



PONCA TRIBE OF NEBRASKA



BENEFIT ENROLLMENT GUIDE

2026



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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 34-35 where Notice of Creditable Coverage begin for more details.

CONTACT INFORMATION



CARRIER CONTACT INFORMATION

MEDICAL

Provider Name: Medica - Customer Service, see the back of your ID Card
Pharmacy – Rx www.Medica.com/DrugCost7
Medica provider finder: www.Medica.com/FindCare



DENTAL

Provider Name: Delta Dental (866) 827-3319
Provider Web Address: www.deltadentalne.org
Network – Delta Dental PPO Premier Plus



VISION

Provider Name: VSP
Provider Contact: (800) 877-7195/ www.vsp.com



GROUP LIFE AND DISABILITY INSURANCE

Contact Human Resources:

CRITICAL ILLNESS—ACCIDENT AND HOSPITAL INDEMNITY PLANS

Provider Name: Unum
Provider Contact: (800) 275 8686
Website: www.unum.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Provider Name: Best Care
Provider Web Address: Website: www.BestCareEAP.org
Provider Phone Number: (800) 801-4182
Login: USER: bcPONCAe – Password: PONCA



PONCA TRIBE OF NEBRASKA - 2026 BENEFITS RATE SHEET (employee costs)



MEDICAL - MONTHLY PREMIUMS				
	National Network Employee Cost	National Network PTN Cost	CHI/Elevate Network Employee Cost	CHI/Elevate Network PTN Cost
Employee Only	\$174.34	\$697.32	\$0.00	\$697.32
Employee + Spouse	\$384.40	\$1,446.08	\$307.52	\$1,156.86
Employee + Child(ren)	\$347.79	\$1,308.36	\$278.23	\$1,046.69
Employee + Family	\$610.16	\$1,830.47	\$488.13	\$1,464.38



DENTAL MONTHLY PREMIUMS		
	Employee Cost	PTN Cost
Employee Only	\$0.00	\$30.82
Employee + Spouse	\$51.87	\$30.82
Employee + Child(ren)	\$51.57	\$30.82
Employee + Family	\$51.87	\$30.82



VISION MONTHLY PREMIUMS		
	Employee Cost	PTN Cost
Employee Only	\$0.00	\$9.94
Employee + Spouse	\$11.42	\$9.94
Employee + Child(ren)	\$11.42	\$9.94
Employee + Family	\$11.42	\$9.94

PONCA TRIBE OF NEBRASKA - 2026 Voluntary Benefits (employee costs)



HOSPITAL – MONTHLY COST	
Monthly Premium	
Employee Only	\$31.71
Employee + Spouse	\$59.80
Employee + Child(ren)	\$41.93
Employee + Family	\$70.02

ACCIDENT – MONTHLY COST	
Monthly Premium	
Employee Only	\$12.19
Employee + Spouse	\$21.34
Employee + Child(ren)	\$26.45
Employee + Family	\$35.60

CRITICAL ILLNESS – MONTHLY COST	
\$10,000	
Age Band ²	Monthly Premium ¹
Under 25	\$4.10
25-29	\$4.80
30-34	\$5.50
35-39	\$6.50
40-44	\$8.00
45-49	\$10.00
50-54	\$12.90
55-59	\$17.10
60-64	\$27.00
65-69	\$36.00
70-74	\$48.90
75-79	\$68.10
80	\$93.80

CRITICAL ILLNESS – MONTHLY COST	
\$20,000	
Age Band ²	Monthly Premium ¹
Under 25	\$8.20
25-29	\$9.60
30-34	\$11.00
35-39	\$13.00
40-44	\$16.00
45-49	\$20.00
50-54	\$25.80
55-59	\$34.20
60-64	\$54.00
65-69	\$72.00
70-74	\$87.80
75-79	\$136.20
80	\$187.60

CRITICAL ILLNESS – MONTHLY COST	
\$30,000	
Age Band ²	Monthly Premium ¹
Under 25	\$12.30
25-29	\$14.40
30-34	\$16.50
35-39	\$19.50
40-44	\$24.00
45-49	\$30.00
50-54	\$38.70
55-59	\$51.30
60-64	\$81.00
65-69	\$108.00
70-74	\$146.70
75-79	\$204.30
80	\$281.40



As consumers of health care, we have many choices on how and where we receive care. Although health care costs continue to rise, your employer is committed to offering a benefits plan that is valuable and accessible to you and your family.

Ponca Tribe of Nebraska has been diligent in searching for benefits that help our employees and their families satisfy their insurance needs. A brief overview of the providers and the benefits offered by each are listed below. For more detailed information on a specific benefit, please refer to the full plan documents.

Medica - Medical

Delta Dental of Nebraska - Dental plan

Vision Service Plan (VSP) - Vision plan

Unum - Basic Life - Supplemental Life - Short-Term Disability - Long-Term Disability

Unum - Critical Illness - Accident - Hospital

Best Care - Employee Assistance Program (EAP)

It is wise to remember the health care choices we make when visiting our physician, purchasing prescription drugs at the pharmacy, or utilizing one of the benefits offered by our plan, impacts both our health and our financial well - being. As smart consumers, we should ask about generic drugs and talk to our doctors about treatment options. Taking care of yourself can positively impact your quality of life.

After you review the enclosed information, please choose the coverage that is best for you and your family.

