2026 BENEFIT GUIDE

January 1 – December 31, 2026

NEXCESS

WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the 1st of month following your date of hire. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1st, 2026.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- Lost coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

INSIDE

ENROLLMENT

Go to www.workforcenow.adp.com There you will find detailed information about the plans available to you and instructions for enrolling.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

OPEN ENROLLMENT DETAILS

Remember, Open Enrollment is an opportunity to make changes to your benefits without a qualifying life event. During this time, you can:

- Add, cancel or change your coverage
- Add or remove eligible family members
- Elect your 2026 HSA contributions (If eligible)
- Enroll in the health care and/or dependent care FSAs (**Note:** The IRS requires you to re-enroll in the FSAs each year)

MARK YOUR CALENDARS

Open Enrollment Begins:

November 13th, 2025

Deadline to Enroll:

November 23rd, 2025

Benefits in Effect:

January 1st, 2026

Virtual benefits information sessions:

November 13th at 2pm EST

November 14th at 9am EST

Click here to watch a video about Open Enrollment.

Important Changes

Each year the Company reviews our benefits program to ensure our partners provide comprehensive and affordable coverage. This year, we're pleased to announce new offerings for our employees to help you better manage your health and well-being in the new year.

2026 Updates At-a-Glance

- This Open Enrollment is Active and requires you to log in and elect your benefits decisions for 2026.
- You must actively re-enroll in the HSA, health care and dependent care FSAs to participate in 2026.
- We are please to confirm the GLP-1 medications will continue to be covered under our new medical plans for FDA approved medical necessity **only**. If you are currently using a GLP-1 medication for weight management, we encourage you to speak with your healthcare provider to review other treatment options in light of this change.

MEDICAL COVERAGE

HDHP + HSA

The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Cigna, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit Publication 502.

Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- The HDHP includes copays for prescription drugs only. You must meet the annual deductible before prescription copays apply.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

PPO

The Preferred Provider Organization (PPO) plan, provided through Cigna, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered "in-network." In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, see page 10 in this benefit guide.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	HDHP + HSA		PPO	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$1,700 / $3,400 [2]	$4,000 / $8,000 [2]	$1,750 / $3,500 [3]	$3,500 / $7,000 [3]
Out-of-Pocket Max (Individual/Family)	$3,000 / $6,000 [4]	$6,000 / $12,000 [4]	$5,000 / $10,000 [5]	$10,000 / $20,000 [5]
Office Visits (physician/specialist)	20%*	40%*	$30	40%*
Virtual Visits (physician/specialist)	20%*	Not Covered	$10 / $30	Not Covered
Routine Preventive Care	No Charge	40%*	No Charge	40%*
Diagnostics (lab/X-ray)	20%*	40%*	20%*	40%*
Complex Imaging	20%*	40%*	20%*	40%*
Ambulance	20%*		20%*	
Emergency Room	20%*		$250 Copay	
Urgent Care Facility	20%*		$70 Copay	40%*
Inpatient Hospital Stay	20%*	40%*	20%*	40%*
Outpatient Surgery	20%*	40%*	20%*	40%*
Prescription (Tier 1/Tier 2/Tier 3)	$10* / $30* / $50*	Not Covered	$10 / $30 / $60	Not Covered
Prescription Mail Order - 90 day supply (Tier 1/Tier 2/Tier 3)	$30* / $90* / $150*		$30 / $90 / $180	

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is aggregate. With an aggregate deductible, the full family deductible must be met before coinsurance applies to any individual.
3. The deductible is embedded. This means that once a family member meets their individual deductible, the plan will begin to pay coinsurance for that family member.
4. The out-of-pocket maximum is aggregate. With an aggregate out-of-pocket maximum, the full family out-of-pocket maximum must be met before an individual's expenses are covered at 100%.
5. The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Click here to watch a video about preventive care.

