



2026

Employee Benefits Overview

This Benefits Overview summarizes your available benefits. Please take time to educate yourself about the options and choose the best coverage for you and your family.

unicogroup.com 402.434.7200

Where connections make a **difference**.



Before You Enroll

- ▶ Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverage that's best for you and your family.
- ▶ Ensure family members meet the eligibility requirements.
- ▶ Understand the cost of the plans you selected.
- ▶ Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
- ▶ Select, review and submit your desired coverage.
- ▶ Check with Human Resources if you have questions.

Glossary

Deductibles — The amount you pay for covered health care services before your insurance plan starts to pay. With a \$2,000 deductible, for example, you pay the first \$2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Your deductible starts over each plan year.

Copays — A fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.

Coinsurances — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.

Out-of-pocket maximums — The most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate."

If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copayment (copay): A fixed amount (\$20, for example) you pay for a covered health care service after you've paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount, you will have to complete an Evidence of Insurability form, and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don't contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount. (See Balance Billing.)

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you may spend for services your plan doesn't cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Eligibility

Full-time employees (30 hours per week) and their dependents are eligible the first of the month following 60 days after your date of hire or 60 days after working full-time status.

Employer Contributions

Gana Trucking & Excavating contributes:

Line of Coverage	Contribution
Medical	Generous contributions to employee only coverage.
Life/AD&D NEW BENEFIT!	100%

Enrollment Process

Initial Enrollment

Gana Trucking & Excavating utilizes an online system called Employee Navigator to make your benefit elections. Your login for Employee Navigator will be emailed to you soon after your full-time start date.

Open Enrollment

Open enrollment is a short time period each year when you can make changes to your benefits. Elections you make during open enrollment will become effective on 1/1/2026. If you have questions about any of the benefits mentioned in this overview, please reach out to HR.

Re-enrollment via Employee Navigator is required for all employees. Deadline to enroll/submit changes in Employee Navigator is **12/1/2025**.

IMPORTANT: If you do not login to complete or confirm your benefit elections by the Open Enrollment deadline, your current elections will carry over into the new plan year with the new plan year rates effective 1/1/2026.

Special Enrollment

Elections completed during the Open Enrollment period will remain in place until the next Open Enrollment period **unless** a qualified change in status occurs and the associated update is requested **within 30-days** of the qualifying event-date. Qualifying events include birth or adoption, marriage, divorce, gain of other coverage, loss of other coverage, etc.

The following details In-Network benefits only. See plan documents for out-of-network benefits.

Medical | Auxiant

In-Network Services	Traditional Plan Amount You Pay	HDHP Plan (HSA Eligible) Amount You Pay	Catastrophic Plan Amount You Pay
Calendar Year Deductible - Individual - Family	\$5,000 \$10,000	\$5,000 \$10,000	\$9,000 \$18,000
Coinsurance	20%	20%	0%
Out-of-Pocket Maximum - Individual - Family	\$6,350 \$12,700	\$6,350 \$12,700	\$9,000 \$18,000
Preventive Care	Covered at 100%		
Physician Office Services Specialist Office Services	\$30 Copay \$60 Copay	Deductible, then 20% Deductible, then 20%	Deductible Deductible
Urgent Care Center	\$75 Copay	Deductible, then 20%	Deductible
Emergency Room	\$500 Copay, then 20%	Deductible, then 20%	Deductible
Prescription Drugs 30-day supply - Preferred Generics - Preferred Brand - Non-Preferred - Specialty	\$10 Copay \$35 Copay \$60 Copay \$300 Copay	Deductible, then \$10 Copay Deductible, then \$35 Copay Deductible, then \$60 Copay N/A	Deductible Deductible Deductible Deductible

Payroll Deductions – 52 Pay Periods				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Traditional Plan Cost	\$97.18	\$336.23	\$297.36	\$522.81
HDHP Plan (HSA Eligible) Cost	\$89.70	\$310.33	\$274.47	\$482.56
Catastrophic Plan Cost	\$53.78	\$279.30	\$247.02	\$434.30

ServeYou will be administrating your pharmacy benefits. It is important when you visit a retail pharmacy or use the mail order pharmacy, you present your new Auxiant ID card as it has your prescription drug information on the front of the card. You can access the ServeYou portal by going to the Serve You website at www.serveyourx.com

For a list of in-network providers, go to: www.midlandschoice.com



What can FocusHealth do for you?