Please log in to ADP to enroll in coverage

Sincerely,

**Your Benefits Team
Ponca Tribe of Nebraska**

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

MEDICAL BENEFITS OVERVIEW



Who is Eligible and When:

You are eligible to enroll in the benefits described in this guide on 1st of the month following 30 days of full-time employment: Spouse/Domestic Partner and children up to age 26.

In-Network Benefits You Receive:

Comprehensive PPO* Group Medical Plans:

- 1,500 deductible
- \$30 office visit copay
- \$60 Specialist office visit copay
- 20% co-insurance

Retail Prescription Drug Benefit:

- Generic Prescriptions – \$10 copay
- Preferred Brand Drugs - \$30 copay
- Non-Preferred Brand Drugs - \$55 copay
- Specialty Drugs – Preferred: 20% after deductible, Non-Preferred: 40%

Mail Order:

- For maintenance medications, you will receive a 90-day supply for three co-pays:
- Generic Prescriptions – \$30 copay
- Preferred Brand Drugs - \$90 copay
- Non-Preferred Brand Drugs - \$165 copay

If your spouse or domestic partner's employer offers a health Insurance plan, they will need to enroll in their employer offered plan. If they do not enroll in their employer offered plan, you can not enroll them in the Ponca Tribe of Nebraska medical plan. If your spouse is not offered health insurance through their employer or your spouse is unemployed, you can enroll your spouse as a dependent on the Ponca Tribe of Nebraska medical plan.



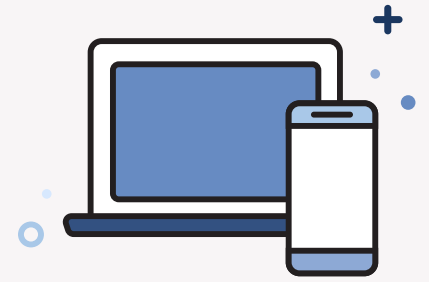
MEDICAL BENEFITS



MEDICAL BENEFIT SUMMARY

Medica	In-Network	Out-of-Network
*Deductible (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Co-insurance	20%	50%
Out-of-Pocket Max (Deductible included)	\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 Family
PCP Office Visit (limits to 30 visits)	\$30 copay per visit	50% after deductible
Specialist Office Visit	\$60 copay per visit	50% after deductible
Preventive Care	No charge	50% after deductible
Urgent Care Visit	\$30 copay per visit	50% after deductible
Emergency Services	20% after deductible	20% after deductible
In-Patient Hospital	20% after deductible	50% after deductible
Home Health Care	20% after deductible	50% after deductible
Outpatient Therapies (Speech- Occupational -Physical) (limits to 60 visits)	\$30 copay per visit	50% after deductible
Lab Work / X-Ray	Lab: 0%; X-Ray 20%, after deductible	50% after deductible
Prescription Drug Coverage – Retail (31 Days)	\$10/\$30/\$55 per prescription	\$15/\$45/\$115 per prescription
Prescription Drug Coverage – Specialty (31 Days)	Preferred: 20% coinsurance. No more than \$200. Non-Preferred: 40%, deductible does not apply	Not covered
Prescription Mail Order – 93 Days	\$30/\$90/\$165 per prescription	Not covered

Virtual care with Amwell



Save time, connect with a provider online

Virtual care, also known as online care or an e-visit, is a quick, cost-effective, and easy way to get care for non-urgent, common health conditions like:

- Allergies
- Bladder infection
- Bronchitis
- Cold and cough
- Ear pain
- Flu
- High blood pressure
- Migraines
- Pink eye
- Rashes
- Sinus infection

With Amwell

- Receive care from a board-certified doctor or nurse practitioner
- Access behavioral health care services, including therapy and psychiatry*
- Get help for many common medical conditions

24/7 doctor access

Amwell is a virtual care clinic available to members in all states anytime, day or night. You can talk to a doctor in minutes without an appointment or long wait times. It's a great option when your primary care doctor isn't available; when you're traveling; or if you need fast, real-time, non-emergency care. Medical visits are \$67 or less, depending on your plan.

Benefits

- Save time — avoid a trip to the doctor's office and get care from the comfort of your home, work, or wherever you are.
- Get care for non-urgent medical conditions when you need it — visits are available 24/7.
- Save money — a virtual care visit typically costs less than a regular visit to the doctor's office, depending on your plan.

Behavioral health services

You can also get behavioral health care services through Amwell, including therapy and psychiatry. With virtual behavioral health care, you get the same care and attention you'd expect from an in-office visit, plus you can schedule at times that are convenient for you. Eligible services are covered under your plan as a behavioral health office visit.*

Other services

Amwell also offers other online services, but is not an in-network provider for those services. You can use those services, but you will pay the full cost.

Getting started with Amwell is easy

Enroll

Take a few minutes to create an account with Amwell:

- **Smartphone/tablet:** Download the free Amwell app from the App Store or on Google Play.
- **Computer:** Go to **Amwell.com/cm**.
- **Phone:** Call **1 (844) 733-3627**.

Choose

Select a doctor or nurse practitioner and follow the prompts to start your visit.

Visit

The provider will review your history, answer questions, diagnose, treat you, and prescribe medication (if needed). If you need a prescription, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's prescription drug coverage.

*To check your plan's coverage for behavior health, sign in to your secure member website at **Medica.com/SignIn** or call the number on the back of your Medica ID card.