VIRTUAL VISITS

MDLive with Cigna

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Call (888)726-3171 or visit www.mycigna.com

Click here to watch a video about how telehealth works.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

DENTAL COVERAGE

PPO

The dental Preferred Provider Organization (PPO) plan, provided through Cigna, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in Cigna's Dental network.

To find an in-network provider, see page 10 in this benefit guide.

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	Dental PPO	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$25 / $75	$25 / $75
Annual Benefit Maximum (per person)	$1,500	$1,500
Preventive Services	100%	100% of Allowable Charges
Basic Services	80%*	80% of Allowable Charges*
Major Services	50%*	50% of Allowable Charges*
Orthodontic Services (Child Only)	$1,500	$1,500

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VISION COVERAGE

Vision Plan

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through EyeMed, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the Insight network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of providers. The provider will coordinate all necessary authorizations you supply in your membership information.

Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

Nexcess offers vision coverage to you at no charge!

To find an in-network provider, see page 10 in this benefit guide.

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Vision	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 Months)	$10 Copay	Up to $50
Materials Copay	$20 Copay	$20 Copay
Frames (once every 12 Months)	20% off balance over $150 allowance	Up to $97.50
Lenses (once every 12 Months)		
Single Vision	No charge after $20 Materials Copay	Up to $50
Bifocal		Up to $70
Trifocal		Up to $90
Contact Lenses (in lieu of glasses; once every 12 Months)		
Medically Necessary	$0 Copay	Up to $210
Elective	15% off balance over $110 allowance	Up to $110

FIND A PROVIDER

Find a Medical and Dental Provider

1. Go to www.Cigna.com and click "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select: "Employer or School"
2. Change the geographic location to the city/state or zip code you want to search.
3. Select the search type and enter a name, specialty or other search term.
4. Click on one of the suggestions or the magnifying glass icon to see your results.
5. Answer any clarifying questions, and then verify where you live (as that will determine the networks available).
6. Questions? Call: **888-806-5094**

Find a Vision Provider

1. Go to Vision Provider Locator
2. Select either "Search by Location" or Search by Doctor" – you are in the **Insight Network**
3. Change the geographic location to the city/state or zip code you want to search.
4. Click on any of your in-network options to begin scheduling your appointment!
5. Questions? Call: **866-723-0596**

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP + HSA features an HSA provided through Health Equity. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.

Employees who elect the HDHP + HSA plan, and make less than $100k annually, will receive $250 HSA seed money from Nexcess.

- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2026
Individual	$4,400
Family	$8,750
Catch-up Contributions	$1,000

Click here to watch a video about HSA limits.

(Employer cont.)

HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a "health care 401(k)." There is no "use it or lose it" rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,[1] retire or leave the organization.

Preventive Medications List

If you are enrolled in an HSA-compatible medical plan, you may be able to access a range of preventive medications for a copay or coinsurance before meeting your deductible. These medications are contained in the HSA Preventive Drug List provided by your employer.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

1. You must be enrolled in an IRS-qualified high-deductible health plan to contribute to an HSA.

Click here to watch a video about how an HSA works.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending accounts (FSAs), provided through Health Equity, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts.

	Health Care FSA (HCFSA)	Limited-Purpose FSA (LPFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be benefits eligible; enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	You must be benefits eligible; most employers also require enrollment in a qualified high-deductible health plan	Available to all eligible employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Dental and vision coinsurance only • Dental and vision deductibles only • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	$3,400	$3,400	$7,500 per family (or $3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds of up to $660 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $660 will **not** be returned to you or carried over to the following year.
- **LPFSA:** This type of account can be used toward eligible dental and vision expenses only.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.
- **Grace Period:** There is 2.5 month grace period during which you can continue to use your remaining health care and limited-purpose FSA balance in the next plan year. This grace period ends on March 15, and you must submit expenses for reimbursement by March 31. Any funds in your account after this date will be forfeited.

Click here to watch a video about how an FSA works.

