



EMPLOYEE BENEFITS PLAN OVERVIEW

JANUARY 1ST - DECEMBER 31ST
2026

Welcome

Community Action has partnered with Bukaty Companies to provide benefit administration services for agency staff. Enrollment for all options, including retirement, are completed through Bukaty's online enrollment system, *Employee Navigator*. Instructions on how to create an account as well as log on to the online enrollment system can be found in the following pages of this booklet. Bukaty's knowledgeable staff will be available by phone during normal business hours to assist and answer any benefit questions staff may have regarding the benefit options being offered. Enrollment must be completed online, or by phone with your team at Bukaty Companies, or with Community Action staff Libby Mathews, HR Director or Carrie Eureka, Business and Planning Director.

Benefits Summary

Community Action provides an allowance towards an employee's individual medical insurance premium. The allowance is 89% of a Silver Plan premium for the employee only. Employees have the option to enroll in any plan available through an **Individual Coverage Health Reimbursement Arrangement (ICHRA)**. The employee's share of the premium is deducted before taxes from 24 pay periods per year (2 pay periods per month). More detailed information can be found on the following pages.

Employees who choose to opt out of enrollment in the ICHRA plan, will be provided an agency allowance of \$150 per pay period (24 pay periods per year) that may be used towards the cost of premiums for the agency's group insurance offerings that include dental, vision, accident, hospital indemnity, and cancer/critical illness, in addition to retirement and flexible spending (FSA) and dependent daycare accounts. Employees who enroll in an ICHRA may also choose to enroll in these benefit options and the premium amounts will be deducted from employee's payroll before taxes.

In addition to the benefit options described above, employees can enroll in Voluntary Life Insurance. The premium will be taken out of an employee's payroll before taxes. Employees enrolling in this option at their first date of eligibility, which is date of hire or a move from part time to full time, will not be required to have a physical.

Staff will be enrolled in, and coverage begins, for all benefit plans the first day of the month following staff's date of hire.

Additional benefits that do not require enrollment include Short Term Disability, EAP (Employee Assistance Program), Paid Holidays, and PTO (Personal Time Off).

The agency benefit year runs January 1, 2026 through December 31, 2026. Open enrollment is held every year and all benefit-eligible employees must complete enrollment upon their hire date, transfer date (if applicable), and annually. For example, employees that begin employment in August, will enroll upon hire, and then again, a few months later for open enrollment for the next benefit year. This includes employees who are enrolled in retirement.

For new hires or internal transfers from part-time to full-time, the deadline for enrollment is the last day of the month following date of hire or date of change. For example, if hire date or date of change is the 15th, enrollment would need to be completed by the 30th or 31st of that month, whichever day is the last day of that month. This allows employees to be enrolled in their options the first of the month following their date of hire or date of change. If enrollment is not completed before the deadline, employees will not be able to enroll until the next open enrollment period.

Head Start partial year staff receive benefits the months they are actively working. During months partial year staff are not working, if they are enrolled in dental or vision, they will have the option to continue those insurances during the months they are off through COBRA. If partial year staff have accident, cancer/critical illness, hospital indemnity, or voluntary life, the premium amounts due during the months they are not working will be deducted from their payroll at the end of the school year; typically, the last payroll in April and the first payroll in May. All elected benefits will begin for partial year staff again in September automatically. *If employees are enrolled in an ICHRA medical plan, contact HR for continuance options during the summer.

Your Bukaty Service Team



Melissa Findley
Account Manager
mfindley@bukaty.com
913-647-5549

Melissa is your primary contact. She assists in the enrollment process and is responsible for day-to-day administrative and service issues.



Chris Stitt
Account Executive
cbstitt@bukaty.com
913-396-0861

Chris is your secondary contact responsible for day-to-day administrative and service issues.



Liz Heller
Principal
lheller@bukaty.com
Liz oversees all aspects of your employee benefits program.



Contact Information

<p>HUMAN RESOURCES</p>	<p>Libby Mathews, HR Director Phone: 308-865-5675 Email: Imathews@mnca.net</p>
<p>MEDICAL</p>	<p>Individual Plans, through Gravie Customer Service: 800-501-2920 Website: https://member.gravie.com/contact https://member.gravie.com/login</p>
<p>DENTAL</p>	<p>Ameritas Group #: 010-048999 Customer Service: 800-487-5553 Website: www.ameritas.com</p>
<p>VISION</p>	<p>Ameritas Group #: 010-048999 Customer Service: 800-487-5553 Website: www.ameritas.com</p> <p>VSP Customer Service: 800-877-7195 Web: https://www.vsp.com/eye-doctor</p> <p>EyeMed Customer Service: 844-225-3107 Web: www.eyemed.com</p>
<p>LIFE & DISABILITY</p>	<p>Mutual of Omaha Group #: G000BFL2 Customer Service: 800-877-5176 Website: www.mutualofomaha.com</p>
<p>ACCIDENT / CRITICAL ILLNESS / HOSPITAL INDEMNITY</p>	<p>Sun Life Group #: 956424 Customer Service: 800-786-5433 Website: www.sunlife.com</p>
<p>EMPLOYEE NAVIGATOR</p>	<p>Website: www.bukaty.com/online-enrollment Email: enrollmentsupport@bukaty.com</p>
<p>HSA / FSA / DEPENDENT CARE FSA</p>	<p>NueSynergy Customer Service: 913-653-8381 Website: www.nuesynergy.com</p>
<p>EAP</p>	<p>Continuum Customer Service: 402-476-0186 or 800-755-7636 Website: www.4continuum.com</p>
<p>GROUP RETIREMENT PLAN (403b)</p>	<p>American Funds Contact: Drew Wagner, Investment Advisor Phone: 308-708-2553</p>

Eligibility and Coverage

<p>NEW HIRE</p>	<p>You are eligible to participate in the employee benefit plan on the first day of the month following your date of hire.</p>
<p>NEW HIRE DEPENDENTS</p>	<p>Eligible dependents may also participate beginning on the first day of the month following the employee’s date of hire; eligible dependents include your legal spouse, domestic partner, and/or dependent child(ren) up to age 26, if your child is disabled prior to age 26 and incapable of self-sustaining employment and dependent on you for support, they may continue to be covered as your dependent, regardless of age.</p>
<p>QUALIFYING LIFE EVENTS</p>	<p>Eligibility outside open enrollment or new hire period: Documented qualifying life event to change coverage must be submitted to the carrier within 30 days of the event. Qualifying Events are as follows: *Marriage *Divorce and/or legal separation *Death or loss of a dependent (including loss of dependent status) *Birth or adoption of a child *Change in spouse’s employment status causing loss or gain of benefits coverage *Change in your employment status *Eligibility for Medicare</p>
<p>OPEN ENROLLMENT</p>	<p>Changes outside your new hire period and a qualifying life event can be made once a year when the company policy renews.</p>
<p>TERMINATION OF COVERAGE</p>	<p>Medical Plans: Employer contribution for your individual policy will continue at your own cost. Coverage for employees ends on the last day of the month in which the employee worked. Dental/Vision Plans: Coverage for employees ends on the last day of the month in which the employee worked. Coverage for spouses/dependents ends on last day of the month. Coverage for dependent children ends on the last day of the month in which the dependent turns age 26. Disability Plans: Coverage for employees ends on the termination date. Life Plans: Coverage for employees (and covered spouses and children) ends on the termination date. Coverage for dependents turning age 26 ends on the day they turn 26. Accident/Critical Illness/Hospital Indemnity Plans: Coverage for employees (and covered spouses and children) ends on the termination date. Coverage for dependents turning age 26 ends on the day they turn 26.</p>
<p>HOW TO ENROLL</p>	<p>Enroll online in Employee Navigator: www.bukaty.com/online-enrollment (See following pages for instructions) or Call service reps at Bukaty Companies – Melissa Findley – 913-647-5549 Chris Stitt – 913-396-0861</p>

ENROLL IN YOUR BENEFITS: ONE STEP AT A TIME

STEP 1. LOG IN

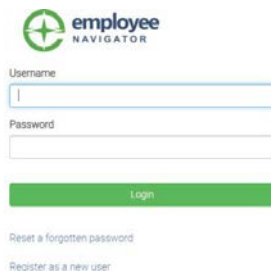
Go to <https://www.employeenavigator.com/benefits>

Returning Users: Log in with the username and password you created.