Medica CallLink®



Put worries to rest with 24/7 support

Medica CallLink connects you with trusted advisors and nurses to get the health answers you need—at no extra cost.

Features you'll love

- Learn more about a diagnosis.
- Decide what type of care will meet your needs.
- Understand symptoms and treatment options.
- Make a plan to add healthy habits to your day.
- Discover the right way to take your medications.
- Find a doctor or hospital and make an appointment.
- Get information on preventive screening services and immunizations.
- Access a 1,000+ audio library on many health and wellness topics.

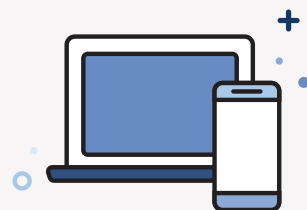


Need help? We're here.

Talk with an advisor or nurse, 24/7. **1 (800) 962-9497** (TTY: **711**).

*Medica CallLink is not available with all Medica plans. If the CallLink phone number is not listed on the back of your Medica ID card, and you want to see if your plan includes this service, please contact Customer Service. The Customer Service number is listed on the back of your Medica ID card. The information offered by this service is not intended to be a substitute for professional medical advice. Always seek the advice of your physician or other qualified health providers with questions you may have regarding a medical condition. No part of this service is intended to provide a medical diagnosis or treatment.

Medica member account

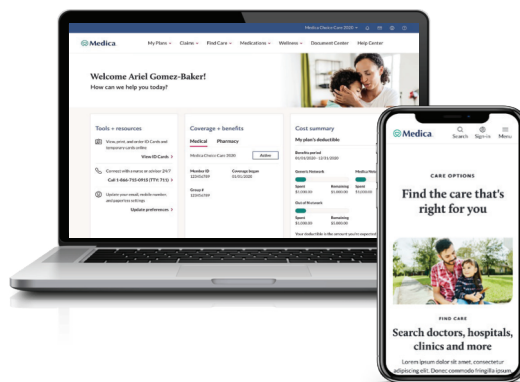


Use your one-stop health plan resource

Member support is just a click away. You'll find answers, claims tracking, and everything in-between. And getting plan information is easy — it's all in your account online or in the app.

With your member account, you can:

- Download or print your ID card
- Find in-network doctors, clinics, and pharmacies
- Track your medical claims and prescription drugs
- See what your plan covers and find out your share of the costs for procedures and prescriptions
- Explore wellness programs and behavioral health resources
- Find documents and forms easily



Create or access your account now to enjoy these benefits. You can do it three ways: Scan the QR code, go to **Medica.com/SignIn**, or search for the “Medica Member” app in the App Store and Google Play store.



Have questions? We're here to help.

Call Member Services at the number on the back of your Medica ID card (TTY: 711) or find answers to commonly asked questions in your member account at **Medica.com/SignIn**.

Ponca Tribe of Nebraska

Group #000456

Plan Benefit Highlights			
Network(s)	Delta Dental PPO™	Delta Dental Premier®	Non-Participating*
Calendar Year Plan Maximum Per person per calendar year	\$1,000	\$1,000	\$1,000
Lifetime Ortho Maximum Per eligible covered member	\$1,000	\$1,000	\$1,000
Deductible Per person per family per calendar year <i>No deductible for diagnostic and preventive, or orthodontic services</i>	None	\$50/person \$150/family	\$50/person \$150/family
Eligible Dependents	Spouse, domestic partner and dependent children up to age 26		
Covered Services	Dental Benefit Plan Coverage		
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Space maintainers	100%	100%	100%
Basic Services Sealants Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth Composite resin restorations (white fillings) on posterior (back) teeth will be paid at the amalgam allowance	85%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	85%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	85%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	85%	80%	80%
Major Restorative Crowns and Crown repair	50%	50%	50%
Prosthetic Repairs and Adjustments Denture adjustments and repairs Bridge repair	50%	50%	50%
Prosthetics Dentures (full and partial) Bridges Standard Implant coverage	50%	50%	50%
Orthodontics Treatment for the prevention/ correction of malocclusion <i>Available for covered members, ages 8 to age 19</i>	50%	50%	50%

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.



Make the Most of Your Benefits

Thank you for choosing Delta Dental of Nebraska as your partner in oral health. Dental insurance is designed to pay a portion of the costs associated with your dental care. Having dental insurance is essential to keeping your mouth healthy by providing access to preventive care, such as cleanings and X-rays, and helps cover extensive dental procedures such as crowns and fillings.

Online Tools for Members:

www.DeltaDentalNE.org



Save Money, Go In Network:

Search for a participating dentist or specialist, clinic or location. By seeking care from a Delta Dental network dentist, you will save the most money because the dentist is not allowed to bill you more than our allowable charge.



The Power of Smile™ Oral Health Library:

Learn about current topics and trends in dentistry and the importance of oral health as it relates to overall health from our team of experts.



Dental Insurance 101:

Robust member tools including commonly defined insurance terms, videos and frequently asked questions.



Prefer to Speak to Someone?

Call our national customer service

Toll Free: 1-866-827-3319
Monday-Friday: 7 a.m.-7p.m. central

Tools Available in the Secure Member Portal



Coverage Summary:

Review your dental plan information including eligibility, waiting periods, plan maximums and frequency limitations.



Claims Inquiry:

View claim status, procedure details, dates of service and applied deductibles.