- Give you quality and cost information
- Assist you in making informed decisions about your health care
- Helps you find higher quality and more cost-effective providers

How do I utilize the FocusHealth program?

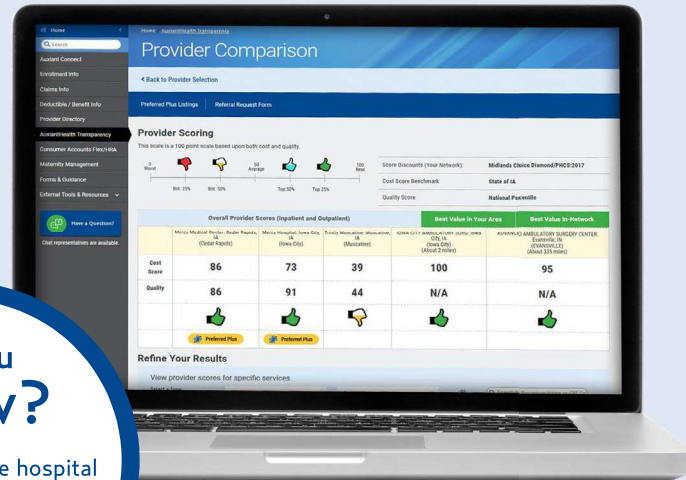
- Go to a FocusHealth Preferred Plus Provider on your FocusHealth scorecard for an inpatient hospital stay or outpatient surgery
- To search for a Preferred Plus Provider or to do quality and cost comparisons, go to Auxiant.com or call **800-475-2232**

How does this impact my plan?

Gana Trucking & Excavating offers the following incentives for utilizing a FocusHealth Preferred Plus Provider:

- \$500 In-Patient Admission
- \$250 Out-Patient Surgical Procedure

Incentives are paid through payroll & taxable by the IRS. Processing of incentives is dependent upon multiple factors and can take 3-4 months.



Did you know?

You can compare hospital quality and cost for both inpatient and outpatient services

Questions?



Contact Auxiant at **800-475-2232**



Contact customer service through **Auxiant Live Chat**

At Auxiant.com you have 24/7 access to your personal health care account information



Independent Solutions > Real Results



FocusHealth Transparency- Frequently Asked Questions

Q: What is FocusHealth Transparency?

A: FocusHealth Transparency is a transparency product designed to assist members in making informed decisions about their healthcare and the value of the services available at area hospitals by providing quality and cost information. Your employer is providing incentives to a pre-determined set of hospitals/facilities that provide the highest Overall Hospital Value, these are the Preferred Plus Providers.

Q: Where can I get a list of Preferred Plus Providers?

A: Visit our website at www.auxiant.com. If you are already a registered member, once you've logged in, click on AuxiantHealth, click on the FocusHealth Transparency icon, and you will be able to click on a link that will provide you the Preferred Plus Provider listing. If you're not a registered user, it only takes a few minutes to sign up; please have your ID card available and click on Register, Plan Member Registration. You will be asked a few questions and you can then create your own username and password.

Q: What services does the FocusHealth Transparency product apply to and will I have additional out of pocket costs?

A: No, you will not have additional out of pocket costs. FocusHealth Transparency applies to inpatient hospital stays (including mental nervous and substance abuse) and to select outpatient surgical services as well.

Q: Does FocusHealth Transparency provide Cost/Quality or steering for physician services?

A: Not directly. It is very important that you make your physician and specialist decisions with the Preferred Plus Hospital list in mind. Ask your physician or specialist if they have admitting rights to any of the Preferred Plus Providers before you make your physician or specialist decision.