New Users: Click on the Registration Link in the email sent to you from your administrator or Register As New User.

Create an account and your own username and password. You will be asked to provide:

- First and last name
- PIN (last four digits of SSN)
- DOB (mm/dd/yyyy)



COMPANY IDENTIFIER: Nebraska

STEP 2. BEGIN ENROLLMENT PROCESS

After you login, click **Let's Begin** to complete your required tasks. Once you've completed any assigned onboarding tasks click **Start Enrollment** to begin your enrollment.

STEP 3. UPDATE PERSONAL INFO

After clicking **Start Enrollment**, you'll need to provide some personal and dependent information before moving to your benefit elections. To enroll a dependent in coverage you will need their DOB and SSN.

STEP 4. ELECT YOUR BENEFITS

You can now choose to either select or waive each of your benefits. To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?** You must click **Save & Continue** at the bottom of each screen to save your elections.

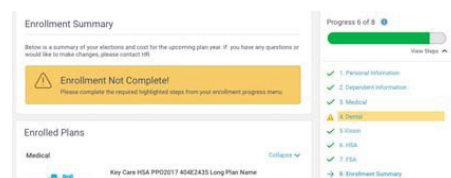
STEP 5. ADDITIONAL FORMS

If you have elected benefits that require a beneficiary or primary care physician designation, or completion of an Evidence of Insurability form, you will be prompted to add those details.

STEP 6. REVIEW AND CONFIRM ELECTIONS

Review the summary of your selected benefits. Click **Sign & Agree** if everything

looks correct to complete your enrollment. You may login and view your online summary at any point during the year.



**Scan me for
Employee Navigator
access at your
fingertips!**



For help contact:
enrollmentsupport@bukaty.com
913.345.0440

SAVE MONEY BY STAYING IN-NETWORK

FIND A NETWORK PROVIDER

Network providers accept negotiated discounts as payment in full for services. By visiting a network provider, you are paying less out-of-pocket for services. Ameritas limit reimbursement to non-network providers, so you may be balance billed for the difference between what a non-network provider charges and what the carrier reimbursed. Here's how to find a network provider:

DENTAL: Ameritas – Classic PPO Network

Direct Link: <https://dentalnetwork.ameritas.com/> – Select Classic PPO Network

Enter your location → Select Classic Network → Additional Filters → Search

VISION: Ameritas – (VSP Choice Network or Eyemed Insight Network)

Plan 1 and Plan 3: VSP Choice Network: <https://www.vsp.com/eye-doctor> = VSP Choice Network

Plan 2 and Plan 4: Eyemed Insight Network:
<https://eyedoclocator.eyemedvisioncare.com/member/en#/member/en> = Insight

BENEFITS ON THE GO

Scan the QR Code and add a shortcut to your home screen. It's that easy!

For iPhone:

1. Scan QR code.
2. Tap "View PDF."
3. Tap the share icon.
4. Tap "add to home screen" and name the icon "Benefits Package."

For Android:

1. Scan QR code.
2. Tap "View PDF."
3. Tap the 3 dots in the top right
4. Tap "add to home screen"



Medical Plans ****NEW****



What type of medical insurance does Community Action Partnership of Mid-Nebraska offer to employees?

Community Action Partnership of Mid-Nebraska offers medical coverage through a plan called an Individual Coverage Health Reimbursement Arrangement (ICHRA). This plan provides a range of affordable healthcare options to staff and your families.

What is an ICHRA?

This is an Individual Coverage Health Reimbursement Arrangement. Community Action Partnership of Mid-Nebraska will provide an allowance that you can use toward the premium cost of a qualified individual health insurance policy. The allowance is 89% of the cost of a Silver Plan Premium.

How do I enroll in my medical benefits?

Community Action Partnership of Mid-Nebraska partners with a firm named Gravie, who is an industry expert with ICHRA plans, to make available a marketplace. Each eligible employee can go to the Gravie online marketplace (through Employee Navigator) to select a health insurance plan that best fits their specific needs. Also, Gravie has insurance advisors to assist each employee with this process.

<https://www.gravie.com/enroll/>

Please note: All benefits (group dental, vision, life insurance, etc.) will be enrolled through Employee Navigator.

Will people who have pre-existing conditions run into any issues with these plans?

No, pre-existing conditions are not an issue. There are no pre-existing conditions limitations on the policies offered through Gravie's ICHRA marketplace. The Affordable Care Act removed any pre-existing condition limitations on individual fully-insured coverage.

What happens if the plan I choose costs more than the monthly allowance?

If you choose a plan in which the premium cost exceeds your available reimbursement (the allowance) to you, your portion of the cost will be deducted via payroll.

Dental Plans



Regular dental checkups are important to maintain good dental health. The dental plans cover routine checkups and many other types of dental services.

Network Benefits	Plan 1	Plan 2	Plan 3
Annual Maximum Benefit	\$1,000 + Rollover	\$1,500 + Rollover	\$2,000 + Rollover
Rollover Benefit			
Benefit Threshold	\$500	\$750	\$750
Annual Carryover Amount	\$250	\$250	\$400
Annual PPO Bonus	\$100	\$150	\$200
Maximum Carryover	\$1,000	\$1,000	\$1,200
Deductible for Basic & Major Dental Services (below)	\$50 / \$150 (Family)	\$50 / \$150 (Family)	\$0 / \$0 (Family)
Preventive Dental Services			
<ul style="list-style-type: none"> • Routine examinations, <i>two per benefit period</i> • Bitewing X-rays, <i>two per benefit period</i> • Full Mouth/Panoramic X-rays, <i>one in three years</i> • Periapical X-rays • Cleanings, <i>two per benefit period</i> • Fluoride for children 18 and under, <i>one per benefit period</i> • Sealants, <i>age 16 and under</i> • Space maintainers 	100%	100%	100%
Basic Dental Services			
<ul style="list-style-type: none"> • Restorative Amalgams • Restorative Composites (<i>anterior and posterior teeth</i>) • Denture Repair • Simple Extractions • Anesthesia • Periodontics (<i>nonsurgical</i>) • Endodontics (<i>nonsurgical</i>) 	50%	80%	100%
Major Dental Services			
<ul style="list-style-type: none"> • Onlays • Crowns, <i>one in five years per tooth</i> • Crown Repair • Endodontics and Periodontics, <i>surgical</i> • Prosthodontics (fixed bridge; removable complete/partial dentures), <i>one in five years</i> • Complex Extractions 	25%	50%	60%
Orthodontic Dental Services			
<ul style="list-style-type: none"> • Orthodontia for dependent children under age 19 • Lifetime Maximum Benefit 	N/A N/A	50% \$1,500	50% \$2,000
Fusion Benefit (combined dental and eye care benefit)	Each member can use up to \$100 towards any covered eye care expense		

Employee Rates Per Pay Period (24 Pay Periods)			
Employee Pays	Plan 1	Plan 2	Plan 3
Employee Only	\$11.78	\$22.14	\$27.28
Employee & Spouse	\$22.10	\$41.46	\$51.10
Employee & Child(ren)	\$30.02	\$50.28	\$61.96
Employee & Family	\$40.34	\$74.82	\$92.22

Dental Rewards[®]

Reward your employees with an increasing annual maximum



Dental benefits help keep your employees healthy and on the job. So why not reward those who care for their dental health and help motivate those who don't? You can do it with Dental Rewards.

How It Works

By using their dental benefits, employees can earn rewards to help pay for more expensive dental services in the future. Here's how.

