1. Complete Highmark BCBS and/or Ameritas COBRA enrollment application form(s)[1].
    a. **Highmark BCBS**
        i. Effective Date – If your coverage was terminated on 2/29/2024, please use 3/1/2024 as effective date.
        ii. Group Number – Please include the COBRA Group number that corresponds to the plan you have chosen (e.g. Gold Plan PPO, PPO 800 = 10645478)
            1. Rates are listed on page 6 of this packet.[2]
            2. Plan summaries are pages 10-60.[3]
        iii. Life Event – COBRA Continuant Start Date - If your coverage was terminated on 2/29/2024, please use 3/1/2024 as effective date.
    b. Ameritas (Dental and/or Vision)
        i. Policy and Div. # - 202649
        ii. Cert. # - Please indicate either Low Plan or High Plan
            1. Rates are listed on page 9 of this packet.[4]
            2. Plan summaries are pages 61-70.[5]
        iii. COBRA Qualifying Event – Loss of coverage eligibility
        iv. Date of Event - If your coverage was terminated on 2/29/2024, please use 3/1/2024 as effective date.
2. Please sign enrollment application form(s) and email to both info@regulatoryresolutions.com and hr@stratfs.com **no later than Monday, May 13, 2024**.
3. Enrollment is usually processed by Highmark BCBS and Ameritas within a few business days.
4. Invoices for COBRA premiums will be emailed to enrolled participants.
5. Checks for COBRA premiums should be **payable to Strategic** and mailed to:

    StratFS Receivership
    C/O Thomas McNamara, Receiver
    655 West Broadway, Suite 900
    San Diego, CA 92101

6. Please email any questions to info@regulatoryresolutions.com and hr@stratfs.com.

[1] COBRA is not an option for Mutual of Omaha disability insurance. You may be eligible to continue (port/convert) your life and/or accidental death & dismemberment insurance. Please see pages 71-83 in this packet for more information.
[2] Rates provided are for plan year April 1, 2024 – March 31, 2025. The medical plans renewed effective 04/01/2024, therefore premiums for March 2024 and prior may be different.
[3] Plan summaries provided are for plan year April 1, 2024 – March 31, 2025. The medical plans renewed effective 04/01/2024, therefore coverage summaries for March 2024 and prior may be different.
[4] Rates provided are for plan year April 1, 2024 – March 31, 2025. The dental and vision plans renewed effective 04/01/2024, therefore premiums for March 2024 and prior may be different.
[5] Plan summaries provided are for plan year April 1, 2023 – March 31, 2024. The dental and vision plans renewed effective 04/01/2024; updated plan summaries will be posted upon receipt from the insurance carrier.

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HIGHMARK WESTERN NEW YORK

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

❑ **ENROLLING** (Complete sections I, II, IV, and V)

❑ **WAIVING** (Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll Location

First Name	MI	Last Name	Social Security Number *(If no SS#, write N/A)*

Address

City	State	Zip	County	Home/Cell Phone

Marital Status *(Please check one)*:
❑ Single/Widowed
❑ Married
❑ Divorced

Full-Time Hire (or Rehire) Date *(Month/Day/Year)*
_____/_____/_____

Enrollment Status
❑ Active Employee
❑ Rehired Employee
❑ Retiree
❑ HIPAA Life Event

Life Event
❑ COBRA Continuant Start Date _____/_____/_____
❑ Divorce
❑ Death of Spouse
❑ Loss of Student Status
❑ Dependent reached max age
❑ Left employ/retirement
❑ Add Dependent

Gender	Date of Birth *(Month/Day/Year)*	Age	Product Selection(s)
❑ M ❑ F ❑ U	/ /		❑ Medical Product Name: _____ ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ No

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Domestic Partner †

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ M ❑ F ❑ U	/ /	

Product Selection(s):
❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ No

† If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child
			❑ Step-child ❑ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s):	Dependent Status if Age 26 or Older
❑ Medical ❑ Vision ❑ Dental	❑ Disabled ❑ Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

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DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ M ❑ F ❑ U	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ❑ Medical ❑ Vision ❑ Dental			Dependent Status if Age 26 or Older ❑ Disabled ❑ Act 4**
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ M ❑ F ❑ U	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ❑ Medical ❑ Vision ❑ Dental			Dependent Status if Age 26 or Older ❑ Disabled ❑ Other
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ❑ Insured under spouse
- ❑ Other

_____

VISION

I HEREBY DECLINE VISION COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage formyself and/ormy dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed fivethousand dollars and the stated value of the claim for each such violation.

_____ _____

Employee/Contract Holder Signature Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

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 in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free Highmark Member Service number: 1-800-241-5704 (TTY/TDD: Dial 711).

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			❑ Active ❑ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Highmark Notice of Privacy Practices is available on the Highmark Web site, or from the Highmark Privacy Office.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (866) 605-9524

enrollmentandbillinghighmarkny@highmark.com

Membership Department
P.O. Box 4208
Buffalo, NY 14240-4208

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার িডে তালকাভ ুক্ত নম্বর ্রে তা পররে বায় ান করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

StratFS

COBRA Rates effective 4/1/2024 - 3/31/2025

Highmark BCBS Medical Plans - POS Plans (Buffalo HMO) COBRA Monthly Premium			
	Bronze Plan - POS	Silver Plan - POS	Gold Plan - POS
	POS 8200	POS 7200	POS 250D
	10645476	10645475	10645477
Employee only	$ 393.18	$ 417.19	$ 433.36
Employee + spouse	$ 982.94	$ 1,042.97	$ 1,083.39
Employee + child(ren)	$ 849.26	$ 901.12	$ 936.04
Employee + family	$ 1,297.48	$ 1,376.71	$ 1,430.07

Highmark BCBS Medical Plans - PPO Plans (outside Buffalo) COBRA Monthly Premium			
	Bronze Plan - PPO	Silver Plan - PPO	Gold Plan - PPO
	PPO 8000	PPO 7200	PPO 800
	10645480	10645479	10645478
Employee only	$ 418.64	$ 445.08	$ 459.55
Employee + spouse	$ 1,046.57	$ 1,112.70	$ 1,148.86
Employee + child(ren)	$ 904.24	$ 961.37	$ 992.61
Employee + family	$ 1,381.48	$ 1,468.76	$ 1,516.49

