reduce your taxable income. The more you contribute, the more you save.

- ✓ Access funds as you make contributions.
- ✓ Enjoy fast, hassle-free reimbursement.
- ✓ Plan ahead because DCFSA funds eventually expire.

**Less tax.
More paycheck.**

Get \$20 tax savings for every \$100 you contribute.²

DCFSA	Tax-free
No DCFSA	Taxed

DCFSA Contribution Limit³
\$7,500



See how much
you can save.
HealthEquity.com/Learn/DCFSA

Scan to download the
HealthEquity mobile app.



Already enrolled?
Set up your account
directly in the app.
No need to go online.

**Spend tax-free on
eligible expenses.**

- Daycare
- Babysitter
- Elder care
- Preschool

Discover more: HealthEquity.com/QME

¹DCFSA's are federally tax-deductible for eligible expenses and usually state-deductible; consult a tax advisor for details. | ²Example for illustration only; savings based on a 20% federal and state tax bracket. | ³Contribution limit accurate as of 07.14.2025. Limit increase effective 01.01.2026. See the latest info. at HealthEquity.com/learn | HealthEquity does not provide legal or tax advice.

Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:¹ Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- ✓ Rolls over every year – funds never expire
- ✓ Available tax-free investing, just like a 401(k)²
- ✓ Requires an eligible high-deductible health plan (HDHP)

Less tax. More paycheck.

Get \$20 tax savings for every \$100 you contribute.³

HSA

Tax-free

No HSA

Taxed

2026 HSA Contribution Limits



\$4,400

Individual plan



\$8,750

Family plan

Members 55+ can contribute an extra \$1,000.



**See how much
you can save.**

HealthEquity.com/Learn/HSA

**Scan to download the
HealthEquity mobile app.**



You can set up your account directly in the app – no need to register online.

Spend tax-free on HSA-qualified expenses.

- Medical
- Vision
- Dental
- Rx and OTC

Discover more: HealthEquity.com/QME

¹HSAs are federally tax-deductible for qualified medical expenses and usually state-deductible; consult a tax advisor for details. | ²Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. | ³Example for illustration only; savings based on a 20% federal and state tax bracket. | HealthEquity does not provide legal, tax or financial advice.