View your explanation of benefits (EOB) online.

Check out our new feature to opt-out of the paper delivery of your EOB.



Print ID Cards:

Print a digital or replacement ID card.

Secure Member Portal Registration

1. On DeltaDentalNE.org, go to the member page and click "Access My Secure Portal"
2. Select the Employer Plan option click "Log In Here" and follow the steps to register.
3. Remember your username and password because you will need them each time you log in.



The Power of Smile™

Learn more about how your oral health connects to your overall health at:
DeltaDentalNE.org



Delta Dental of Nebraska

VISION INSURANCE



Benefits You Receive:



Benefit	Co-Pay	Frequency
Eye Exam	\$10	Limited to once every 12 months
Lens	\$20	Limited to once every 12 months
Frame Allowance	\$200 allowance; Extra \$20 allowance for featured brands	Limited to once every 24 months
Contact Lenses (up to \$130 max)	\$130 allowance, Fitting/Evaluation up to \$60	Limited to once every 12 months

Contacts and frames cannot be purchased in the same benefit year.



LIFE INSURANCE



LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Insured by Unum



Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Ponca Tribe of Nebraska. The company provides basic life insurance of **\$50,000** at no cost to you if you participate in the medical plans offered by Ponca Tribe of Nebraska. Note: Benefit age reduction schedule: 65% of the original amount when you reach age 65, 50% of the original amount when you reach age 70

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Ponca Tribe of Nebraska provides AD&D coverage of **\$50,000** at **no cost** to you. This coverage is in addition to your company-paid life insurance described above if you participate in the medical plans offered by Ponca Tribe of Nebraska.

Voluntary Life

Insured by Unum

You may purchase life insurance in addition to the company-provided coverage. You may also purchase life insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to \$150,000 and up to \$50,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee—Increments of \$10,000; \$500,000 maximum amount or 5 times earnings- Age reduction schedule: 65% of the original amount when you reach age 65; 50% of the original amount when you reach age 70.

Spouse—Up to \$250,000 in increments of \$5,000 of the employee elected and approved and approved amount \$50,000 of coverage without medical underwriting.

Children—Live birth to 14 days is \$1,000; 14 days to 6 months is \$1,000; 6 months and older is \$1,000 increments to a maximum of \$10,000.

Disability Insurance

Insured by Unum

Ponca Tribe of Nebraska also provides disability insurance through Unum. This benefit replaces a portion of your income if you become disabled and are unable to work.

	How it Works	Who Pays for the Benefit
Short-term Disability	You receive 67% of your income up to \$1,000 per week. Benefits begin after 7 calendar days of absence from work and continue for up to 12 weeks.	Company
Long-term Disability	You receive 67% of your income up to \$7,000 per month. Benefits begin after 90 calendar days of absence from work and continue until you reach the Social Security Normal Retirement Age.	Company

Calculate your costs

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate.
Use the rate table (at right) to find the rate based on age.
(Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date.)
4. Enter your cost.

	1	2	3	4
Employee	\$_____,000	÷ \$10,000 = \$_____	X \$_____	= \$_____
Spouse	\$_____,000	÷ \$5,000 = \$_____	X \$_____	= \$_____
Child	\$_____,000	÷ \$1,000 = \$_____	X \$_____	= \$_____
Total cost				

Supplemental Life Insurance Rates

Employee monthly rate		Spouse monthly rate	Child monthly rate
Age	Per \$10,000 of coverage	Per \$5,000 of coverage	\$0.650 per \$1,000 of coverage
	Cost	Cost	
15-24	\$0.300	\$0.150	
25-29	\$0.500	\$0.250	
30-34	\$0.800	\$0.400	
35-39	\$1.300	\$0.650	
40-44	\$1.800	\$0.900	
45-49	\$2.700	\$1.350	
50-54	\$3.800	\$1.900	
55-59	\$5.600	\$2.800	
60-64	\$6.800	\$3.395	
65-69	\$8.500	\$4.245	
70-74	\$15.600	\$7.795	
75+	\$55.110	\$27.560	

1. Enter the AD&D coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate.
Use the AD&D rate table (at right) to find the rate.
4. Enter your cost.

AD&D				
	1	2	3	4
Employee	\$_____,000	÷ \$10,000 = \$_____	X \$0.530	= \$_____
Spouse	\$_____,000	÷ \$5,000 = \$_____	X \$0.265	= \$_____
Child	\$_____,000	÷ \$1,000 = \$_____	X \$0.053	= \$_____
Total cost				

AD&D monthly rates		
	Coverage amount	Rate
Employee	per \$10,000 of coverage	\$0.530
Spouse	per \$5,000 of coverage	\$0.265
Child	per \$1,000 of coverage	\$0.053

Group Critical Illness Insurance



How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive \$50 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose \$10,000, \$20,000 or \$30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 100% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses

- Heart attack
- Stroke
- Major organ failure
- End-stage kidney failure
- Sudden cardiac arrest
- Coronary artery disease
Major (50%):
Coronary artery bypass graft or valve replacement
Minor (10%):
Balloon angioplasty or stent placement

Cancer conditions

- Invasive cancer — all breast cancer is considered invasive
- Non-invasive cancer (25%)
- Skin cancer — \$500

Progressive diseases

- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss
- Huntington's Disease
- Lupus
- Muscular Dystrophy
- Myasthenia Gravis
- Systemic Sclerosis (Scleroderma)
- Addison's Disease

Supplemental conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D
- Occupational PTSD
- Paid at 25%:**
- Infectious Diseases
- Pulmonary Embolism
- Transient Ischemic Attack (TIA)
- Bone Marrow/Stem Cell

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations.