CLEAR FORM

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. of New York 1350 Broadway, Suite 2201 / New York, NY 10018 / 1-800-628-8889

Ameritas

Policy and Div. # **026-**_____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No
Are you covered under another **eye care** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐	☐	☐					☐
2	☐	☐	☐	☐					☐
3	☐	☐	☐	☐					☐
4	☐	☐	☐	☐					☐
5	☐	☐	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

StratFS

COBRA Rates effective 4/1/2024 - 3/31/2025

Ameritas Dental Plans COBRA Monthly Premium		
	Low Plan	High Plan
Employee only	$ 23.38	$ 29.54
Employee + spouse	$ 46.06	$ 58.18
Employee + child(ren)	$ 49.61	$ 72.13
Employee + family	$ 75.44	$ 105.88

Ameritas Vision Plans COBRA Monthly Premium		
	Low Plan	High Plan
Employee only	$ 6.00	$ 7.87
Employee + spouse	$ 9.59	$ 12.61
Employee + child(ren)	$ 9.79	$ 12.89
Employee + family	$ 15.79	$ 20.77

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-844-639-2441. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,000 individual/$8,000 family combined in-network and out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, and prescription drug benefits are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual/$10,000 family in-network out-of-pocket limit. $10,000 individual/$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	In-network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No coverage for preventive care visits 40% coinsurance for immunizations 40% coinsurance for screening services.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Formulary Generic drugs	$10/$20/$30 copay per prescription (retail) $10/$20/$20 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$30/$60/$90 copay per prescription (retail) $30/$60/$60 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Generic & Non-Formulary Brand drugs	$50/$100/$150 copay per prescription (retail) $50/$100/$100 per prescription (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$10 copay per prescription (formulary generic) $30 copay per prescription (formulary brand) $50 copay per prescription (non-formulary generic & non-formulary brand) (retail) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible.
	Urgent care	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible
If you have a hospital stay	Facility fees (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Precertification may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: 60 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Internal)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-844-639-2441.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, an independent consumer assistance program can help you file your appeal. Contact the consumer assistant services at 1-888-614-5400.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2441.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-844-639-2441. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual/$3,000 family combined in-network and out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services, and prescription drug benefits are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual/$10,000 family in-network out-of-pocket limit. $10,000 individual/$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	In-network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	$40 copay/visit	30% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No coverage for preventive care visits 30% coinsurance for immunizations 30% coinsurance for screening services.	
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/visit	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	$40 copay/visit	30% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Formulary Generic drugs	$10/$20/$30 copay per prescription (retail) $10/$20/$20 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$35/$70/$105 copay per prescription (retail) $35/$70/$70 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Generic & Non-Formulary Brand drugs	$70/$140/$210 copay per prescription (retail) $70/$140/$140 per prescription (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$10 copay per prescription (formulary generic) $35 copay per prescription (formulary brand) $70 copay per prescription (non-formulary generic & non-formulary brand) (retail) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Out-of-network: Subject to in-network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	$100 copay	$100 copay	Out-of-network: Subject to in-network deductible.
	Urgent care	$75 copay/visit	$75 copay/visit	Out-of-network: Subject to in-network deductible
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	30% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	30% coinsurance	Precertification may be required.
	Inpatient services	No charge	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge after first $25 copay	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	30% coinsurance	Combined in-network and out-of-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	$40 copay/visit	30% coinsurance	Combined in-network and out-of-network: 60 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	No charge	30% coinsurance	Precertification may be required.
	Durable medical equipment	50% coinsurance (DME) $25 copay (diabetic equipment & diabetic supplies)	50% coinsurance (DME) 30% coinsurance (diabetic equipment & diabetic supplies)	Precertification may be required.
	Hospice services	No charge (facility) $40 copay (professional)	30% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Internal)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com

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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-844-639-2441.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, an independent consumer assistance program can help you file your appeal. Contact the consumer assistant services at 1-888-614-5400.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2441.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-844-639-2441. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 individual/$2,000 family in-network. $1,000 individual/$2,000 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, preventive care services, emergency room care, emergency medical transportation, urgent care, outpatient mental health, outpatient substance abuse, home health care, and prescription drug benefits are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 individual/$6,000 family in-network out-of-pocket limit. $10,000 individual/$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

An example of a benefit book can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

What is not included in the out–of–pocket limit?	In-network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	$30 copay/visit Deductible does not apply.	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No coverage for preventive care visits 40% coinsurance for immunizations 40% coinsurance for screening services.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Formulary Generic drugs	$10/$20/$30 copay per prescription (retail) $10/$20/$20 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$30/$60/$90 copay per prescription (retail) $30/$60/$60 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Generic & Non-Formulary Brand drugs	$50/$100/$150 copay per prescription (retail) $50/$100/$100 per prescription (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$10 copay per prescription (formulary generic) $30 copay per prescription (formulary brand) $50 copay per prescription (non-formulary generic & non-formulary brand) (retail) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	$200 copay/visit Deductible does not apply.	$200 copay/visit Deductible does not apply.	Copay waived if admitted as an inpatient.
	Emergency medical transportation	$150 copay Deductible does not apply.	$150 copay Deductible does not apply.	----------none----------
	Urgent care	$30 copay/visit Deductible does not apply.	$30 copay/visit Deductible does not apply.	----------none----------
If you have a hospital stay	Facility fees (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge Deductible does not apply.	40% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge after first $30 copay Deductible does not apply.	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit Deductible does not apply.	40% coinsurance	Combined in-network and out-of-network: 200 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: 30 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	50% coinsurance (DME) $30 copay (diabetic equipment & diabetic supplies)	50% coinsurance (DME) 40% coinsurance (diabetic equipment & diabetic supplies)	Precertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Internal)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-844-639-2441.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, an independent consumer assistance program can help you file your appeal. Contact the consumer assistant services at 1-888-614-5400.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,900**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,630**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2441.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-844-639-2441. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 individual/$2,000 family in-network. $1,000 individual/$2,000 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, preventive care services, urgent care, outpatient mental health, outpatient substance abuse, home health care, and prescription drug benefits are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 individual/$6,000 family in-network out-of-pocket limit. $5,000 individual/$10,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out–of–pocket limit?	In-network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	$30 copay/visit Deductible does not apply.	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No coverage for preventive care visits 40% coinsurance for immunizations 40% coinsurance for screening services.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Formulary Generic drugs	$10/$20/$30 copay per prescription (retail) $10/$20/$20 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$30/$60/$90 copay per prescription (retail) $30/$60/$60 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Generic & Non-Formulary Brand drugs	$50/$100/$150 copay per prescription (retail) $50/$100/$100 per prescription (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$10 copay per prescription (formulary generic) $30 copay per prescription (formulary brand) $50 copay per prescription (non-formulary generic & non-formulary brand) (retail) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Out-of-network: Subject to in-network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	$150 copay	$150 copay	Out-of-network: Subject to in-network deductible.
	Urgent care	$30 copay/visit Deductible does not apply.	$30 copay/visit Deductible does not apply.	----------none----------
If you have a hospital stay	Facility fees (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge Deductible does not apply.	40% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge after first $30 copay Deductible does not apply.	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit Deductible does not apply.	40% coinsurance	Precertification may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: 20 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	50% coinsurance (DME) $30 copay (diabetic equipment & diabetic supplies)	50% coinsurance (DME) 40% coinsurance (diabetic equipment & diabetic supplies)	Precertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Internal)
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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