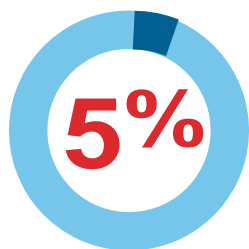
1. Plan members visit a dental provider each year and submit a claim.
2. If all claims for the year stay under the benefit threshold, plan members qualify to carry over benefit dollars.
3. Members build rewards up to the maximum reward accumulation. They can use their rewards to help pay for more expensive dental procedures after the initial plan benefit is used.

In most states members can earn PPO Bonus rewards when visiting an Ameritas Dental Network provider.

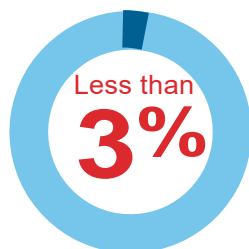
Dental Rewards[®] Options

Annual Maximum	Annual Benefit Threshold	Annual Carryover	Annual PPO Bonus*	Maximum Reward Accumulation
\$500	\$250	\$125	\$50	\$500
750	250	125	50	500
1,000	500	250	100	1,000
1,200	500	250	100	1,000
1,500	750	250	150	1,000
1,750	750	400	200	1,200
2,000	750	400	200	1,200

*PPO Bonus is not available in MT or RI.



5% reach an annual maximum of \$1,000



2.4 % reach an annual maximum of \$1,500

On average, only 5% of Ameritas plan members reach an annual dental benefit maximum of \$1,000. Less than 3% reach a \$1,500 maximum. Save on premium costs by offering a plan with a lower annual maximum and Dental Rewards.¹

Example

Best Investment Inc. currently has a dental plan with a \$2,000 annual maximum. To reduce costs, they decide to lower their dental annual maximum to \$1,000 and include Dental Rewards.

With their new plan, members may qualify for \$250 in rewards per year by using their dental plan, with an additional \$100 per year for visiting a network provider. Members who qualify may use their rewards for covered dental services after their dental plan's annual maximum is used. By the fourth year on the plan, qualified members can reach the original \$2,000 annual maximum by earning the \$1,000 maximum reward accumulation, in addition to the \$1,000 dental annual maximum.

	Year 1	Year 2	Year 3	Year 4
Annual maximum benefit	\$1,000	\$1,000	\$1,000	\$1,000
Accumulated rewards	NA	+ \$350	+ \$700	+ \$1,000
Total available benefits	= \$1,000	= \$1,350	= \$1,700	= \$2,000

Important Details

- Accumulated rewards may be applied to the remaining amount due on covered services after the member exceeds the annual maximum benefit.
- Rewards are subject to the applicable deductible, coinsurance and plan provisions.
- If claims exceed the dental threshold, no rewards are earned that year.
- If no dental claims are submitted, accumulated rewards are lost and the member begins accumulating rewards again the next year.
- Each member has their own rewards account.



Fusion

The Ultimate Choice®



Two benefits – dental and vision – combined into one plan that lets you and your family receive the care you need most.

Using Your Benefits is Easy

You may visit any vision or dental provider.

Vision: At your vision appointment, pay the provider and request an itemized receipt. Then submit a claim, including a copy of your receipt, for reimbursement up to your vision plan benefit.

Dental: To make your dental benefit dollars go further, visit an Ameritas Dental Network provider. Network savings are typically 25-50% below, based on ZIP Code. To find a network provider in your area, visit ameritas.com, Find a Provider. Dental providers in the Ameritas Dental Network will file claims for you. Providers outside of the network may ask you to submit the claim.

Claim forms can be found at ameritas.com/dental, Resource Center, Members, Forms. Generic claim forms from your provider also will work. *****Remember to submit your claims within 90 days after completion of the service.*****

Understanding Your Plan Benefits

Your highlight sheet details the benefits available to each person covered on your plan. You may see up to three features combined between your dental and vision plans – maximum, deductible and frequency – which can reduce either your monthly plan payment or out-of-pocket expenses. The sample highlight sheet included here shows a Fusion plan with a shared maximum.

Example

FUSION Highlight Sheet

Plan 1
FUSION: THE ULTIMATE CHOICE™ combines dental and eye care benefits in one easy-to-administer plan. This plan combines the annual maximum between the dental and eye care plans.
 For the maximum:

- The member can use up to \$1,500 toward any covered dental expense.
- The member can use up to \$250 towards any covered eye care expense.
- Total benefits paid between the two coverages will not exceed \$1,500.

Dental Plan Summary subject to FUSION plan design listed above

Plan Benefit Type 1	100%
Deductible	\$50 per calendar year
Waiting Period	Type 2 & 3

Eye Care Summary subject to FUSION plan design listed above

	Allowances	Frequencies Based on date of service
Exam	Subject to maximum	None
Lenses (per pair)	Subject to maximum	None
Single	Subject to maximum	None
Bifocal	Subject to maximum	None
Progressive	Subject to maximum	None
Frames	Subject to maximum	Maximum \$250
Contacts	Subject to maximum	Deductibles (None) \$0*
Elective/Medically Necessary	Subject to maximum	
Frames	Subject to maximum	

*Deductible applies to the first service received

Waiting Period

None



Plan Maximums



Dental Plan Summary



Eye Care Summary

How it Works

Plan benefits are paid as services are received. Let's assume Sam visited his dentist twice during the year and needed some additional dental procedures. He also replenished his supply of contacts. Based on the sample highlight sheet above, here is how the plan would cover his dental and vision expenses.

Service	Cost*	Insurance covers	Sam pays
1st dental preventive visit (Type 1)	\$165	\$165	\$0
Dental filling (Type 2)	\$160	\$88	\$72 (includes \$50 deductible)
Dental crown (Type 3)	\$1,100	\$550	\$550
Eye exam	\$154	\$154	\$0
Contacts with fitting	\$370	\$96	\$274
2nd dental preventive visit (Type 1)	\$165	\$165	\$0
TOTAL	\$2,114	\$1,218	\$824

The dental plan features a \$1,500 maximum. The \$50 shared deductible for Type 2 and 3 services was paid before the coinsurance was applied on the filling.

Sam met his \$250 vision annual maximum.

Although the vision maximum was met, there is still money left for additional dental expenses.

With a \$1,500 combined Fusion maximum, Sam paid only \$824 for the dental and vision services he received.

*Cost estimates without insurance from United States Government Accountability Office-Dental 2013, and All About Vision 2016. Check with your dental and vision providers for procedure costs.

Vision Plans



Annual eye exams are important to your overall health. During your eye exam, a doctor will look for vision problems and signs of other health conditions, like diabetic eye disease, high blood pressure and high cholesterol.

Network Benefits	Plan 1 VSP Network	Plan 2 EyeMed Network	Plan 3 VSP Network	Plan 4 EyeMed Network
Routine Exams <i>(once every 12 months)</i>	\$10 Copay	\$10 Copay	\$10 Copay	\$10 Copay
Contact Lens Fit & Follow Up <i>(once every 12 months)</i>	Up to \$60 Copay	Std: Up to \$40 Copay Prem: 10% off Retail	Up to \$60 Copay	Std: Up to \$40 Copay Prem: 10% off Retail
Standard Lenses <i>(once every 12 months)</i> Single Vision Bifocal Trifocal Lenticular	\$25 Copay \$25 Copay \$25 Copay \$25 Copay	\$25 Copay \$25 Copay \$25 Copay 20% Discount	\$25 Copay \$25 Copay \$25 Copay \$25 Copay	\$25 Copay \$25 Copay \$25 Copay 20% Discount
Premium Lenses <i>(once every 12 months)</i> Progressive Standard Polycarbonate (Adult) Standard Polycarbonate (Child) Scratch Resistant Coating Anti-Reflective Coating Ultraviolet Coating	Provider's Lined Bifocal Fee \$33 Copay \$0 Copay \$17-\$33 Copay \$43-\$85 Copay \$16 Copay	\$90 - \$135 Copay \$40 Copay \$40 Copay \$15 Copay \$45-80% of Charge \$15 Copay	Covered in Full \$33 Copay \$0 Copay Covered in Full Covered in Full Covered in Full	Covered in Full \$33 Copay \$0 Copay Covered in Full Covered in Full Covered in Full
Frame Allowance <i>In Lieu of Contact Lenses</i>	\$200 Allowance <i>(once every 12 months)</i>	\$200 Allowance <i>(once every 12 months)</i>	\$130 Allowance <i>(once every 24 months)</i>	\$130 Allowance <i>(once every 24 months)</i>
Contact Lenses <i>(once every 12 months)</i> <i>In Lieu of Frames</i>	\$200 Allowance	\$200 Allowance	\$130 Allowance	\$130 Allowance

Employee Rates Per Pay Period (24 Pay Periods)

Employee Pays	Plan 1 VSP Network	Plan 2 EyeMed Network	Plan 3 VSP Network	Plan 4 EyeMed Network
Employee Only	\$5.44	\$5.44	\$6.54	\$6.54
Employee & Spouse	\$10.24	\$10.24	\$10.46	\$10.46
Employee & Child(ren)	\$12.12	\$12.12	\$10.66	\$10.66
Employee & Family	\$16.24	\$16.24	\$17.18	\$17.18

Vision Benefits With Options for Diverse Employee Needs

Dual choice vision plans
for groups of 20-1,000 eligible employees

Are you faced with the following benefits challenges?