Monthly costs		
Age	Employee coverage: \$10,000 Spouse coverage: \$10,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$4.10	\$4.10
25 - 29	\$4.80	\$4.80
30 - 34	\$5.50	\$5.50
35 - 39	\$6.50	\$6.50
40 - 44	\$8.00	\$8.00
45 - 49	\$10.00	\$10.00
50 - 54	\$12.90	\$12.90
55 - 59	\$17.10	\$17.10
60 - 64	\$27.00	\$27.00
65 - 69	\$36.00	\$36.00
70 - 74	\$48.90	\$48.90
75 - 79	\$68.10	\$68.10
80 - 84	\$93.80	\$93.80
85+	\$139.40	\$139.40

Monthly costs		
Age	Employee coverage: \$30,000 Spouse coverage: \$30,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$12.30	\$12.30
25 - 29	\$14.40	\$14.40
30 - 34	\$16.50	\$16.50
35 - 39	\$19.50	\$19.50
40 - 44	\$24.00	\$24.00
45 - 49	\$30.00	\$30.00
50 - 54	\$38.70	\$38.70
55 - 59	\$51.30	\$51.30
60 - 64	\$81.00	\$81.00
65 - 69	\$108.00	\$108.00
70 - 74	\$146.70	\$146.70
75 - 79	\$204.30	\$204.30
80 - 84	\$281.40	\$281.40
85+	\$418.20	\$418.20

Monthly costs		
Age	Employee coverage: \$20,000 Spouse coverage: \$20,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$8.20	\$8.20
25 - 29	\$9.60	\$9.60
30 - 34	\$11.00	\$11.00
35 - 39	\$13.00	\$13.00
40 - 44	\$16.00	\$16.00
45 - 49	\$20.00	\$20.00
50 - 54	\$25.80	\$25.80
55 - 59	\$34.20	\$34.20
60 - 64	\$54.00	\$54.00
65 - 69	\$72.00	\$72.00
70 - 74	\$97.80	\$97.80
75 - 79	\$136.20	\$136.20
80 - 84	\$187.60	\$187.60
85+	\$278.80	\$278.80

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees may have a waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date. If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at <https://www.medicare.gov/publications/02110-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people-with-medicare.pdf>



Ponca Tribe of Nebraska

Group Accident Insurance



How does it work?

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

How much does it cost?

Your monthly premium	
You	\$12.19
You and your spouse	\$21.34
You and your children	\$26.45
Family	\$35.60

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 25% increase in payable benefits within the Injury and Treatment schedule of benefit categories. See disclosures and schedule of benefits for more information.

Building Benefit

Your plan includes the building benefit, which continues to increase the value to your Accident plan each year you are insured. Your plan has the following building benefit: coverage inforce 13 - 36 months = 5%; coverage inforce 37 - 60 months = 10%; coverage inforce 61+ months = 15%.

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	\$75,000
Spouse	\$37,500
Children	\$18,750
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	\$75,000
Spouse	\$37,500
Children	\$18,750
Dismemberment	
Both Feet	\$75,000
Both Hands	\$75,000
One Foot	\$37,500
One Hand	\$37,500
Thumb and Index Finger of the same Hand	\$18,750
Coma	
Coma	\$15,000
Home & Vehicle Modifications	
Home & Vehicle Modifications	\$1,750
Loss of Use	
Hearing (one ear)	\$18,000
Hearing	\$37,500
Sight of one Eye	\$37,500
Sight of both Eyes	\$75,000
Speech	\$37,500
Paralysis	
Uniplegia	\$18,750
Hemi/Paraplegia	\$37,500
Triplegia	\$56,250
Quadriplegia	\$75,000
Hospitalization	
Admission	\$1,500
Admission – Hospital ICU (added to Admission)	\$2,500
Daily Stay (365 days)	\$400
Daily Stay – Hospital ICU (added to Daily Stay)	\$600
Short Stay	\$200
Injury	
Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	\$1,000
2nd Degree Burns - 20% or greater of skin surface	\$2,000
3rd Degree Burns - Less than 5% of skin surface	\$4,000

Injury

3rd Degree Burns - At least 5%, but less than 20% of skin surface	\$10,000
3rd Degree Burns - 20% or greater of skin surface	\$20,000
Concussion	
Concussion	\$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	\$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	\$150
Dislocations	
Ankle bone or bones of the foot (other than toes)	\$3,000
Collarbone (acromioclavicular and separation)	\$600
Collarbone (sternoclavicular)	\$1,200
Finger or Toe (Digit)	\$300
Hand (other than Fingers)	\$900
Elbow joint	\$900
Wrist joint	\$900
Shoulder	\$900
Hip joint	\$6,000
Knee joint (other than patella)	\$3,000
Kneecap (patella)	\$900
Lower Jaw	\$900
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	\$200
Fractures	
Ankle (lower tibia or fibula)	\$800
Foot or Heel (other than Toes)	\$800
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	\$1,200
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	\$800
Finger or Toe (Digit)	\$400
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	\$800
Hip or Thigh (femur)	\$6,000
Kneecap (patella)	\$800
Leg (mid to upper tibia or fibula)	\$2,400
Lower Jaw, Mandible (other than alveolar process)	\$800
Pelvis	\$2,400
Rib	\$800
Tailbone (coccyx), Sacrum	\$800
Vertebral Processes	\$800