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Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,900**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2441.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-844-639-2441. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,000 individual/$8,000 family combined in-network and out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, and prescription drug benefits are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual/$10,000 family in-network out-of-pocket limit. $10,000 individual/$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	In-network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No coverage for preventive care visits 40% coinsurance for immunizations 40% coinsurance for screening services.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Formulary Generic drugs	$10/$20/$30 copay per prescription (retail) $10/$20/$20 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$30/$60/$90 copay per prescription (retail) $30/$60/$60 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Generic & Non-Formulary Brand drugs	$50/$100/$150 copay per prescription (retail) $50/$100/$100 per prescription (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$10 copay per prescription (formulary generic) $30 copay per prescription (formulary brand) $50 copay per prescription (non-formulary generic & non-formulary brand) (retail) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible.
	Urgent care	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible
If you have a hospital stay	Facility fees (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Precertification may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: 60 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Internal)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-844-639-2441.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, an independent consumer assistance program can help you file your appeal. Contact the consumer assistant services at 1-888-614-5400.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2441.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-844-639-2441. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual/$3,000 family combined in-network and out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services, and prescription drug benefits are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual/$10,000 family in-network out-of-pocket limit. $10,000 individual/$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	In-network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	$40 copay/visit	30% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No coverage for preventive care visits 30% coinsurance for immunizations 30% coinsurance for screening services.	
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/visit	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	$40 copay/visit	30% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myhighmark.com.	Formulary Generic drugs	$10/$20/$30 copay per prescription (retail) $10/$20/$20 copay per prescription (mail order) Deductible does not apply.	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply.
	Formulary Brand drugs	$35/$70/$105 copay per prescription (retail) $35/$70/$70 copay per prescription (mail order) Deductible does not apply.	Not covered	
	Non-Formulary Generic & Non-Formulary Brand drugs	$70/$140/$210 copay per prescription (retail) $70/$140/$140 per prescription (mail order) Deductible does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$10 copay per prescription (formulary generic) $35 copay per prescription (formulary brand) $70 copay per prescription (non-formulary generic & non-formulary brand) (retail) Deductible does not apply.	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Out-of-network: Subject to in-network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	$100 copay	$100 copay	Out-of-network: Subject to in-network deductible.
	Urgent care	$75 copay/visit	$75 copay/visit	Out-of-network: Subject to in-network deductible
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	30% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	30% coinsurance	Precertification may be required.
	Inpatient services	No charge	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge after first $25 copay	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	30% coinsurance	Combined in-network and out-of-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	$40 copay/visit	30% coinsurance	Combined in-network and out-of-network: 60 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	No charge	30% coinsurance	Precertification may be required.
	Durable medical equipment	50% coinsurance (DME) $25 copay (diabetic equipment & diabetic supplies)	50% coinsurance (DME) 30% coinsurance (diabetic equipment & diabetic supplies)	Precertification may be required.
	Hospice services	No charge (facility) $40 copay (professional)	30% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Internal)
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About these Coverage Examples:

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Peg is Having a Baby

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

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture

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

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2441.

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

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using in-network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-844-639-2441.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

Strategic Financial Solutions, LLC

Dental Highlight Sheet

Ameritas

Low Plan 1: Dental Plan Summary **Effective Date: 4/1/2023**

Plan Benefit	In Network	Out of Network
Type 1	100%	100%
Type 2	80%	80%
Type 3	50%	50%
Deductible	$25/Calendar Year Type 2 & 3 Waived Type 1 $50/family	$25/Calendar Year Type 1,2,3 $50/family
Maximum *(per person)*	$1,000 per calendar year	$1,000 per calendar year
Allowance	Discounted Fee	90th U&C
Waiting Period	None	None
Annual Eye Exam	None	None
Annual Open Enrollment	None	None

Orthodontia Summary - Child Only Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Plan Benefit	50%	50%
Lifetime Maximum *(per person)*	$1,500	$1,500
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network.*

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network

Type 1

- Routine Exam (1 in 6 months)
- Bitewing X-rays (1 in 12 months)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Periapical X-rays
- Cleaning (1 in 6 months)
- Fluoride for Children 14 and under (1 in 12 months)

Type 2

- Sealants (age 14 and under)
- Space Maintainers
- Fillings for Cavities
- Restorative Composites
- Denture Repair
- Simple Extractions

Type 3

- Onlays
- Crowns (1 in 10 years per tooth)
- Crown Repair
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
- Complex Extractions
- Anesthesia

Out of Network

Type 1

- Routine Exam (1 in 6 months)
- Bitewing X-rays (1 in 12 months)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Periapical X-rays
- Cleaning (1 in 6 months)
- Fluoride for Children 14 and under (1 in 12 months)

Type 2

- Sealants (age 14 and under)
- Space Maintainers
- Fillings for Cavities
- Restorative Composites
- Denture Repair
- Simple Extractions

Type 3

- Onlays
- Crowns (1 in 10 years per tooth)
- Crown Repair
- Endodontics (nonsurgical)
- Endodontics (surgical)
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- Periodontics (surgical)
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
- Complex Extractions
- Anesthesia

Strategic Financial Solutions, LLC

Dental Highlight Sheet

Ameritas

Ameritas of New York Information

We're Here to Help

This plan was designed specifically for the associates of **Strategic Financial Solutions, LLC.** At Ameritas of New York, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-659-5556. For plan information any time, access our automated voice response system or go online to ameritas.com.