- Enrollment is low, resulting in higher premiums for those who do enroll.
- Employees visit out-of-network providers, so they don't experience the savings and value of their benefits.
- Employees visit network providers to save money, but don't feel good about having to change providers.

Dual choice vision plans may be the solution.

You offer two different vision plan designs. Your employees have the freedom to decide which plan is right for them.

- Offer two plans with the convenience of one carrier, one enrollment form, one plan administration process.
- When employees can choose benefits that fit their needs, enrollment and benefit usage are typically higher, and employees value their benefits more.
- Cost saving options both in- and out-of-network encourage members to enroll and use their benefits.



You can offer employees one or both of the nation's largest vision networks, so their vision provider is more likely to be in-network.

Plans include network and non-network options:

VSP network	EyeMed network	No network
<p>Network includes:</p> <p> Eyeconic.com is in the VSP network, so vision benefits are applied directly to the online order.</p>	<p>Network includes:</p> <p> Contacts Direct and Glasses.com are in the EyeMed network and apply vision benefits to the online shopping cart.</p>	<p>Reimbursement based plan – pick one of two plan design options</p> <ul style="list-style-type: none"> • Members select the vision provider of their choice, pay the provider directly

Additional network information

VSP network	EyeMed network	No network
<ul style="list-style-type: none"> • The option to apply your lens and frame allowances to prescription safety glasses in lieu of regular eyeglasses or contacts. • 86% of VSP doctors offer early morning, evening or weekend hours, and they take care of filing your claim. 	<ul style="list-style-type: none"> • EyeMed providers are open an average of 10 evening hours and 12 weekend hours each week, and they submit your claim form for you. • Nearly 100 frames priced \$130 or lower at every location. 	<p>Choose to offer either a Flat Max or MCE plan.</p> <ul style="list-style-type: none"> • Flat Max plans reimburse members for eligible exams, eyeglass lenses, frames, contacts and prescription safety glasses collectively, up to the plan's fixed annual maximum. There are no benefit frequency limitations. • MCE plans reimburse members based on fixed amounts assigned to vision services and materials. Exam-Lens-Frames benefit frequencies apply.

All plans offer member discounts

VSP network	EyeMed network	No network
<ul style="list-style-type: none"> • An extra \$20-\$40 to spend on featured frame brands. • 20% off the remaining frame balance, additional pair of prescription glasses and non-prescription sunglasses. Plus 20-40% off lens enhancements. • 15% average off retail for LASIK or PRK laser eye correction, or 5% off promotional price, through a VSP provider. <p>Based on applicable law, reduced costs may vary by doctor location.</p> <p>*Members visiting a Costco location will receive the wholesale equivalent price instead of the 20% discount</p>	<ul style="list-style-type: none"> • EyeMed provider discounts include 20% off the remaining frame balance, additional prescription glasses, and non-covered lens options. 40% off a second pair of prescription glasses, plus discounts on lens options. • 15% average off retail for LASIK or PRK promotional price, through a VSP provider. <p>Based on applicable law, reduced costs may vary by doctor location.</p>	<ul style="list-style-type: none"> • Members can receive discounts on eyewear from Walmart Vision Centers nationwide. • Benefits can be used in conjunction with provider special pricing, coupons, and even "buy one get one free" offers. <p>Based on applicable laws, reduced costs may vary by doctor location.</p>

Short-Term Disability



This important benefit provides financial security in the event of a short-term illness or accident that doesn't allow you to work. This benefit is provided by the agency at no cost to employees. **Employees are automatically enrolled on the first day of the month following your date of hire. You do not need to elect enrollment in this option to be enrolled.**

Benefits	
Weekly Benefit	60% of Salary, up to \$600
Elimination Period (Number of days you are off work because of injury or illness before benefits begin)	7 Days — Due to Injury or Illness
Benefit Duration (Number of weeks you receive disability payments if approved for a condition other than pregnancy)	12 Weeks
Benefit Duration for Pregnancy (Number of weeks you receive disability payments if your claim is approved due to pregnancy)	Natural Birth: 5 Weeks Cesarean Section: 7 Weeks



Accident Plans



Accidents are unexpected and can strike any member of your family. The costs associated with treatment can mount quickly. Fixed benefits are paid directly to you regardless of any other coverage you may have, and you can spend it any way you choose. Benefits include coverage for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more.

Benefits	Low Plan		High Plan	
	Open	Closed	Open	Closed
Dislocations				
Hip	\$4,000	\$2,000	\$8,000	\$4,000
Knee, Ankle, or Bones of the Foot	\$2,000	\$1,000	\$4,000	\$1,000
Elbow, Wrist or Lower Jaw	\$800	\$400	\$2,000	\$1,000
Shoulder	\$1,000	\$500	\$2,000	\$1,000
Collarbone or Bones of the Hand	\$1,600	\$800	\$2,000	\$1,000
Finger(s) or Toe(s)	\$200	\$100	\$400	\$200
Fractures	Open	Closed	Open	Closed
Hip or Thigh	\$4,000	\$2,000	\$6,000	\$3,000
Skull				
• Depressed	\$6,000	\$3,000	\$10,000	\$5,000
• Simple	\$3,000	\$1,500	\$5,000	\$2,500
Vertebral Processes, Bones of the Face, Nose, Lower Jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	\$700	\$350	\$1,500	\$750
Leg	\$2,000	\$1,000	\$3,000	\$1,500
Vertebrae, Sternum	\$1,600	\$800	\$3,000	\$1,500
Pelvis	\$1,600	\$800	\$3,200	\$1,600
Upper Jaw or Upper Arm	\$800	\$400	\$1,500	\$750
Rib, Finger, Toe, or Coccyx	\$400	\$200	\$600	\$300
Multiple Ribs	\$1,000	\$500	\$2,000	\$1,000
Additional Injuries	Low Plan		High Plan	
Paralysis				
• Paraplegia	\$12,500		\$25,000	
• Quadriplegia	\$25,000		\$50,000	
Coma	\$5,000		\$10,000	
Concussion	\$150		\$300	
Lacerations	Low Plan		High Plan	
No Sutures and Treated by Doctor	\$20		\$35	
Single Laceration Under 5cm With Sutures	\$35		\$65	
5-15cm With Sutures (total of all lacerations)	\$125		\$250	
Greater Than 15cm With Sutures (total of all lacerations)	\$250		\$500	
Burns	2nd Degree	3rd Degree	2nd Degree	3rd Degree
21 – 40 Square Centimeters	\$200	\$500	\$400	\$1,000
41 – 65 Square Centimeters	\$400	\$1,000	\$800	\$2,000
66 – 160 Square Centimeters	\$600	\$3,000	\$1,200	\$6,000
161 – 225 Square Centimeters	\$800	\$7,000	\$1,600	\$14,000
More Than 225 Square Centimeters	\$1,000	\$10,000	\$2,000	\$20,000
Skin Graft	50% of the applicable Burn Benefit		50% of the applicable Burn Benefit	