Click here to watch a video comparing an HSA and an FSA.

401(K) RETIREMENT SAVINGS ACCOUNT

TRANSAMERICA®

According to experts, you should aim to have 70–80% of your pre-retirement income saved by the time you retire. With help from the 401(k) provided through TransAmerica you can help secure your financial future. Whether retirement is decades away or just around the corner, the time to save for retirement is today.

Click here to watch a video about how a retirement plan works.

The Basics

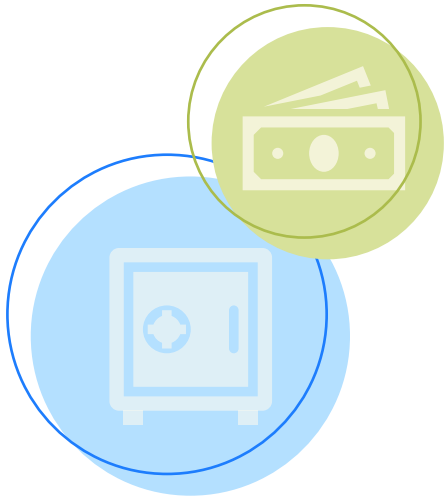
- The 401(k) is a tax-advantaged savings account that lets you save money for retirement.
- You can contribute either pre-tax or after-tax tax funds through automatic payroll deductions.
- How much you can contribute depends on the annual limits set by the IRS. Catch-up contributions are also allowed if you are age 50 or older.
- Vesting period: 2 years

Employer Match

To help the account grow, we match your contributions as outlined below:

- 100% match on the first 3% of your deferred compensation
- 25% match on the next 2% of your deferred compensation

This results in a **total potential employer match of 3.5%** when you contribute at least 5% of your compensation to the plan.



LIFE INSURANCE

Life insurance, provided through Mutual Of Omaha, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Employee	$50,000

Click here to watch a video about how life insurance works.

Supplemental Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	$500,000, in increments of $10,000	$150,000
Spouse	100% of employee's benefit, in increments of $5,000, up to $250,000	100% of employee's benefit, up to $50,000
Child(ren)	100% of employee's benefit, in increments of $1,000, up to $10,000 minimum benefit of $2,000	$10,000

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

Age Banded per $1,000 of Coverage	Monthly EE & SP Rate (per $1,000)
00 – 29	$0.06
30 – 34	$0.06
35 – 39	$0.09
40 – 44	$0.14
45 – 49	$0.24
50 – 54	$0.38
55 – 59	$0.56
60 – 64	$0.73
65 – 69	$1.05
70 – 74	$1.77
75+	$4.72

Per $1,000 of Coverage	Monthly CH Rate (per $1,000)
Applicable Ages	$0.16

DISABILITY INSURANCE

Mutual of Omaha

Disability insurance, provided through Mutual Of Omaha, provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Short-Term Disability

Provided at an affordable group rate.	
Benefit	60% of base salary
Maximum weekly benefit	$1,500
When benefit begins[1]	After 1st day of your accident; After 7th day of your illness
When benefit ends	13 weeks

1. Subject to 3/6 pre-existing condition exclusion. Any medical condition for which the insured received treatment within the 3 months prior to the effective date of coverage is excluded from benefits.Once you have been insured for 6 months, the exclusion no longer applies.

Long-Term Disability

Provided at an affordable group rate.	
Benefit	60% of base salary
Maximum monthly benefit	$15,000
When benefit begins[1]	After 90th day of disability
When benefit ends	Social Security Normal Retirement Age (SSNRA)*

* See Benefit Summary for full Benefit Reduction Schedule.
1. Subject to 3/12 pre-existing condition exclusion. If you file a claim within the first 12 months of your policy, Mutual of Omaha will look back 3 months prior to the policy's effective date to determine if the reported condition was pre-existing.