Injury

Skull (except bones of Face or Nose), Depressed	\$8,000
Skull (except bones of Face or Nose), Non-depressed	\$4,000
Upper Arm between Elbow and Shoulder (humerus)	\$1,200
Upper Jaw, Maxilla (other than alveolar process)	\$1,200
Vertebrae, body of (other than Vertebral Processes)	\$2,400
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	\$200
Lacerations	
No Repair	\$85
Repair Less than 2 inches	\$250
Repair At least 2 inches but less than 6 inches	\$500
Repair 6 inches or greater	\$1,000
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	\$1,250
One Digit (a Thumb or Big Toe)	\$1,875
Two or more Digits	\$2,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	\$250
Ruptured or Herniated Disc	
One Disc	\$210
Two or more Discs	\$350
Other	
Injury due to felony & sexual assault	\$250
Organized Sports	25%
Recovery	
At-Home Care	\$100
Physician Follow-Up Visits	\$75
Physician Follow-Up Maximum Visits	2 Visits
Prescription Drug	\$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	\$100
Behavior Health Therapy	\$20
Behavior Health Therapy visits	15 Days
Therapy Services (chiro, speech, PT, occ, acupuncture/alternative)	\$20
Therapy Services Maximum Days	15 Days

SCHEDULE OF BENEFITS

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	\$60
General Anesthesia	\$150
Connective Tissue	
Exploratory without Repair	\$75
Repair for One Connective Tissue	\$600
Repair for Two or more Connective Tissues	\$900
Eye Surgery	
Eye Surgery, Requiring Anesthesia	\$200
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	\$1,000
Exploratory	\$100
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	\$100
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	\$100
Knee Cartilage (Meniscus) with Repair	\$500
Outpatient Surgical Facility	
Outpatient Surgical Facility	\$200
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	\$100
One Disc	\$525
Two or more Discs	\$800

Treatment

Organized Sports	25%
Ambulance	
Air	\$2,000
Ground	\$800
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	\$65
Tier 2 (bedside commode, cold therapy system, crutches)	\$125
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	\$250

Treatment

Emergency Dental Repair	
Dental Crown	\$450
Dental Extraction	\$150
Filling or Chip Repair	\$115
Imaging	
Tier 1 - X-rays or Ultrasound	\$150
Tier 2 - Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	\$300
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	\$200
Prosthetic Device	
One Device or Limb	\$1,000
Two or more Devices or Limbs	\$2,000
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	\$375
Not Burns - 20% or greater of skin surface	\$750
Treatment	
Emergency Room Treatment	\$200
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	\$50
Pain Management Injections (epidural, cortisone, steroid)	\$150
Transfusions	\$500
Transportation (per trip)	\$150
Family Care	\$50
Pet Boarding (per day)	\$30
Treatment in a Physician's Office or Urgent Care Facility (initial)	\$200



Ponca Tribe of Nebraska

Group Hospital Insurance



How does it work?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

Group Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

Who can get coverage?

You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

How much does it cost?

Your monthly premium	
You	\$31.71
You and your spouse	\$59.80
You and your children	\$41.93
Family	\$70.02

Coverage may vary by state. See exclusions and limitations.

The plan does not include a pre-existing condition limitation. You are covered from day one.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicaid <https://www.medicare.gov/publications/02110-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people>

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	\$1,500
ICU Admission (added to Admission)	Payable for a maximum of 1 day per year	\$500
Hospital Daily Stay	Payable per day up to 365 days	\$200
ICU Daily Stay (added to Daily Stay)	Payable per day up to 30 days	\$400
Short Stay	Payable for a maximum of 1 day per year	\$250

Exclusions and Limitations

Hospital insurance filed policy name is Group Hospital Indemnity Insurance Policy. The definition of hospital does not include certain facilities. See your contract for details.

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees may have a waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Continuity of coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date of this certificate.

Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate.

If you have not returned to Active Employment before any Insured's covered loss, any benefits payable will be limited to what would have been paid by the prior carrier.

Childbirth Limitation

We will pay benefits due to Childbirth for any Insured after the Insured's Coverage Effective Date.

Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- Committing or attempting to commit a felony;
- Being engaged in an illegal occupation;
- Injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- Active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- Participating in war or any act of war, whether declared or undeclared;
- Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- Being intoxicated;
- A Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- Elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;{{CHILDBIRTH}}
- Any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- Voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
- Stroke, Alzheimer's disease, trauma, viral infection; or
- Other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for hospital insurance.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GHIP16-1 and Certificate Form GHIC16-1 or contact your Unum representative.

Unum complies with applicable civil union and domestic partner laws.