Benefits <i>(continued)</i>	Low Plan	High Plan
Medical Services	Low Plan	High Plan
Diagnostic Exams		
• Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI <i>(1 time per benefit year)</i>	\$200	\$300
• X-ray <i>(1 time per covered accident)</i>	\$75	\$100
Accident Emergency Treatment, Non-Emergency Room <i>(once per covered accident)</i>	\$100	\$200
Physician's Follow-up Treatment Office Visit <i>(per visit, up to 6 times per covered accident)</i>	\$50	\$50
Physical Therapy <i>(Per visit, up to 10 visits per accident)</i>	\$50	\$50
Medical Devices	\$300	\$400
Epidural Pain Management <i>(up to 2 times per accident)</i>	\$100	\$150
Prescription Drug	\$35	\$50
Prostheses <i>One / Two</i>	\$250 / \$500	\$500 / \$1,000
Blood, Plasma, or Platelet Transfusion	\$100	\$200
Hospital	Low Plan	High Plan
Hospital Admission <i>(once per benefit year)</i>	\$1,000	\$2,000
Hospital Confinement <i>(per day up to 365 days per covered accident)</i>	\$200	\$400
Intensive Care Unit Admission <i>(once per Benefit Year; payable instead of Hospital Admission benefit if confined immediately to ICU)</i>	\$1,500	\$2,500
Intensive Care Unit Confinement <i>(per day up to 15 days, payable in addition to any Hospital Confinement benefit)</i>	\$400	\$1,000
Ambulance <i>Ground / Air</i>	\$100 / \$500	\$200 / \$750
Emergency Room Admission	\$100	\$200
Rehabilitation Unit <i>(per day, max 30 days per accident)</i>	\$50	\$100
Surgery	Low Plan	High Plan
Miscellaneous Surgery Requiring General Anesthesia <i>(not covered by any other benefit)</i>	\$300	\$750
Open Surgery	\$1,000	\$1,250
Exploratory Surgery or Debridement	\$150	\$250
Tendon/Ligament/Rotator Cuff Tear	\$500	\$1,000
Torn Knee Cartilage	\$500	\$500
Ruptured/Herniated Disc	\$500	\$500
Emergency Dental	Low Plan	High Plan
Emergency Dental Extraction	\$30	\$65
Emergency Dental Crown	\$100	\$200
Wellness Screening Benefit <i>(once per benefit year)</i>	\$75	\$75

Employee Rates Per Pay Period (24 Pay Periods)

Employee Pays	Low Plan	High Plan
Employee Only	\$5.91	\$8.55
Employee & Spouse	\$9.35	\$14.31
Employee & Child(ren)	\$11.03	\$17.19
Employee & Family	\$14.47	\$22.96

Critical Illness and Cancer Plan



For many, a critical illness can expose an individual to an unexpected gap in protection. While health plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income, childcare, travel to and from treatment, high deductibles and co-pays may quickly diminish savings.

Critical Illness and Cancer coverage pays a lump sum benefit upon initial diagnosis of a covered critical illness/cancer. After 100% has been paid in a benefit category for an insured person, the insured person will no longer be eligible for benefits under that category.

Benefits	Employee	Spouse	Child
Benefit Amount	Benefit Amounts May Range From \$10,000 to \$40,000 in \$10,000 Increments	Benefit Amounts May Range From \$10,000 to \$40,000 in \$10,000 Increments <i>Amount Cannot Exceed 100% of the Employee Amount</i>	Benefit Amounts May Range From \$2,500 to \$20,000 in \$2,500 Increments. <i>Amount Cannot Exceed 50% of the Employee Amount</i>
Guaranteed Issue Amount	\$40,000	\$40,000	\$20,000
Core Conditions	Initial Diagnosis	Recurrence	
Heart Attack, Stroke, Major Organ Failure, End-Stage Kidney Disease	100%	100%	
Coronary Artery Bypass	25%	25%	
Angioplasty	5%	5%	
Occupational HIV/Hepatitis B, C, or D	100%	N/A	
Cancer Conditions	Initial Diagnosis	Recurrence	
Invasive Cancer	100%	100%	
Non-Invasive Cancer	25%	25%	
Skin Cancer	5%	5%	
Supplemental Conditions Option 1	Initial Diagnosis	Recurrence	
Complete Blindness, Loss of Speech, Complete Loss of Hearing	100%	N/A	
Supplemental Conditions Option 2	Initial Diagnosis	Recurrence	
Benign Brain Tumor, Paralysis, Coma, Severe Burns	100%	N/A	
Supplemental Conditional Option 3	Initial Diagnosis	Recurrence	
Advanced ALS or Lou Gehrig's disease	100%	N/A	
Advanced Alzheimer's, Advanced Parkinson's	25%	N/A	
Childhood Conditions – Child Only	Initial Diagnosis	Recurrence	
Down Syndrome, Cerebral Palsy, Cystic Fibrosis, Cleft Lip/Palate, Type I Diabetes Mellitus, Muscular Dystrophy, Complex Congenital Heart Disease, Spina Bifida	100%	N/A	
Wellness Benefit			
Annual Wellness Screening Benefit	\$75 per day payable 1 time per calendar year per insured		
Additional Provisions			
Maximum Benefit	1 time per condition		
Recurrence Waiting Period	12 months		
Cancer Recurrence Waiting Period	12 months		
Recurrence Maximum	Unlimited		

See Employee Navigator for Rate Details

Hospital Indemnity Plans



If you become seriously ill or injured, it's likely you will have a hospital stay. Out-of-pocket costs that come from being hospitalized can add up quickly. By purchasing hospital indemnity insurance, you can receive cash benefits based on your covered sickness or injury, treatments and services. The cash benefits are paid directly to you, and you decide how to use them.

Benefits	Low Plan	High Plan
First Day Benefits		
First Day Hospital <i>payable 1 time per calendar year</i>	\$500 per day	\$1,000 per day
Confinement Benefits		
Hospital Confinement <i>payable up to 15 days per calendar year</i>	\$100 per day	\$200 per day
ICU Confinement <i>payable up to 15 days per calendar year</i>	\$100 per day	\$200 per day
Additional & Enhanced Benefits		
Wellness Screening <i>payable 1 time per calendar year per insured</i>	\$75	\$75
Covered Conditions		
Newborn Care <i>payable under Hospital or ICU Confinement</i>	Complications only	Complications only
Complications of Pregnancy	Included	
Normal Pregnancy	Included	
Normal Pregnancy Waiting Period	No Waiting Period	
Mental/Nervous	Included	
Substance Abuse	Included	
Pre-existing Condition Limitation	Not included	

Employee Rates Per Pay Period (24 Pay Periods)		
Employee Pays	Low Plan	High Plan
Employee Only	\$8.60	\$14.17
Employee & Spouse	\$16.66	\$28.51
Employee & Child(ren)	\$13.57	\$22.83
Employee & Family	\$21.63	\$37.16

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Group Retirement (403b) Plan



Employees can choose to have any or all of the \$150 per pay period benefit allowance contributed to an American Funds Retirement Account. Employees who enroll in an ICHRA medical plan can also participate in retirement by contributing their own money through payroll deduction.

The agency allowance you elect to put towards retirement is considered an employer contribution. In addition to the employer contribution, employees can also contribute their own money towards retirement. *These are considered employee contributions.* Employee contributions are limited each year. Current maximum contribution amounts allow an employee to contribute up to \$23,500 of their own money towards retirement annually (this does NOT include employer contributions, but is in addition to). The catchup contribution limit for employees age 50 and over is \$7,500 annually.

Community Action Partnership of Mid-Nebraska's 403(b) Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis and to provide additional income for retirement. It is recommended that you take the time to read the full 403(b) Summary Plan Description to get a better understanding of your rights and obligations under the Plan. The Summary Plan Description can be found on the benefit information page on Community Action Partnership of Mid-Nebraska's website (www.communityactionmidne.com), or Bukaty's online enrollment site. Employees choosing to enroll in this benefit option will enroll through the Employee Navigator online enrollment system.