STD Age Banded Monthly Rates		LTD Age Banded Monthly Rates	
<24	$0.204	**<24**	$0.09
25 – 29	$0.236	**25 – 29**	$0.09
30 – 34	$0.244	**30 – 34**	$0.10
35 – 39	$0.236	**35 – 39**	$0.14
40 – 44	$0.314	**40 – 44**	$0.25
45 – 49	$0.330	**45 – 49**	$0.39
50 – 54	$0.511	**50 – 54**	$0.59
55 – 59	$0.550	**55 – 59**	$0.83
60 – 64	$0.676	**60 – 64**	$0.82
65 – 69	$0.747	**65 – 69**	$0.89
70 +	$0.747	**70 +**	$0.62

Click here to watch a video about how disability insurance works.

VOLUNTARY BENEFITS

Accident Insurance

Accident insurance, provided through Mutual Of Omaha, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

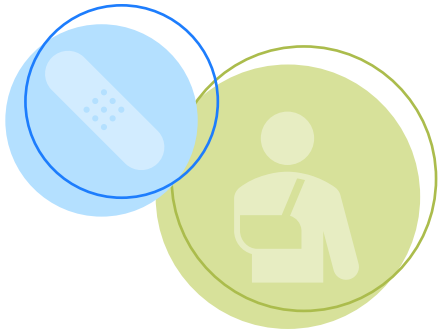
Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions
- Accident Insurance

Click here to watch a video about how an accident plan works.

Accident Insurance in Practice	
Situation	Abed broke his leg in a bike accident.
Covered Benefits	• Doctor's office visits • Diagnostic exams • Broken leg rehab treatment • Physical therapy sessions
Total Benefit Paid Directly to Employee	$4,250

Coverage	Per Paycheck Monthly Contributions
	Accident
Employee Only	$11.77
Employee + Spouse	$19.36
Employee + Child(ren)	$20.74
Family	$28.22



VOLUNTARY BENEFITS

Critical Illness Insurance

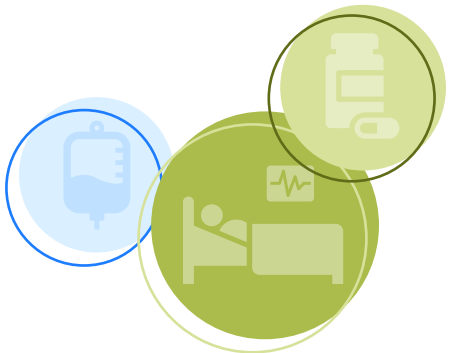
About half of U.S. adults report being unable to pay an unexpected medical bill of $500 without going into debt.[1] With critical illness insurance provided through Mutual Of Omaha, you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for:

- Increased living expenses
- Prescriptions
- Travel expenses
- Treatments

Critical Illness Insurance in Practice	
Situation	Britta had a heart attack while raking leaves.
Covered Benefits	Heart attack diagnosis
Total Benefit Paid Directly to Employee	$15,000

Click here to watch a video about how a critical illness plan works.

Critical Illness Age Banded Monthly Rates EE (Per $1,000)		SP (Per $1,000)
<25	$0.28	$0.11
25 – 29	$0.32	$0.17
30 – 34	$0.37	$0.24
35 – 39	$0.47	$0.35
40 – 44	$0.68	$0.58
45 – 49	$0.99	$0.90
50 – 54	$1.54	$1.37
55 – 59	$2.38	$2.09
60 – 64	$3.57	$3.15
65 – 69	$5.27	$4.65
70 – 74	$7.04	$6.47
75 – 79	$9.10	$8.87
80+	$11.59	$11.89