FocusHealth Transparency does not rate individual physicians, but the physicians allowed to perform services at hospitals have a large impact on that hospitals cost and quality.

FocusHealth Transparency- Frequently Asked Questions

Q: What if my physician doesn't have admitting privileges at a Preferred Plus Provider?

A: FocusHealth Transparency does not dictate what providers you should choose; it does provide information and incentive that should be considered in your choice. We understand your relationship with your physician is extremely important to you.

After considering the cost, quality, and financial incentive information available to you, you can either:

- Continue on with care with your specialist; or
- Seek out a relationship with a physician or specialist that has admission rights to a Preferred Plus Hospital in your area.

Remember: FocusHealth Transparency does not rate individual physicians, but the physicians allowed to perform services at hospitals have a large impact on that hospital's cost and quality.

Q: How do I access quality and cost information?

A: Visit our website at www.auxiant.com, click on AuxiantHealth, and click on the FocusHealth Transparency icon. There you can choose to see a listing of the Preferred Plus Providers, select up to three hospitals to compare, view Overall Hospital Scores, as well as drill down by specific procedure.

Q: How does the FocusHealth Transparency scoring system work?

A: FocusHealth Transparency scores (both cost and quality) are on a 100 point scale with 100 being the best, 0 being the worst, and 50 being average. Hospitals with the best combination of cost and quality score provide the best value. Remember for cost, the higher the cost score, the lower the price. Scoring is as follows: a green thumb(s) up is the top 25%, a yellow thumb(s) up is the top 50%, a yellow thumb(s) down is the bottom 50%, and a red thumb(s) down is the bottom 25%.

Cost example- a hospital with a cost score of 70 is less expensive than a hospital with a cost score of 37.

Quality example- a hospital with a quality score of 98 has better quality than a hospital with a quality score of 48

Lower Cost Prescriptions with Rx Valet

Your plan added Rx Valet to your pharmacy benefit, so you have more options for safe and cost-effective prescription medications. Rx Valet works with trusted pharmacy partners domestically and internationally to bring you high-cost prescriptions for little or no cost.

You can rest assured that the branded medications come from the same manufacturers that produce them for the US market.

HOW YOU BENEFIT

- **Save Money** with Rx Valet. You can reduce or eliminate co-pays or co-insurance. Medications are shipped from other US pharmacies or countries that meet or exceed US FDA standards, including Canada, the United Kingdom, Israel, Australia, New Zealand, and Germany.
- **Safe Delivery** of temperature-controlled medications like insulin. Medications that require temperature controls are shipped in cold-chain containers to reach the destination at the right temperature.

WHAT YOU CAN EXPECT

Your plan uses Rx Valet to contain costs associated with high-priced medications. If your prescription meets a cost threshold defined by your plan, Rx Valet will reach out to you to get your medication filled.

- You will be able to fill your medication at your regular pharmacy up to two times before switching to Rx Valet.
- Once Rx Valet has medication and contact detail, they will call you to set up your next medication refill.
- Once Rx Valet reaches out to you, you will receive your medications at little or no cost.
- Shipping typically takes around 15 days.
- If you opt out of using Rx Valet, you will not receive the program's savings benefits.
- **For Specialty drugs**, you will not be able to fill your medications at a retail pharmacy. Instead, you will go through Rx Valet or our other specialty programs.

International Sourcing FAQs

Rx Valet uses domestic and international pharmacies to find the lowest-cost medications. .

What is International Prescription Sourcing?

Rx Valet works with international pharmacy partners to get you lower-cost prescriptions. In many cases, this eliminates co-pays or co-insurance.

How Are Medications Shipped?

If a pill or capsule is being shipped, it is usually mailed through USPS. Sometimes, FedEx, DHL, and UPS are used when cold chain shipping is necessary. All packages are shipped using a tracking number that you can request.

Is International Sourcing Safe?