Dental Health Scorecard

How would you rate your dental health?

In 2016, you can receive your Dental Health Report Card by signing into your secure member account online. Your assessment is based on claims submitted. The report card also offers suggestions if you strive to improve your dental health. Ameritas of New York members can access the personalized report card by going to ameritas.com, click Account Access in the top right corner and choose the Dental/Vision/Hearing drop down. Select the Secure Member Account link and sign in to see your report.

Rx Savings

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

To receive this Rx discount, Ameritas of New York plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eyewear Savings

Ameritas of New York plan members may receive up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas of New York plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER,** then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice.

Your provider network is Ameritas Classic Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Dental Cost Estimator

Members can use our dental cost estimator at any time to find average procedure charges in their area. The estimates do not include network discounts or plan benefits. Find the dental cost estimator at ameritas.com/applications/group/estimator.

After coverage begins, members can view average in-network charges in their secure member account. Members also may ask their dentist's office to submit a pretreatment estimate so they can see exactly how a proposed service would be covered and avoid any surprises. The pretreatment estimate is based on their plan benefits.

Strategic Financial Solutions, LLC

Dental Highlight Sheet

Ameritas

Worldwide Support

If a member has a dental emergency outside the U.S., AXA Assistance can help. AXA provides credible provider referrals and can even help with making the appointment. Providers referred by AXA are not members of the Ameritas of New York network. AXA contact information is available in the secure member account.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

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

Strategic Financial Solutions, LLC

Dental Highlight Sheet

Ameritas

High Plan 1: Dental Plan Summary **Effective Date: 4/1/2023**

Plan Benefit	In Network	Out of Network
Type 1	100%	100%
Type 2	80%	80%
Type 3	50%	50%
Deductible	$25/Calendar Year Type 2 & 3 Waived Type 1 $50/family	$25/Calendar Year Type 1,2,3 $50/family
Maximum *(per person)*	$1,500 per calendar year	$1,500 per calendar year
Allowance	Discounted Fee	90th U&C
Waiting Period	None	None
Annual Eye Exam	None	None
Annual Open Enrollment	None	None

Orthodontia Summary - Child Only Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Plan Benefit	50%	50%
Lifetime Maximum *(per person)*	$1,500	$1,500
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network.*

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network

Type 1

- Routine Exam (1 in 5 months)
- Bitewing X-rays (1 in 5 months)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Periapical X-rays
- Cleaning (1 in 5 months)
- Fluoride for Children 14 and under (1 in 5 months)
- Sealants (age 16 and under)
- Space Maintainers

Type 2

- Fillings for Cavities
- Restorative Composites
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Denture Repair
- Simple Extractions
- Complex Extractions
- Anesthesia

Type 3

- Onlays
- Crowns (1 in 5 years per tooth)
- Crown Repair
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Out of Network

Type 1

- Routine Exam (1 in 5 months)
- Bitewing X-rays (1 in 5 months)
- Full Mouth/Panoramic X-rays (1 in 3 years)
- Periapical X-rays
- Cleaning (1 in 5 months)
- Fluoride for Children 14 and under (1 in 5 months)
- Sealants (age 16 and under)
- Space Maintainers

Type 2

- Fillings for Cavities
- Restorative Composites
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Denture Repair
- Simple Extractions
- Complex Extractions
- Anesthesia

Type 3

- Onlays
- Crowns (1 in 5 years per tooth)
- Crown Repair
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

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Dental Highlight Sheet

Ameritas

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Language Services

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Strategic Financial Solutions, LLC

Eye Care Highlight Sheet

Ameritas

Plan 1: Focus® Plan Summary **Effective Date: 4/1/2023**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Member cost up to $60	No benefit
Elective	Up to $150	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$150**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (member cost)*

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Strategic Financial Solutions, LLC

Eye Care Highlight Sheet

Ameritas

Additional Focus® Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Rx Savings

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

To receive this Rx discount, Ameritas of New York plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eye Care Plan Member Service

Focus eye care from Ameritas of New York features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

Strategic Financial Solutions, LLC

Eye Care Highlight Sheet

Ameritas

Plan 2: Focus® Plan Summary **Effective Date: 4/1/2023**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Member cost up to $60	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$130**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (member cost)*

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Strategic Financial Solutions, LLC

Eye Care Highlight Sheet

Ameritas

Additional Focus® Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

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VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

LIFE INSURANCE

PORTABILITY PROCESS

If your group coverage ends, you may have the opportunity to continue ("port") your life/accidental death and dismemberment insurance policy to a group term life insurance policy at an affordable group rate. These rates are not the same as what you paid on a payroll deduction basis. However, you may port an amount up to your previous coverage level without medical underwriting.*

Follow these steps to successfully port your life insurance:

1. Obtain a Portability Request Form at mutualofomaha.com/support/forms
2. Select I am a Plan Member and choose your state
3. Click on the Coverage Continuation Forms - Portability and Conversion drop down, then select the Standard Term Life Portability request form
4. Complete all sections of the request form
5. Attach check or money order for the premium payment (see request form to determine amount)
6. Completed form must be received by Mutual of Omaha within 60 days of the coverage end date
7. Mutual of Omaha will contact your employer to verify any discrepancies, if needed
8. You will receive a notification once a determination has been made

For questions regarding eligible insurance amounts or the portability process, please contact Mutual of Omaha at (877) 466-8367.