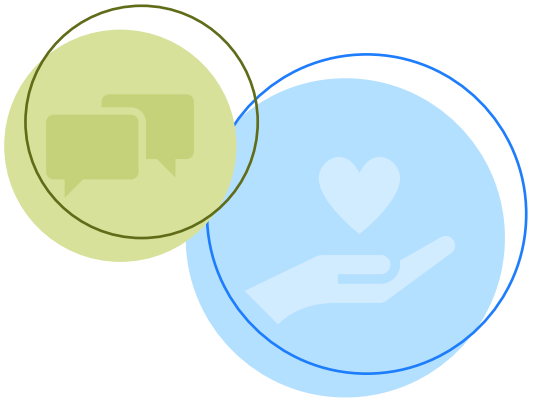
1. Kaiser Family Foundation. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation, kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through Mutual Of Omaha.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues



EAP Benefits

- Assistance for you and your household members
- Up to 3 in-person or virtual sessions with a counselor per event, per year, per individual
- Unlimited toll-free phone access and online resources

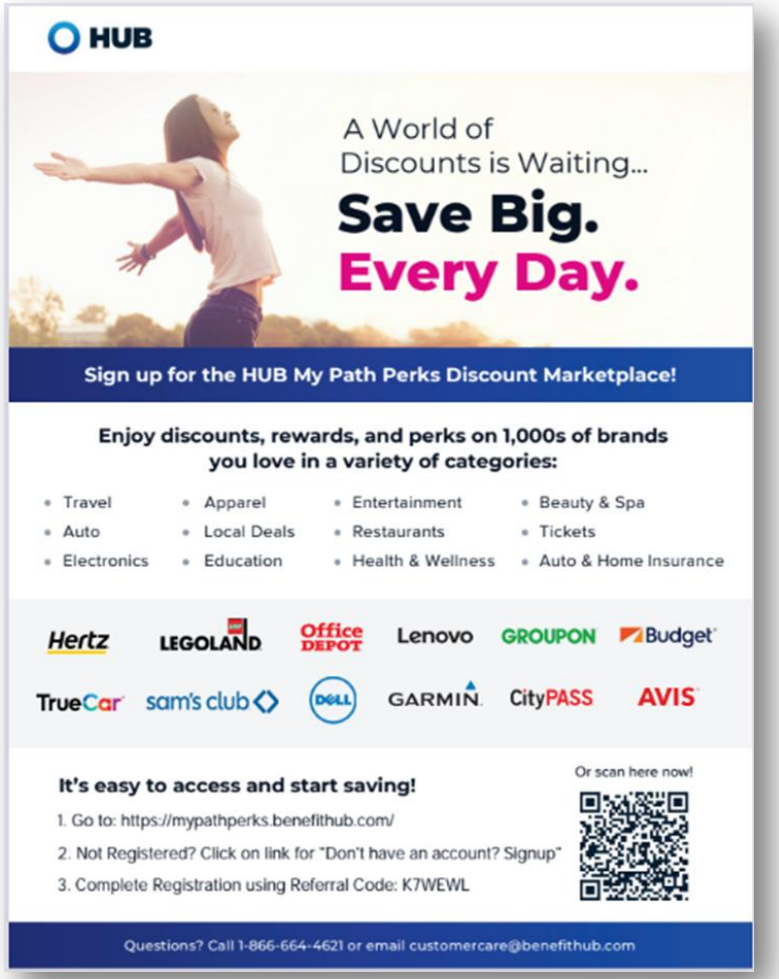
QUESTIONS?

To learn more, visit mutualofomaha.com/eap

For questions, contact Mutual Of Omaha at 1-800-316-2796

Click here to watch a video about how an EAP works.

EMPLOYEE DISCOUNTS



BenefitHub is an exclusive employee discount program that can help you save big on thousands of items daily such as travel, apparel, tickets, auto, electronics, insurance, education, restaurants and so much more! To get started:

- Go to https://mypathperks.benefithub.com/ or scan QR Code
- Click on link for "Don't have an account? Signup.
- Complete Registration using Referral Code: **K7WEWL**