International sourcing imports the same branded or generic medications from countries with lower pricing than the US. The branded medications come from the same manufacturers that produce the medications available in the US. Rx Valet carefully reviews pharmacy partners for quality, shipping time, and accuracy for the best possible service.

How Long Does It Take to Get Medication?

It normally takes about fifteen (15) days from when Rx Valet gets the prescription from the provider. You will be able to fill your medication at your local pharmacy up to two times while Rx Valet processes your prescription.

Contact Rx Valet directly for help with medications filled by Rx Valet: 1-855-798-2538



CancerCARE

Right Care. Right Place. Right Time.

What is CancerCARE?

The CancerCARE Program is a free, fully integrated cancer solution included in YOUR health plan that supports you from the first day of your diagnosis well into the stages of aftercare. CancerCARE coordinates care and benefits for patients with new or existing cancers. Our expert medical team advocates for the best possible care in your community or at a leading national Centers of Excellence location.

Day One Help

The day you receive a cancer diagnosis is overwhelming. Our CancerCARE professionals will answer questions about your diagnosis and help you evaluate your treatment options. They will also help maximize your health benefits and minimize your out-of-pocket expenses.

Register online or by phone promptly (within 72 hours) of diagnosis for the highest care impact.

Personalized Care

Today's cancer treatments vary by cancer type, stage of spread, and the patient's genetic makeup. The most effective care occurs when it is genetically personalized for you. Genetic testing is often not a covered benefit; however, it is fully covered when used for treatment planning with CancerCARE's recommendation.

National Resources

New treatments are developed and tested at leading cancer centers called Centers of Excellence. Treatment received from your local oncologist is often the best possible, but in some instances, we may suggest new treatments that are only offered at a Center of Excellence when those treatments could be more beneficial to you. Two examples would be Clinical Trials or proven new treatments that have not yet been written and given to community oncologists.

Expert Medical Team

During your Initial registration call, our highly trained Intake Coordinators will quickly gather your medical and health plan information. When a diagnosis permits, you will be assigned your own personal Oncology Nurse Expert who will answer any questions you have regarding your diagnosis as well as your care options. CancerCARE's entire team of Doctors, Nurses, and Medical Experts is dedicated to being with you throughout your treatment journey.





Frequently Asked Questions

How do I use the Program?

To gain access to our services, register online at [CancerCAREprogram.com](https://cancercareprogram.com), or call us at 1-877-640-9610. **Once you are registered in our system, a nurse will be assigned to your case and they will help you for the rest of your cancer journey.**

Do I have to pay for CancerCARE?

The CancerCARE Program is an additional service included in the health plan offered by your company. **Registration and program features are covered by your health plan. Contact your HR representative for more information.**

What if I am already being treated for cancer?

You can join CancerCARE at any point during your treatment. Once registered, **we are able to collaborate with your local oncologist** and give them access to resources they may not have at their facility. We will also review your treatment plan to ensure everything is evidence-based quality care.

I don't have cancer, do I still need to register?

Registration is only required if you have been diagnosed with cancer. If you had cancer in the past and are now cancer-free, you can still register as a survivor and we will help you deal with any long-term issues and concerns. **Covered dependents can also register for CancerCARE.**



Dental | Ameritas

In-Network Services	Amount You Pay
Preventive Services – Deductible Waived - Exams, cleanings, x-rays - Fluoride (for dependent children 15 & under)	Covered at 100%
Calendar Year Deductible - Basic & Major Services	\$25 Lifetime
Basic Services - Fillings, simple & complex oral surgery, root canal	Deductible, then 20%
Major Services - Crowns, repairs, implants, dentures	Deductible, then 50%
Calendar Year Maximum (per person)	\$1,000

Payroll Deductions – 52 Pay Periods				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Employee Cost	\$6.72	\$13.45	\$13.48	\$21.10

DENTAL REWARDS

Plan members can carry over \$250 of their unused annual maximum. Member must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount of \$500. Members can earn an extra reward of \$100, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the maximum carry over amount of \$1,000, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member does not submit a dental claim during a benefit year, all accumulated rewards will be lost, but the member can begin earning rewards again the very next benefit year.