*Portability is available for amounts up to $500,000 if you are under 70 years old.

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Companion Life Insurance Company
Mutual of Omaha Affiliates

615173_1123

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

Group Portability
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (877) 466-8367

A Guide for Successfully Completing the Mutual of Omaha Term Life Portability Request Form

Mutual of Omaha appreciates the opportunity to provide you with valuable life insurance protection for yourself and/or your loved ones. So that we can effectively process your request for life insurance under the Term Life Portability Plan, we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

About the Form

The Term Life Enhanced Portability Form is a request for insurance under Mutual of Omaha's Term Life Portability Plan. Insurance under this plan is available to employees/members (hereafter referred to as "members") and/or eligible dependents when insurance under a Mutual of Omaha group term life insurance plan (voluntary and/or basic) offered by an employer/group ceases.

A completed and signed form with initial premium payment MUST be mailed to Mutual of Omaha within 60 days after insurance has ceased under the group plan for your request to be considered. All sections of the form are to be completed. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of the form will be delayed. Please contact the employer/benefits administrator to determine or confirm information as needed.

Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.

Section 1: Employer/Group Information

Provide the name and ID number for the employer/group. The number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to the employer/group. The original date of hire or date of association for the member must also be provided.

Section 2: Applicant Information

Please provide all required applicant information. If the Member is eligible to port insurance, the member must be the applicant and elect insurance for dependents to be eligible. If the member is not eligible to port insurance, the spouse (in the event of divorce or the employee's death, for example) can be the applicant and is eligible to port term life insurance for her/himself and dependents.

The applicant must be age 70* or less to be eligible for insurance. Insurance under the portability plan terminates at age 70*.

To ensure any additional correspondence regarding your request occurs as quickly as possible, check the box to consent to receive future correspondence via email.

Section 3: Dependent Information

To be eligible to port term life insurance, dependents must have been insured under the group plan on the day preceding the day coverage ceased under the plan. If the member is eligible to port insurance, the member must elect insurance for dependents to be eligible.

Section 3: Dependent Information (continued)

In addition, a spouse must be age 70* or less and children age 26* or less to be eligible for insurance. Spouse insurance under the portability plan terminates at age 70*, and child insurance terminates at age 26*.

If the applicant is a spouse, do not provide spouse information in this section.

Section 4: Current Term Life Insurance Amount(s) Eligible For Portability

For the applicant and eligible dependents, provide the term life insurance amount(s) that were both:

- In-force at the time coverage ceased under the group plan; and
- Eligible for portability† (the contract for coverage contained a portability provision).

These are the maximum amount(s) of coverage that can be requested under the portability plan.

†You may have had group life insurance under a Voluntary Term Life Insurance plan, a Basic Life Insurance plan, or both, from the group. Any plan must include a portability provision for the insurance available to you under the plan to be portable. It may be possible that the insurance you had under a Voluntary Term Life Insurance plan is portable, but the insurance you had under a Basic Life Insurance plan is not, for example. Please consult the contract for each plan or the employer/benefits administrator to determine if portability is available.

IMPORTANT: If a living benefit payment has been received, portability continuation is not available.

Section 5: Monthly Rates Per $1,000 of Insurance

These are the monthly rates per $1,000 of insurance that apply under the Term Life Portability Plan.

The member and spouse rates are age banded, which means that the premium for member and spouse insurance is assessed according to age – as the member or spouse age and advances to the next age band, premiums for insurance will increase accordingly. The initial premium payment is based on the current age of the member or spouse. The child rate does not vary by age.

If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose. This rate is the same for member, spouse and child(ren) and does not vary by age.

The rates presented in Section 5 are used in Section 6 to determine premium for insurance under the portability plan.

Section 6: Portability Insurance Election & Initial Premium Payment Calculation

To complete insurance election and initial premium payment calculation, the type of insurance requested must be indicated, then premium amounts must be calculated for each individual for whom ported insurance is being requested, and a billing mode must be selected.

First, select the type of insurance requested, either "Life Insurance Only" or "Life and AD&D Insurance." If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose.

Next, do the following to complete this section:

(1) Provide the first name of each individual for whom ported insurance is being requested.

(2) Provide the Insurance Amount each individual is requesting (rounded up to the nearest $1,000), subject to the following:

- The Insurance Amount for each individual must be less than or equal to the amount of insurance the individual had when insurance ceased under the group plan, not to exceed $500,000. The maximum amounts are equivalent to the Current Insurance Amounts indicated in Section 4.
- The Insurance Amount for the employee must be $10,000 or more. The Insurance Amount for spouse must be $5,000 or more, and for child(ren), $2,000 or more.
- If the applicant is an employee, dependent spouse and child(ren) insurance amounts must be less than or equal to 50% of the insurance amount applied for by the member.
- Insurance Amount(s) must be in increments of $5,000 for the member and/or spouse. (Example: $10,000 and $25,000 are acceptable insurance amounts, but $12,000 and $27,000 are not.) The Insurance Amount for child(ren) must be in $1,000 increments.

(3) Calculate the Coverage Factor for each individual, by dividing your Insurance Amount (2) by 1,000. (Example: $25,000 / 1,000 = 25; 25 is the Coverage Factor.)

Section 6: Portability Insurance Election & Initial Premium Payment Calculation (continued)

(4) Insert the appropriate monthly rate per $1,000 of insurance for each individual, for the current age for member and/or spouse. Rates are provided in Section 5. If you are requesting both life and AD&D insurance, you must add the AD&D monthly rate per $1,000 ($0.060) to the life monthly rate per $1,000 to obtain the appropriate monthly rate per $1,000. (Example: The appropriate monthly rate per $1,000 for a 34 year old applicant requesting life and AD&D coverage is $0.254 ($0.194 for Life plus $0.060 for AD&D).)

(5) Calculate the Monthly Premium for each individual, by multiplying the Coverage Factor (3) by the Monthly Rate (4).

(6) Calculate the Total Monthly Premium, by adding together all of the amounts in the Monthly Premium (5) column.

(7) Select a billing frequency. To pay premium every 3 months (quarterly), insert a "3" into column (7). To pay premium twice a year (semi-annually), insert a "6" into column (7). To pay premium annually, insert a "12" into column (7).