Employees are 100% vested in the Plan and eligible to participate upon their date of hire, or date of transfer. You will be able to direct the investment of your Plan account, including your elective deferrals. You should remember that the amount of your Plan account under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. Community Action will not provide investment advice or guarantee the performance of any investment you choose. Drew Wagner, who is affiliated with Edward Jones, is the Plan's investment advisor and can assist you, at no cost, in your financial planning decisions. You can contact him at 308-708-2553.

You may be able to rollover distributions you have received from other plans and certain IRAs into your 403(b) account. You will need to contact Drew Wagner at Edward Jones to see if it is eligible and to fill out the paperwork to complete the rollover process.

You have the ability to direct the investment of your Plan account at any time while you are enrolled in the plan. Drew Wagner with Edward Jones is available to assist you in making these investment decisions and changes. You may also contact American Funds directly to make investment changes at 800-421-0180.

Generally, your account may only be distributed upon retirement, terminations of employment, death or disability, and after attaining age 59 1/2.

You may elect to have your vested benefit distributed to you, or rolled over to an IRA or another plan, as soon as administratively feasible following your end of employment. Distribution forms are mailed out within 30 days of an individual's end date with the agency.



Your Flexible Spending Account

What is a FSA?

Your Employer provides you with the opportunity to enroll in a Flexible Spending Arrangement or FSA. The FSA allows you to set aside money on a pre-tax basis to pay for eligible medical, dental, and vision expenses. The amount you choose to contribute is taken out of your paycheck in equal amounts each pay period. There are two types of FSAs available to help you save – a healthcare FSA and a dependent care FSA.

Why Enroll?

If you could save 25% or more on your medical, dental, vision, and dependent care expenses, would you? The FSA can help you do just that.

Savings Can Add Up

For example, an employee earns \$32,000 annually, which is \$1,333.33 per bi-monthly payroll. This employee elects \$250 per pay period (pre-tax) to cover the cost of insurance, health and daycare expenses.

	Without FSA	With FSA
Gross Earnings	\$1,333.333	\$1,333.333
FICA, Fed/State Taxes	\$275.48	\$203.24
Insurance Premiums	\$50.00	\$50.00
Health & Daycare Exp.	\$200.00	\$200.00
NET EARNINGS	\$807.85	\$880.09
Savings Per Paycheck		\$72.24
Savings Per Month		\$144.48
Savings Per Year		\$1,733.76

Carryover

Your employer has allowed you to carry over up to \$680 of unused Health Care FSA dollars to the next plan year, allowing you to enjoy tax savings without risk.

Healthcare FSA

With this account you are able contribute up to \$3,400 to pay for eligible medical, dental, prescription, vision not covered by insurance. Eligible expenses include but are not limited to:

Copays, coinsurance & deductibles | Prescriptions Dental (excludes cosmetic) | Orthodontics
Over-the-counter (OTC) items* | Vision Items

*Most OTC items require a prescription. Below are OTC items that do not require prescription:

Contact lens supplies | Braces & Supports
Band-aids, elastic bandages | Denture adhesive
Insulin & diabetic supplies | Reading glasses
Ostomy products First aid supplies

Tools and Resources

NueSynergy Mobile

A free mobile app that provides access to your benefit account anywhere at any time.

- File a claim and submit documentation
- Check balances and transaction history
- View plan communications

NueSynergy Benefits Debit Card

Provides participants a convenient way to pay for eligible expenses directly from their designated benefit account, rather than paying out-of-pocket and waiting for reimbursement.

- Online and mobile account access to conveniently manage transactions
- Able to access all bene it accounts with one card





Eligible FSA Expenses

HEALTH CARE EXPENSES	DEPENDENT CARE FSA EXPENSES
Acupuncture	After school program
Ambulance service	Au Pair
Artificial limb/teeth	Babysitting (work-related, in your home or someone else's home)
Bandages, Band-Aids, wraps, and splints	Babysitting by your relative who is not a tax dependent (work-related)
Birth control pills (Norplant, ovulation kits)	Before or after school programs
Chiropractor professional fees	Child care
Contact Lenses/solution	Dependent care (while you work, to enable you to work or look for work)
Contraceptives	Extended care (supervised program before or after regular school hours)
Crutches/braces & supports	Housekeeper who cares for child (only portion of payment attributable to work-related child care)
Dental treatment	Nanny
Diagnostic services and tests	Nursery school
Drugs (prescriptions)	Payroll taxes related to eligible care
Eye Surgery (includes cataract, LASIK, etc.)	Preschool
Physical therapy	Registration fees (required for eligible care, after actual services are received)
Pregnancy test kits	Sick child care
Psychologist fees	Summer day camp
Schools and education (for mentally impaired or physically disabled person – see IRS publication 502)	Transportation to and from eligible care (provided by your care provider)
Speech Therapy	Tutoring
Stop-smoking program	Adult day care center
Therapy, physical or speech	Elder care (while you work, to enable you to work or look for work)
Eyeglasses, prescription (includes prescription sunglasses and over-the-counter reading glasses)	Elder care (in your home or someone else's)
Hearing aids and batteries	Senior day care
Hospital services	
Insulin, syringes	
Laboratory fees	
Orthodontia	
X-ray fees	





FLEXIBLE SPENDING ACCOUNT

Dependent Care FSA



How does a Dependent Care FSA work?

A dependent care Flexible Spending Account (FSA) allows you to set aside pre-tax dollars for dependent care expenses, such as daycare, that allow you to work or look for work.

You choose an annual election amount – **up to \$7,500**. The money is placed in your account via payroll deduction, in equal installments, and then used to pay for eligible dependent care expenses incurred during the plan year.

Why should I enroll in a Dependent Care FSA?

Child and dependent care is a large expense for many families. Millions of people rely on child care to be able to work, while others are responsible for older parents or disabled family members.

If you pay for care of dependents in order to work, you'll want to take advantage of the savings this plan offers. Money contributed to a dependent care account is free from federal and state taxes and remains tax-free when it is spent on eligible expenses. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving on dependent care expenses!

Mobile and online access

NueSynergy makes it easy to access and manage your dependent care FSA information.

- **NueSynergy smart mobile app:** Our smart mobile app provides real-time, secure benefit account access anywhere at any time.
- **NueSynergy member portal:** Log in to our website, www.NueSynergy.com, as a member and you'll have a wide variety of tools and resources available to you.

How do I use my Dependent Care FSA to pay for eligible expenses?

You can use the NueSynergy smart debit card we'll provide to pay for eligible dependent care expenses. Or you can pay with your personal funds and submit a claim for reimbursement.

Simple to use and easy to save

A dependent care FSA is easy to use and simple to understand. Here are some helpful hints to know before you take advantage of your tax savings:

- You must have funds in your dependent care FSA before you can spend them.
- Keep your receipts. You will need itemized invoices for all reimbursement requests. Make sure the receipt has the provider's name, address, telephone number, amount and date(s) of service. If you're using a babysitter, you'll also need the individual's social security number.
- The easiest way to manage your account is online at www.NueSynergy.com or through the NueSynergy smart mobile app.
- You can't change your election amount during the plan year, unless you experience a change in status or qualifying event.
- Any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your dependent care FSA by the end of the plan year.



Convenient & Controlled.
Easy to use and easy to budget.

Annual tax-free contribution
of up to \$7,500.

Have questions or need more
information? Call 855-890-7239.



Example of qualifying expenses

Your dependent care FSA can cover costs for many different types of providers, such as:

- Before school or after school care for children 12 and younger
- Child care at a day camp or nursery school
- Child care by a private sitter
- Custodial care for dependent adults
- Licensed day care centers
- Nanny/Au Pair
- Placement fees for a dependent care provider, such as an au pair
- Nursery schools or preschools
- Late pick-up fees
- Summer or holiday day camps

Example of non-qualifying expenses

There are certain expenses that are not eligible for reimbursement from your dependent care FSA, such as:

- Expenses incurred in a prior plan year
- Expenses for non-disabled children 13 and older
- Educational expenses including kindergarten or private school tuition fees
- Food, clothing, sports lessons, field trips and entertainment
- Overnight camp expenses
- Late payment fees for child care

More information about eligible expenses

A comprehensive list of eligible expenses can be found at www.NueSynergy.com.