Underwritten by: Unum Insurance Company, Portland, Maine

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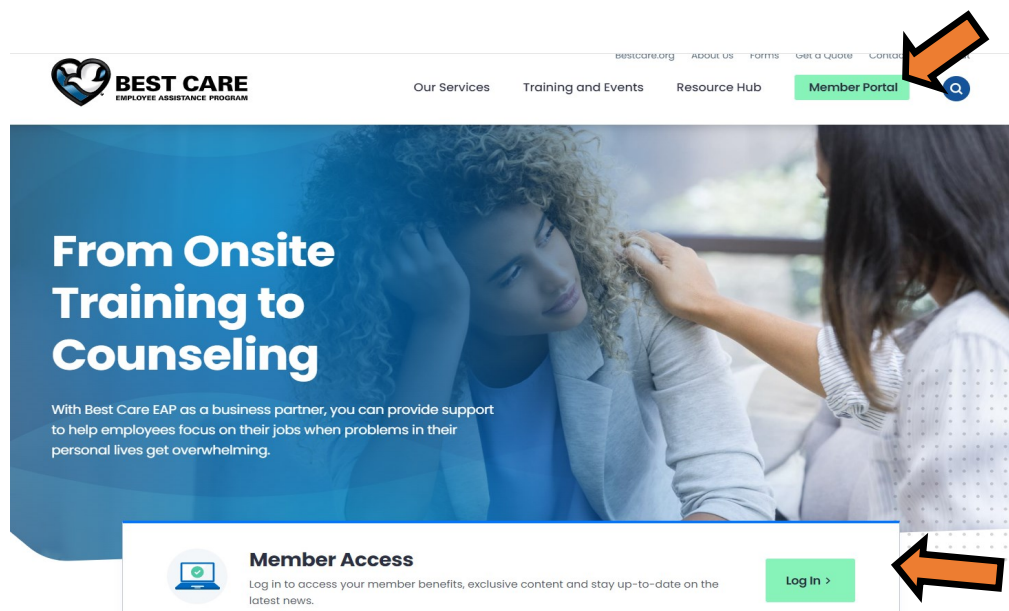
Best Care Employee Assistance Program (EAP)

Summary of Services for **PONCA TRIBE of NEBRASKA**

- **Short Term Counseling** Best Care EAP (Employee Assistance Program) provides short-term confidential counseling for any kind of personal or job issue including but not limited to: stress, marriage/relationship, family, work/life balance, addiction and recovery, grief and loss, parenting, depression and anxiety.
- **Your Benefit Includes FIVE (5)** counseling sessions for you or your eligible family members.
- **Legal & Financial Services** Assistance is available for legal and financial concerns that can cause much stress in your life. Contact Best Care EAP to access this service.
- **Training and Wellness Resources** Best Care EAP provides a comprehensive web site including numerous health and wellness articles, educational webinars and well-being assessments.
- **Confidential** Your use of Best Care EAP counseling is completely confidential and protected under HIPAA. Information cannot be shared with anyone (including your employer) without your written permission, unless otherwise required by law.
- **Cost Effective** Best Care EAP services are purchased by your employer, and available to you at no cost.
- **Convenient** Day, evening and weekend appointments are available to meet your needs. Sessions are available in-person, online via secure website or by phone. Crisis and emergency services are available 24 hours a day, 7 days a week.

To access your web portal, visit www.BestCareEAP.org, click on the Member Login tab at the top right hand corner and login with the following info:

Member ID: bcPONCAe, Password: PONCA



We're here for you! Call (402) 354-8000 or (800) 801-4182

Email eap@BestCareeap.org



RETIREMENT PROGRAM - 401(K)

Insured by ADP Retirement Services

The Ponca Tribe of Nebraska is pleased to offer you the Ponca Tribe of Nebraska 401(k) Plan as a benefit to help you reach your financial goals for retirement. Helping you to save for a more financially secure retirement is one way that Ponca Tribe of Nebraska thanks you for your contribution to the organization's success.

Participating in the plan is easy. You contribute a percentage of your salary to your plan each payday through convenient payroll deductions. The Ponca Tribe of Nebraska will match your contribution up to 7% of your annual salary. To participate, you must be at least 21 years of age and have completed your 90 day introductory period. You are eligible to participate in the plan the first day of the quarter following completion of the eligibility requirements. Participation is open to both full-time and part-time employees.

Your contributions and any rollover contributions are always 100% vested for your benefit. You are fully vested to retain company contributions after 3 years of continuous service to the Ponca Tribe of Nebraska.

Please refer to your plan booklet provided at your orientation for more information in regards to the specifics of your plan.

To get started go to www.mykplan.com to set-up your log-in information!



Public Service Loan Forgiveness (PSLF) Program

The Public Service Loan Forgiveness program is a federal benefit that helps eligible employees with federal student loan debt by forgiving the remaining balance on their *Direct Loans* after they meet specific service and payment requirements. To qualify, an employee must:

- **Work full-time** (typically ≥ 30 hours/week) for a *qualifying public service employer* such as a government agency or certain nonprofit organization. [Consumer Financial Protection Bureau+1](#)
- Have eligible **federal Direct Loans**. Other federal loans (e.g., FFELP or Perkins) may qualify only if consolidated into a Direct Consolidation Loan. [Consumer Financial Protection Bureau](#)
- Be enrolled in a **qualifying repayment plan**, usually an income-driven repayment (IDR) plan. [Consumer Financial Protection Bureau](#)
- Make **120 qualifying monthly payments** (equivalent to 10 years if working full-time) while employed by a qualifying employer and under a qualifying repayment plan. students-residents.aamc.org

Once these conditions are met, the remaining loan balance may be **forgiven tax-free** under current law. PSLF is designed to support careers in public service by reducing the long-term burden of federal student loans.

The Ponca Tribe of Nebraska is an eligible employer for PSLF.