(8) Calculate the Initial Premium Payment, by multiplying the Total Monthly Premium (6) by the Billing Frequency (7).

Section 7: Beneficiary For Death Benefits

You must designate a beneficiary for any life insurance proceeds in the event of your death. You (the applicant) are the beneficiary for any dependent life insurance.

If you wish to designate additional beneficiaries (beyond what space allows for on the form), please attach an additional sheet of paper to the form that includes the required information.

Section 8: Acknowledgement and Signature

Read the statements in this section. If you understand and agree to the statements, sign and date the form to complete the form. Your signature binds you to the statements in this section, and allows the form to be processed by Mutual of Omaha.

Section 9: Instructions

Follow these instructions to ensure your request is properly submitted and received by Mutual of Omaha. Be sure to include the Group ID Number on any payment, and mail the request form and the payment to Mutual of Omaha as soon as possible after your coverage ends under the group plan.

Remember, to be considered for coverage under the Term Life Portability Plan, your request must be received within 60 days of the date coverage under the group plan ended.

*The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, lets say you are 69 years old on October 1, 2015. Your Attained Age for the policy year (October 1, 2015 – September 30, 2016) is 69, even if your 70th birthday is in November. In this example, you are eligible for coverage under this plan until September 30, 2016.

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

Group Portability
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (877) 466-8367

Term Life Portability Request Form

Please refer to "A Guide for Successfully Completing the Term Life Portability Request Form" when completing this form. Please consult the employer/benefits administrator if you need assistance with information for the form.

Section 1: Group Information and Date of Hire/Association (Please print clearly. Required fields are marked with an asterisk (*).)

Group/Employer Name* | Group ID Number* G000 ___ ___ ___ ___ | Date of Hire/Association (MM/DD/YYYY)*

Section 2: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name* | First Name* | MI

Street Address* | Email Address

City* | State* | ZIP Code* | Telephone*

Birth Date (MM/DD/YYYY)*† | Social Security Number* | Gender*

†The applicant must be the Attained Age of 70 or less to be eligible for insurance.

❑ Female ❑ Male

Consent to Email Correspondence
❑ Check this box if you consent to receiving future correspondence regarding this request via email.

Applicant Type*
❑ Employee/Member
❑ Spouse

Individuals for Whom Ported Insurance is Being Requested* (†Applies to employee/member applicants)
❑ Myself ❑ Myself & Spouse† ❑ Myself, Spouse & Child(ren)† ❑ Myself & Child(ren)

Reason for Request*
If you are an employee/member applicant, indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:
❑ Status Change/Reduction in Hours Date of Change: _____
❑ Employment/Association Terminated Date of Termination: _____
❑ Plan Terminated by Group/Employer Date of Termination: _____
❑ Employee/Member Retirement Date of Retirement: _____

If you are a spouse applicant, please indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:
❑ Divorce Date of Divorce: _____
❑ Death of Employee/Member Date of Death: _____
❑ Ineligible Due to Employee/Member Age Date of Ineligibility: _____
❑ Ineligible Due to Employee/Member Active Military Status; Date of Ineligibility: _____

Section 3: Dependent Information (Please print clearly. All fields are required for any dependents requesting insurance.)

Dependent Type	Last Name	First Name	MI	Date of Birth† (MM/DD/YYYY)	Gender
❑ Spouse ❑ Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male

†A spouse must be the Attained Age of 70 or less and children must be the Attained Age of 26 or less to be eligible for insurance.

Section 4: Current Term Life Insurance Amount(s) Eligible for Portability (Please print clearly.)

	Applicant*	Spouse (If applicable)	Child(ren) (If applicable)
Eligible Insurance Amount	$	$	$

Section 5: Monthly Rates Per $1,000 of Insurance

	Employee/Member and Spouse Rates										Child Rate
Age	0 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	All Ages
Life Rate	$0.173	$0.173	$0.194	$0.248	$0.395	$0.642	$1.009	$1.660	$2.533	$4.083	$0.120
AD&D Rate	$0.060 (applies to Employee/Member, Spouse and Child for all ages)										

†The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, lets say you are 69 years old on October 1, 2016. Your Attained Age for the policy year (October 1, 2015 - September 30, 2016) is 69, even if your 70th birthday is in November. In this example, you are eligible for insurance under this plan until September 30, 2016.

Section 6: Portability Insurance Election & Initial Premium Payment Calculation

Type of Insurance Requested

❑ Life Insurance Only ❑ Life and AD&D Insurance *(This option can only be selected if an AD&D rider was available under the group plan)*

Initial Premium Payment Calculation

	(1) First Name	(2) Insurance Amount	(3) Coverage Factor (2) / 1,000	(4) Monthly Rate Life + AD&D if applicable	(5) Monthly Premium (3) X (4)	(6) Total Monthly Premium Sum of column (5) amounts	(7) Billing Frequency	(8) Initial Premium Payment (6) X (7)
Applicant								
Spouse								
Child								
Child						$ _____	_____	$ _____
Child								
Child								
Child								

Section 7: Beneficiary For Death Benefits

Important Note: AZ, CA, ID, LA, NV, NM, TX, WA and WI are community property states. If you live in a community property state and you designate someone other than your spouse as a beneficiary, state law requires that your spouse consent to such designation. If you do not obtain your spouse's consent to the foregoing designation(s), then such designation(s) may not be effective.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Applicant	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Applicant	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Section 8: Eligibility Conditions

To be eligible for Life continuation insurance, you satisfy the following conditions:

- You have not received a living benefit payment.