Questions? Call 866-664-4621 or email customercare@benefithub.com

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical - Cigna

Coverage	Biweekly Contributions					
	HDHP + HSA			PPO		
Employee Cost is based on your Annual Salary	<$50k	$50 - $100k	$100k+	<$50k	$50 - $100k	$100k+
Employee Only	$0	$15.29	$25.36	$76.40	$101.75	$114.25
Employee + 1	$16.64	$17.52	$35.47	$121.68	$160.23	$185.08
Employee + 2 or More	$18.61	$19.71	$45.54	$172.45	$223.86	$262.42

Dental - Cigna

Coverage	Biweekly Contributions
	Dental PPO
Employee Only	$1.02
Employee + 1	$2.04
Employee + 2 or More	$3.57

Vision - EyeMed

Coverage	Biweekly Contributions – Employer Paid

IMPORTANT CONTACTS

Benefit	Carrier	Group Number	Phone Number	Website/Email
Medical	Cigna	3347145	888-806-5094	www.mycigna.com
	Cigna MDLive	3347145	800-726-3171	www.mycigna.com
Dental	Cigna	3347145	888-806-5094	www.mycigna.com
Vision	EyeMed	9954124	866-723-0596	www.eyemedvisioncare.com Choose ACCESS Network
Life/AD&D	Mutual Of Omaha	G000CTFB	800-775-6000	www.mutualofomaha.com
Disability	Mutual Of Omaha	G000CTFB	800-775-6000	www.mutualofomaha.com
Accident / Critical Illness	Mutual Of Omaha	G000CTFB	800-775-6000	www.mutualofomaha.com
Employee Assistance Program (EAP)	Mutual Of Omaha	G000CTFB	1-800-316-2796	www.mutualofomaha.com/eap
FSA and HSA	Health Equity	N/A	866-346-5800	Memberservices@healthequity.com www.healthequity.com/learn/hsa

QUESTIONS?

You may also contact:

HUB International

Amanda "Andy" Braden – Employee Benefits Advocate

Amanda.Braden@hubinternational.com | (727) 499-0712

Nexcess – People Experience Team

px@nexcess.com

BENEFIT TERMINOLOGY

Aggregate deductible

All covered family members work together to meet the family deductible. Once any collection of family members meets the deductible through their combined medical expenses, the plan's benefits will begin to pay for all family members at the coinsurance amount for the rest of the plan year.

For example, the HDHP + HSA features an in-network family deductible of $3,400. If three members of the family satisfy the $3,400 family deductible, the medical carrier will pay 80% of the remaining in-network expenses for all family members.

Aggregate out-of-pocket maximum

All covered family members work together to meet the family out-of-pocket-maximum. Once any collection of family members meets the out-of-pocket maximum through their combined medical expenses, all covered expenses for all family members will be paid at 100%.

For example, the PPO features a family out-of-pocket maximum of $10,000. If three members of the family satisfy the family out-of-pocket maximum of $10,000, the medical carrier will pay 100% of remaining in-network expenses for all family members.

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

BENEFIT TERMINOLOGY

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. The Company also allows domestic/civil union partners to be listed as dependents.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it."

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Emergency Room

You should visit an emergency room if you are experiencing any life-threatening condition, such as chest pain, shortness of breath, serious bodily injury, severe abdominal pain or loss of consciousness.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, the PPO features an in-network family deductible of $3,500. If one member of the family satisfies the individual $5,000 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $10,000, the embedded family deductible is considered satisfied.

BENEFIT TERMINOLOGY

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, the HDHP + HSA features a family out-of-pocket maximum of $6,000. If one member of the family satisfies the individual out-of-pocket maximum of $3,000, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically "Tier 1" drugs in the Company's medical plans.)

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

BENEFIT TERMINOLOGY

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically "Tier 3" drugs in the Company's medical plans.)

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

BENEFIT TERMINOLOGY

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically "Tier 2" drugs in the Company's medical plans.)

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

BENEFIT TERMINOLOGY

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and the Company share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

BENEFIT TERMINOLOGY

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Click here to watch a video about benefits terms.