Paid Time Off (PTO) Summary

The Tribe offers a generous Paid Time Off (PTO) program to support employee well-being, work-life balance, and cultural values.

Vacation Leave

Regular full-time employees accrue vacation leave based on years of service:

- **0–4 years of employment:** 96 hours per year
- **5 years of employment:** 120 hours per year

- **6+ years of employment:** Employees accrue an additional 8 hours per year, up to a maximum accrual cap of 184 hours

Vacation Cash-Out Option:

Employees may cash out up to 80 hours of vacation leave on the second pay date of November, provided they maintain a minimum balance of 80 hours after the cash-out.

Carryover Limit:

Employees may carry over a maximum of 120 hours of vacation leave each year.

Sick Leave

All regular and introductory full-time employees accrue sick leave at a rate of 10 days per year.

Holidays

The Tribe observes the following paid holidays:

1. New Year's Day (January 1)
2. Martin Luther King Jr. Day (Third Monday in January)
3. Chief Standing Bear Day (May 12)
4. Memorial Day (Last Monday in May)
5. Independence Day (July 4)
6. Labor Day (First Monday in September)
7. Northern Ponca Restoration Day (October 31)
8. Veterans Day (November 11)
9. Thanksgiving Day (Fourth Thursday in November)
10. Native American Day (Fourth Friday in November)
11. Christmas Eve (December 24)
12. Christmas Day (December 25)

Cultural Leave

The Ponca Tribe of Nebraska recognizes the importance of cultural and religious practices. Regular full-time employees receive 24 hours of paid Cultural Leave per calendar year.

Volunteer Leave

Employees are eligible for 24 hours of paid Volunteer Leave per year to assist programs or departments and support activities that enhance and serve the Tribal Community. This leave is specific to Ponca Tribe of Nebraska events.

Bereavement Leave

- Immediate family member: Up to 40 hours per death, which may also be used for end-of-life or hospice care prior to death
- Extended family member: Up to 16 hours per death

LEGAL NOTICES



MICHELLE'S LAW

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under the Group Health Medical Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under the Group Health Medical Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under the Group Health Medical Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's Law, please contact Human Resources.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	NORTH DAKOTA – Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	OREGON – Medicaid and CHIP Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	UTAH – Medicaid and CHIP Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	VIRGINIA – Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	WEST VIRGINIA – Medicaid and CHIP Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Stephanie Slobotski.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Ponca Tribe of Nebraska

Stephanie Slobotski, THRP – HR Benefits Manager

1600 Windhoek Drive Lincoln, NE 68512

United States

402-438-9222

¹<https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Ponca Tribe of Nebraska About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ponca Tribe of Nebraska and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ponca Tribe of Nebraska has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ponca Tribe of Nebraska coverage will not be affected. You can keep this coverage if you elect Part D, but the group health plan will not coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Ponca Tribe of Nebraska coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or a special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ponca Tribe of Nebraska and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 01, 2026
Name of Entity/Sender:	Ponca Tribe of Nebraska
Contact—Position/Office:	Stephanie Slobotski, THRP – HR Benefits Manager
Office Address:	1600 Windhoek Drive Lincoln, Nebraska 68512 United States
Phone Number:	402-438-9222

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Medica Choice National NE 1500-30-60-20% (Individual: 20% coinsurance and \$1,500 deductible; Family: 20% coinsurance and \$3,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 402-438-9222 or sslobotski@poncatrbe-ne.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Ponca Tribe of Nebraska Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Ponca Tribe of Nebraska Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Stephanie Slobotski - Benefit Coordinator at 402-438-9222 or sslobotski@poncatrbe-ne.org.



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Ponca Tribe of Nebraska		4. Employer Identification Number (EIN) 47-0744117	
5. Employer address 1600 Windhoek Drive		6. Employer phone number 402-438-9222	
7. City Lincoln	8. State NE	9. ZIP code 68512	
10. Who can we contact about employee health coverage at this job? Stephanie Slobotski, THRP			
11. Phone number (if different from above) 402-438-9222		12. Email address sslobotski@poncatribes-ne.gov	

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

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

☒☐

Some employees. Eligible employees are:

- With respect to dependents:

☒

We do offer coverage. Eligible dependents are:

☐

We do not offer coverage.

☒

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

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

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

SUMMARY ANNUAL REPORT

For Ponca Tribe of Nebraska Health and Welfare Benefit Plan

This is a summary of the annual report of the Ponca Tribe of Nebraska Health and Welfare Benefit Plan, EIN 47-0744117, Plan No. 50I, for period January 1, 2023 through December 31, 2023. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Ponca Tribe of Nebraska Health and Welfare Benefit Plan includes self-insured health and dental benefits. The plan sponsor has committed itself to paying certain medical and dental claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with Nebraska Methodist Health System D/B/A Bestcare Eap, Symetra Life Insurance Company and Vision Service Plan to pay vision, life insurance, temporary disability, long-term disability, indemnity, employee assistance program and accident and critical illness claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2023 were \$230,178.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Ponca Tribe of Nebraska at 1600 Windhoek Drive, Lincoln, NE 68512, or by telephone at (402) 438-9222.

You also have the legally protected right to examine the annual report at the main office of the plan (Ponca Tribe of Nebraska, 1600 Windhoek Drive, Lincoln, NE 68512) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13)(PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including

This benefit summary prepared by



Gallagher

Insurance | Risk Management | Consulting