Section 9: Acknowledgement and Signature

I understand that I may request insurance under the portability plan subject to the following:

- I understand that this insurance is subject to the rules of the policy governing the portability plan.
- I understand that the individuals covered under this plan must satisfy the plan's requirements to be eligible for benefits and that payment of premium does not ensure eligibility for insurance. In the event that any premium is collected after eligibility for portability insurance ceases, I understand that the unearned premium will be refunded in accordance with the terms of the policy governing the portability plan.
- This request for insurance must be received by Mutual of Omaha within 60 days of the date that insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha.
- Premium amounts may increase if any of the individuals insured under the plan enter a higher premium age category, or if portability plan experience requires a change for all individuals insured under the plan.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF APPLICANT _____ DATE _____/_____/_____

Section 10: Instructions

1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ceased under the group plan. The form and payment must be received by Mutual of Omaha within 60 days of the date insurance under the group plan ended.
2) Make the check or money order for the Initial Premium Payment payable to United of Omaha Life Insurance Company. Be sure to include the Group ID Number (from Section 1) on the payment.
3) Submit this form and payment to:
   Mutual of Omaha
   Policyowner Services
   P.O. Box 2147
   Omaha, NE 68103-2147

If you have any questions regarding this form, please contact the employer/benefits administrator, or contact Mutual of Omaha toll-free at (877) 466-8367.

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

EMPLOYEE BENEFITS

PORTABILITY VS. CONVERSION

If your group coverage ends or reduces, you may be eligible to continue ("port") your employer sponsored life/accidental death & dismemberment insurance to a group term life insurance policy or convert your life insurance policy to an individual whole life insurance policy in order to maintain coverage.

The grid below outlines the differences between Portability and Conversion to help you determine the best option for you. If you have any questions regarding the Portability or Conversion process, please contact your Benefits Administrator or take advantage of the toll-free number provided by Mutual of Omaha Insurance Company. You can reach a service representative by calling (877) 466-8367, Monday through Friday 8:00 a.m. to 4:30 p.m. (Central Standard Time).

	Portability	Conversion
Availability	Standard with voluntary life plans Optional with basic life	Standard with all plans
Coverage Continues as	Group Term Life Insurance	Whole Life Insurance
Eligibility	Employee and/or spouse are under age 70 when group coverage ends	Group life coverage terminates or is reduced for any reason
Children	Eligible as long as employee and/or spouse has ported coverage and child is under age 26	Eligible if group life coverage terminates or is reduced for any reason
Election Period	Request form must be received within 60 days of employer sponsored insurance ending	Application must be received within 60 days of employer sponsored insurance ending/reducing
Medical Information	None required	None required
Rates	Based on amount of insurance and age with rates increasing as the employee or spouse ages	Based on amount of insurance, gender, age and rates do not change as the employee or spouse ages
Billing Options	Quarterly, semiannually, annually	Quarterly, semiannually, annually
Cash Value	No (Term Insurance)	Yes (Permanent Insurance)
Termination	Age 70 for Employee and/or Spouse Limiting age for children 26	Death
Living Benefit	Included	Not included
Minimum	Employee: $10,000 Spouse: $5,000 Dependents: $2,000	$1,000 increments
Maximum	Lesser of prior coverage under group plan or $500,000 for Employee or $250,000 for Spouse	Amount of prior coverage under group plan

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Companion Life Insurance Company
Mutual of Omaha Affiliates

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EMPLOYEE BENEFITS

CONVERSION PROCESS

If your group coverage ends or reduces, you have the opportunity to convert your employer sponsored life insurance policy, or voluntary life insurance policy, to an individual whole life policy. You may convert an amount up to your previous coverage level without medical underwriting.

Follow these steps to successfully convert your life insurance:

1. Obtain a Group Life Conversion Form at mutualofomaha.com/support/forms
2. Select I am a Plan Member and choose your state
3. Select the Group Life Conversion Form
4. Complete all sections of the application form
5. Mutual of Omaha will contact your employer to verify any discrepancies, if needed
6. Attach check or money order for the premium payment (see application to determine amount)
7. Send completed form and premium payment within **60 days** of group insurance ending or reducing to the address on the application
8. Receive notification from us once your request has been processed

For questions regarding eligible insurance amounts or the conversion process, please contact Mutual of Omaha at (800) 826-8054.

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Companion Life Insurance Company
Mutual of Omaha Affiliates

615172_1123

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

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 826-8054

Life Conversion Coverage

Life Goes on with Group Conversion

Your group life insurance has been valuable protection for you and your family. Now that it will be terminated, you may wish to convert this important coverage to an individual policy. This information has been prepared to help you take advantage of your right to continue your protection.

About Life Conversion Coverage

Life Conversion Coverage is individual permanent life insurance issued without evidence of insurability.

Life Conversion Coverage can be obtained when your life insurance under the group policy ends. Your group certificate will describe when conversion coverage is available to you, and will show the amount of coverage you can convert.

Conversion coverage will be issued without evidence of good health, provided:

(a) you complete the attached application,
(b) you enclose a check or money order for the first premium payment and
(c) these items are forwarded to us within 60 days after your group insurance ends.

Your conversion policy will be effective on the 60th day after your group insurance ends. During this 60-day period, you remain covered under the continued coverage provision of your group certificate.

You may apply for an amount that is not more than the amount of your current group insurance coverage (this is your maximum). You may elect coverage in $1,000 increments up to your maximum.

The individual policy is Permanent Life Insurance, which provides a level benefit throughout your lifetime. Premiums for this coverage are payable while living until the policy anniversary following age 100.

Premium rates are shown in the table that follows. If premium payments are discontinued after your coverage has been issued, you may:

(a) receive any existing cash value or
(b) use the cash value to purchase extended term insurance or a reduced amount of paid-up life insurance.

For additional information or premium rates on conversion coverage, please write or call us at:

Attn: Group Policy Services, Group Conversion
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: 1-800-826-8054

To Apply for Life Conversion Coverage

In order to apply for life conversion coverage, you must do the following:

1) Complete the Life Conversion Application that follows. Use black or blue ink. Write clearly and do not erase – any corrections should be crossed out and initialed by you. Answer each question fully – do not use dashes or ditto marks.

2) Make sure the section entitled "Information to be Completed by the Personnel Office" is completed by the employer or administrator of the group policy.

3) Attach your check or money order payable to United of Omaha Life Insurance Company for the first annual, semiannual or quarterly premium payment.

4) Send your premium payment and completed application to the above address and must be received within 60 days after your group insurance ends.