Here's an example

With a \$35,000 salary, an individual electing the dependent care FSA and contributing \$7,500 for the plan year **can save \$1,125.**

	DEPENDENT CARE FSA	EXPENSES	NOT PARTICIPATING	
	\$35,000	INCOME BEFORE TAX	\$35,000	
Elects to contribute \$5,000	\$7,500	FSA CONTRIBUTION	\$0	No contribution
Only taxed on \$30,000	\$30,000	TAXABLE INCOME	\$35,000	Taxed on full \$35,000
	\$6,750	TAXES (FEDERAL, STATE, FICA)	\$7,875	
No out-of-pocket expense	\$0	OUT-OF-POCKET DEPENDENT CARE	\$7,500	Ends up spending \$5,000
Income is \$1,125 more with an FSA	\$20,750	INCOME AFTER TAX	\$19,625	Income is \$1,125 less than with an FSA
Total Savings: \$1,125 a year				

The agency benefit allowance cannot be used for the Voluntary Life Benefits
If you elect to enroll in this option, the premiums will be deducted from 2 payrolls per month.

Voluntary Life/AD&D Plan



You have the option of purchasing additional life insurance for yourself and your family. You are eligible to participate in the employee benefit plan on the first day of the month following your date of hire. Eligible dependents include your legal spouse and/or dependent child(ren) up to age 26.

Insurance Schedule	Increments	Maximum Benefit Amount	Guarantee Issue Amount*	Benefit Reduction / Termination
Employee	\$10,000	Lesser of \$500,000 or 5X Annual Earnings	\$150,000	Benefits reduce off the original amount to: <ul style="list-style-type: none"> • 65% at age 70 • 45% at age 75 • 30% at age 80 • 20% at age 85 • 15% at age 90
Spouse	\$5,000	\$250,000	\$30,000	Coverage Terminates at Age 70
Child(ren)	\$10,000	\$10,000	\$10,000	Coverage Terminates at Age 26

Employees may increase current benefit each year by \$10,000 without providing medical documentation, up to the Guarantee Issue Amount.





TAX SAVINGS FOR QUALIFIED EXPENSES

Health Savings Account (HSA)

Available for enrollment in eligible HDHP Plans



A Health Savings Account is an individually owned, tax-favored account that allows consumers to pay for qualified health care expenses.

An HSA must be coupled with a High Deductible Health Plan (HDHP) to receive the tax advantages allowed by the IRS. Premiums associated with an HDHP are typically lower than a traditional plan, allowing you to capture the savings to fund an HSA.

Similar to a 401(k), you can make tax-deductible contributions into an HSA and the account can earn interest tax-free. HSA funds can then be used to pay for any qualified, out-of-pocket medical expenses, such as deductible and prescription drug expenses. Once the deductible is met, the health plan begins paying some or all covered expenses, depending on the plan selected.

HSA Eligibility

In general, to be eligible for an HSA, you must meet the following criteria:

- You must be covered under a qualified HDHP and cannot have other health care coverage.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Benefits and Savings

HSAs provide several tax- and cost-savings benefits. By combining an HSA with a qualified HDHP, you can reduce your insurance premiums. Because it is a triple-tax savings account, contributions are 1) made tax free, 2) grow tax free and 3) can be withdrawn tax free to pay for a variety of qualified medical expenses, many of which are not covered by traditional health insurance plans (including dental visits, prescription drugs, eyeglasses, contact lenses, and chiropractor visits).

Unlike other benefit accounts, unused funds are rolled over annually, enabling them to be used for future expenses.

How Much Can I Contribute to an HSA?

The U.S. Treasury Department establishes annual contribution limits and minimum deductible amounts for HSAs and HSA-qualified health plans, which are adjusted each year for inflation. **The 2026 HSA limits are as follows:**

Contribution Limits

- Individual: \$4,400
- Family: \$8,750
- Catch-Up (55 and older): \$1,000

Deductible Requirements

- Individual: Not less than \$1,700
- Family: Not less than \$3,400

Max Out-of-Pocket Requirements

- Individual: Not to exceed \$8,500
- Family: Not to exceed \$17,000

You must be covered under a qualified HDHP and cannot have other health care coverage.

HSA Services

- User guide and educational communications
- NueSynergy smart debit card
- Competitive interest rates earned on the first dollar
- Dedicated HSA customer service assistance beyond simple balance inquiry
- Consultative support to help maximize HSA savings and benefits
- Monthly electronic account statements
- Claims shoebox (electronic record keeping of all receipts to help you stay compliant)
- Seamless integration allows funds to transfer between HSA and personal checking accounts for ease of contribution and reimbursement
- Online web tools, including personalized health plan cost comparison, out-of-pocket cost and future savings calculators, and educational tutorials
- NueSynergy smart mobile app with provider locator and cost transparency tools.

HSA Administration Fee: \$2.25 per employee, per month



Full-service administration of consumer-driven and traditional account-based plans.
855.890.7239 • 4601 College Blvd. Suite 280, Leawood, KS 66211 • www.NueSynergy.com



Example of HSA-eligible expenses

The IRS allows certain medical, dental, vision, and related services to be reimbursed through an HSA. Below is a partial list of expenses that qualify for HSA reimbursement. Over-the-counter (OTC) medications, while not listed below, are now eligible for HSA reimbursement.

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Artificial limb/teeth
- Bandages, Band-Aids, wraps, and splints
- Breast-reconstructive surgery following a mastectomy
- Birth control pills (Norplant, ovulation kits)
- Braille books and magazines
- Chiropractor professional fees
- Christian Science Practitioner fees
- Contact lenses/solution
- Contraceptives
- Crutches/braces and supports
- Dental treatment (exams, x-rays, fillings, root canals, dentures, and orthodontia; cosmetic treatments are not allowed}
- Diagnostic services and tests
- Drug dependency treatments
- Drugs (prescriptions)
- Eye surgery (includes cataract, LASIK, corneal rings, etc.)
- Physical therapy
- Pregnancy test kits
- Psychologist fees
- Schools and education (for mentally impaired or physically disabled person - see IRS publication 502)
- Special home for person adjusting from life in a mental institution to community living
- Sterilization procedures (vasectomy or tubal ligation)
- Stop-smoking program
- Surgical fees (for legal operations not cosmetic in nature)
- Speech therapy
- Eyeglasses, prescription
- Fertility treatment (ovulation predictor kits and pregnancy tests, in vitro fertilization, reverse a prior surgery that prevents you from having children)
- Guide dog or other animal used to assist persons with physical disabilities
- Health institute
- Hearing aids and batteries
- Hospital services
- Insulin, syringes
- Laboratory fees
- Lead-based point removal
- Legal fees (to authorize treatment for mental illness)
- Meals (only as part of inpatient hospital care)
- Nursing home (if necessary for medical care)
- Nursing services
- Operations (legal operations that are not cosmetic in nature)
- Orthodontia
- Orthopedic devices
- Osteopath fees
- Oxygen equipment
- Transplants (donor expenses, if you)
- Transportation and related travel expenses for a person seeking treatment (see IRS Publication 502)
- Treatment for learning disability caused by mental impairment, physical impairment, or nervous system disorders (Treatment must be recommended by a physician - see IRS Publication 502)
- Vaccinations
- Weight-loss program (only if medically necessary to treat existing disease and prescribed by a physician)
- Wheelchair
- Wigs (if purchased upon advice of a physician for the mental health of a patient)
- X-ray fees

More information about eligible expenses

This list is subject to change without notice due to legislation. A list of these expenses is available at www.IRS.gov in IRS Publication 502, "Medical, Dental, and Vision Expenses." In addition, HSAstore.com is also a useful resource.