Privacy Notice: When United of Omaha Life Insurance Company evaluates an application for life conversion coverage, only the information on the application is reviewed. This information, and other information we may later collect to administer coverage, may sometimes be disclosed without your express authorization. We have a procedure which allows you to review and amend any information we collect about you – other than information relating to a claim, lawsuit or criminal proceeding. If you would like to know more about our information practices, please write us at the address shown above.

Calculating the Premium

The premium amounts in the table below are per $1,000 of coverage. Calculate your annual, semiannual or quarterly premium in the calculation worksheet, following the steps and example below.

To Calculate Annual, Semiannual and Quarterly Premium:

1) Divide your desired death benefit amount by 1,000.
2) Locate your age group and gender on the table below to identify the premium rate per thousand.
3) Multiply #1 by #2 above.
4) Add $36 for the annual policy fee to obtain the **annual premium** for the coverage.
5) Multiply the annual premium by .52 to obtain the **semiannual premium** for the coverage.
6) Multiply the annual premium by .275 to obtain the **quarterly premium**.

Rate/$1,000		
Issue Age	Female	Male
0-4	4.33	4.33
5-9	5.32	5.32
10-14	6.18	6.18
15-17	8.10	8.10
18-19	9.00	10.00
20-24	10.50	11.60
25-29	12.50	13.80
30-34	14.50	16.50
35-39	17.00	20.00
40-44	19.50	24.99
45	21.80	24.99
46	22.27	25.81
47	22.86	26.76
48	23.57	27.82
49	23.91	28.45
50	24.12	29.16
51	25.00	30.45

Rate/$1,000		
Issue Age	Female	Male
52	25.48	31.37
53	26.31	32.58
54	27.26	34.16
55	28.31	35.83
56	29.29	37.36
57	30.17	38.99
58	31.04	40.52
59	32.02	42.26
60	33.33	44.44
61	35.18	47.39
62	36.92	50.22
63	38.78	53.16
64	40.63	56.11
65	42.48	59.05
66	45.21	63.08
67	47.93	67.11
68	50.66	71.15

Rate/$1,000		
Issue Age	Female	Male
69	53.49	75.18
70	56.22	79.21
71	60.03	84.44
72	63.95	89.57
73	68.23	95.29
74	72.56	101.07
75	77.76	108.23
76	84.32	116.48
77	90.23	124.09
78	95.77	131.07
79	101.36	138.23
80	107.00	145.45
81	115.74	157.07
82	124.44	168.92
83	132.70	180.01
84	140.84	191.10
85	149.10	202.19

Example (Assumes a 50-year-old male with current group life coverage of $20,000.)

20	x	$29.16	=	$583.20	+	$36	=	$619.20
Desired coverage amount/$1,000		Premium rate per thousand		Premium for coverage		Annual policy fee		**Total annual premium**

$619.20	x .52	=	$321.98
Total annual premium			**Total semiannual premium**

Calculation Worksheet

_____	x	_____	=	_____	+	$36	=	$ _____
Desired coverage amount/$1,000		Premium rate per thousand		Premium for coverage		Annual policy fee		**Total annual premium**

_____	x .52	=	_____
Total annual premium			**Total semiannual premium**

Conversion Application

This completed application with premium payment must be received within 60 days after your group insurance ends. Mail the conversion to: **Attn: Group Policy Services**, Group Conversion, United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175.

Life Insurance Section

1) Applicant's Name (First, Middle, Last)

_____

2) Social Security Number

_____

3) ❑ Male ❑ Female

4) Age _____ 5) Date of Birth _____ _____ _____
Month Day Year

6) Residence (Number, Street, City, State ZIP)

_____

_____

7) Home Phone Number (_____) _____

8a) Amount of Insurance $ _____
(Show amount in thousands, not greater than the amount you are entitled to convert.)

8b) Has a living benefit been paid? ❑ Yes ❑ No

9) Mode of Premium Payments
❑ Annually ❑ Semiannually ❑ Quarterly

10) Amount Paid with Application

$ _____
Important: If a living benefit has been paid, the full amount of coverage must be continued.

11) Beneficiary Information

Primary Beneficiary

Full Name _____

Relationship to Applicant _____

Secondary Beneficiary

Full Name _____

Relationship to Applicant _____

Payment will be shared equally by all primary beneficiaries who survive you; if none, it will be shared equally by all contingent beneficiaries who survive you. Unless otherwise stated, you have the right to change the beneficiary.

Group Insurance Section

1) Group Policyholder _____

Group Policy No. _____

2) I have been insured under the above Group Policy as:
❑ An employee or member ❑ A dependent

3) I became insured under the Group Policy:

_____ Month _____ Day _____ Year

4) My group insurance terminated:

_____ Month _____ Day _____ Year

5) Was termination due to disability? ❑ Yes ❑ No
(If "Yes," give date and cause of disability.)

_____

Life Agreements Section

I am applying to United of Omaha for the life conversion coverage shown above. I agree United will not be under any obligation or liability under this application unless:

1) I have the right to convert the insurance shown above.

2) The application is fully completed, premium payment enclosed and received within 60 days after my group insurance ends.

Date _____ , _____

State signed in _____

Applicant's
Signature _____

Whole Life Policy Form ICC17L161P, or state equivalent. In CT, D662LCT17P. In FL, D654LFL17P. In ND, D658LND17P. In SD, D656LSD17P.

Information to be Completed by the Personnel Office

Group Policyholder _____

Policy No. _____ Phone (_____) _____

Address (Number, Street, City, State ZIP) _____

Applicant's Name _____

Certificate No. _____

1) The Applicant was insured under the above Group Policy as: ❑ An employee or member ❑ A dependent

2) For what amount of coverage was the Applicant insured? $ _____

3) What is the Applicant's date of birth? _____ Month _____ Day _____ Year

4) When did the Applicant become insured under the Group Policy? _____ Month _____ Day _____ Year

5) The Applicant's coverage was: ❑ terminated on _____ Month _____ Day _____ Year

❑ reduced by $ _____on _____ Month _____ Day _____ Year

6) On what date was the Applicant notified of their right to continue this life insurance coverage? _____

Because of _____

_____

Completed by _____ Signature (Employer or Administrator)

Title _____ Date_____ , _____

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.