COMMUNITY ACTION PROGRAM OF MID-NEBRASKA

EMPLOYEE ASSISTANCE PROGRAM SERVICES



Continuum EAP provides the benefits and solutions to help Mid employees and their families deal with virtually any personal issue, as well as resources to deal with a variety of workplace concerns. As a confidential employer benefit, the cost of services is covered by Mid to help employees proactively address their well-being.

EMPLOYEES AND THEIR IMMEDIATE FAMILY MEMBERS BENEFIT FROM THE FOLLOWING SERVICES:



Work/Life services

Help with life's daily challenges from parenting to elder care issues, stress management or workplace conflict. Continuum offers consultation and resources that can be accessed by talking directly with an EAP professional or by logging on to the online member site, HelpNet, which offers thousands of tools, including training courses, articles and videos to help you on and off the job.

Click "Member Login" at 4continuum.com
UN = ACTION
PW = 7636



Short-term counseling

Problem solving for all types of issues, including individual and family situations. Licensed counselors offer these services in person, over-the-phone and via video.



Legal assistance

Professional consultation with an attorney, discounted rates if further legal representation is desired for non-employment related issues; and self-help website with legal forms and resources.



Wellness coaching

Access to telephonic or online assistance with a certified wellness coach to help explore your personal wellness and get assistance with goal setting, behavioral change and overall health.



Financial coaching

Seasoned financial professionals will help analyze your relationship with money and your financial habits. Education on the basics of personal finance will help improve your financial confidence and well-being.

WILL PREPARATION SERVICES

Services provided by Epoq, Inc.

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Living Will and Trust
- Power of Attorney
- Healthcare Directive
- Pour-Over Will
- Last Will and Testament

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
- Answer the simple questions from any device and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Create your will at www.willprepservices.com
and use the code **MUTUALWILLS** to register



Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Will and other document preparation services are independently offered by Epoq, Inc. (Epoq) and are subject to its terms of service and privacy policy. Epoq is an online service that provides certain legal forms and legal information. Epoq is not a law firm and is not a substitute for an attorney's advice. United of Omaha Life Insurance Company and Epoq are independent, unaffiliated companies. Although United of Omaha Life Insurance Company make Epoq's services available to group life insurance customers, the use of Epoq's services is entirely voluntary. United of Omaha Life Insurance Company does not provide, is not responsible for, does not assume any financial liability for and does not guarantee the accuracy, adequacy or results of any service, advice or documents provided by Epoq. United of Omaha Life Insurance Company also is not responsible and do not assume liability for any disclosure of personal data or information by Epoq. These services are only available to group life insurance customers of United of Omaha Life Insurance Company. This service is not available in New York.



YOUR HEARING DISCOUNT PROGRAM

Program Benefits

In addition to your hearing care benefit, you will have access to complimentary aftercare*, including:

- Custom hearing solutions** — wide choice of products from the industry's leading brands
- Risk-free trial** — find your right fit by trying your hearing aids for 60 days
- Follow-up care** — ensures a smooth transition to your new hearing aids
- Battery support** — battery supply or charging station to keep your hearing aids powered
- Warranty** — 3-year coverage for loss, repairs, or damage
- Financing** — no interest for those who qualify
- Savings for family and friends** — your parents, siblings, in-laws, and friends qualify, too

**Risk-free trial - 100% money back guarantee if not completely satisfied, no return or restocking fees. Follow-up care - for one year following purchase. Batteries - two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty - Exclusions and limitations may apply. Contact Client Services at 1-844-267-5436 for details.*

Accessing Your Benefits is Easy

1. Call Amplifon at 1-888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

To learn more visit amplifonusa.com/mutualofomaha.

	Level 1	Level 2	Level 3	Level 4	Level 5
Hearing Aid Features	Standard features	Additional, easy-to-use functions	Designed for work and play	Enhanced to keep you on the go	Leading technology keeps you connected
One Simple Price	\$995	\$1,495	\$1,795	\$2,195	\$2,645



Rights and Disclosures

This information is intended to be shared by employees with their spouse and dependents

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 15 days after your or your dependents other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 15 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or to obtain more information contact Bukaty Companies at 888.657.0440.

Woman's Health and Cancer Rights Act (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Bukaty Companies at 888.657.0440 for more information.

COBRA Rights in the Event You Lose Your Dental or FSA Coverage

A group Dental or FSA plan is required to offer COBRA continuation coverage to you, your spouse and your dependents enrolled in the Plan when a qualifying event occurs that causes loss of group health coverage. Coverage may be available for 18 months up to a maximum of 36 months, depending upon the qualifying event. The employer is required to notify the Plan if the qualifying event is:

- Termination (for any reason other than gross misconduct) or reduction in hours of employment of the covered employee - eligible for up to 18 months of continuation coverage
- Death of the covered employee - eligible for up to 36 months of continuation coverage
- Covered employee becomes entitled to Medicare - eligible for up to 36 months of continuation coverage depending upon date of Medicare entitlement

The covered employee or one of the qualified beneficiaries is responsible for notifying the Plan Administrator within 60 days of the occurrence if the qualifying event is:

- Divorce or legal separation - eligible for up to 36 months of continuation coverage
- A child's loss of dependent status under the Plan - eligible for up to 36 months of continuation coverage.

Disability Extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of coverage for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To obtain the extended coverage, a copy of the SSA disability determination must be received by the Plan Administrator within 60 days after the determination is issued and within the individual's first 18 months of continuation coverage. If SSA determines later the individual is no longer disabled, that individual must notify the Plan Administrator within 30 days after the date of the second determination.

Second Qualifying Event

If while on 18 months of continuation coverage, family members enrolled in the Plan experience another qualifying event, they may be entitled to an additional 18 months of coverage, for a maximum of 36 months.

The extension may be granted if the employee or former employee dies, becomes entitled to Medicare or gets divorced or legally separated, or if the dependent child loses dependent status, but only if the events would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. When responsibility for notification rests with the covered employee or qualified beneficiary, notice of the qualifying event must be made within 60 days of the occurrence to the company's Plan Administrator.

Other Coverage Options Besides COBRA

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

Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to company's Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are

available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Us Informed of Status Changes

It is very important that you keep your Plan Administrator informed of address changes and other personal data changes for you and/or dependents who are or may become qualified beneficiaries on any of the company's group benefits. Changes should be reported to the Plan Administrator.

Lifetime Limit

The lifetime limit on the dollar value of benefits under your group health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan.

Individuals have 30 days from the date of this notice to request enrollment. For more information contact Bukaty Companies at 888.657.0440.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1.877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1.866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

Nebraska - Medicaid

Website:

<http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 1-402-473-7000

Omaha: 1-402-595-1178

Important Notice from Community Action Partnership of Mid-Nebraska

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Community Action Partnership of Mid-Nebraska and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Community Action Partnership of Mid-Nebraska has determined that the prescription drug coverage offered by Gravia Individual Coverage Health Reimbursement Account is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the ICHRA. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. You can keep your current coverage from Gravia Individual Coverage Health Reimbursement Account. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Community Action Partnership of Mid-Nebraska changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: November 5, 2025

Name of Entity/Sender: Community Action Partnership of Mid-Nebraska

Contact / Position: Libby Mathews / HR Director

Address / Phone: 16 W 11th Street, Kearney, NE 68847 / 308-865-5675



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins on November 1st for coverage starting as early as the following January 1st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.02% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact [Libby Mathews](#).

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Community Action Partnership of Mid-Nebraska		4. Employer Identification Number (EIN) 47-6039628	
5. Employer address 16 W 11th Street		6. Employer phone number 308-865-1354	
7. City Kearney	8. State Nebraska	9. ZIP code 68847	
10. Who can we contact about employee health coverage at this job? Libby Mathews, HR Manager			
11. Phone number (if different from above)		12. Email address lmathews@mnca.net	

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees. Eligible employees are:
Full-time employees working at least 30 hours per week.
 - Some employees. Eligible employees are:

- With respect to dependents:
 - We do offer coverage. Eligible dependents are:
legal spouse, and/or dependent children up to age 26
 - We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
- No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

- Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

- a. How much would the employee have to pay in premiums for this plan? \$ see employer
- b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? None

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)