For a list of in-network providers, go to: www.ameritas.com

Vision | Ameritas

In-Network Services	Amount You Pay
Exam	\$10 Copay
Materials	\$25 Copay
Frames	Up to \$130 Allowance
Frequency - Exams - Lenses or Contact Lenses - Frames	12 Months 12 Months 24 Months
Lenses - Single - Bifocal - Trifocal - Lenticular - Progressive or Lens Enhancements	Materials Copay, then Covered Materials Copay, then Covered Materials Copay, then Covered 20% Discount Options Available
Contact Lenses (instead of glasses) Contact lens services	Up to \$130 Allowance & 10% Off Retail Up to \$40 Copay
Laser Vision Correction	Discounts Available

Note: You may only receive benefits for either contact lenses or lenses for your glasses in a given year (but not both); however additional discounts will be available.

Payroll Deductions – 52 Pay Periods				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Employee Cost	\$1.43	\$2.70	\$3.18	\$4.47

For a list of in-network providers, go to: www.ameritas.com. Network is EyeMed.

Basic Life/AD&D | MetLife **NEW BENEFIT!**

Plan Features	Group Life/AD&D Benefit	Benefit Reduction*
Employee Benefit	\$20,000	35% reduction at age 65 with an additional 15% reduction at age 70

Voluntary Worksite Benefits | Assurity

Accident

Accident Expense insurance pays a benefit directly to you when you receive treatment from a physician for a covered accident.

Accident Expense insurance is guaranteed issue no medical exams or tests.

This plan also includes a health screening benefit which pays \$50 twice per year for a number of covered medical tests or procedures.

Please see the brochure in Employee Navigator for additional information.

Critical Illness

Critical Illness insurance pays a lump-sum benefit directly to you if you are diagnosed with a stroke, heart attack or a number of other covered conditions.

Critical Illness insurance is guaranteed issue with no medical exams or tests.

This plan also includes a health screening benefit which pays \$50 twice per year for a number of covered medical tests or procedures.

Please see the brochure in Employee Navigator for additional information.

Hospital Indemnity

Hospital Indemnity coverage pays a lump sum benefit directly to you for a hospital confinement.

This policy provides for a \$2,000 benefit for an initial hospitalization in a calendar year. This policy also provides for a \$100 confinement for up to 30 days and a \$200 per day (up to 10) for confinement in an ICU

Hospital Indemnity insurance is guaranteed issue no medical exams or tests.

Please see the brochure in Employee Navigator for additional information.

Employee Navigator

Enrollment Portal

Login and Start

Company Identifier: **ganatrucking**

You will receive an email directing you to log in to Employee Navigator.

Please use Google Chrome web browser. Chrome is the preferred browser with Employee Navigator.

Using the link in the email you received, you will be prompted to create an account with Employee Navigator. You can then log in to begin your enrollment.

A registration form for Employee Navigator. At the top left is the logo. The heading is "Complete Account Registration". Below it, it says "Welcome Emily Demo!". The instruction is "Enter your desired username and password." A sub-instruction reads: "To protect your account, enter the requested personal information to verify your identity." The form includes fields for Username, Password (with a visibility toggle), Confirm Password (with a visibility toggle), Email Address (pre-filled with "eartz@unicogroup.com"), and Last 4 Digits of SSN. A large green "Register" button is at the bottom. At the very bottom, there are links for "Privacy Policy", "Terms of Use", and "Legal Notice", and a copyright notice: "© 2024 Employee Navigator, LLC".

Welcome to Your Benefit Management Portal!

A few of the online services which are available to you include:

- 24/7 access to detailed information about our employee benefits program
- Benefits managing including open enrollment and life events
- HR document library, and more

Let's get started.

[Continue](#)

1/2

Let's Start With a Few Things HR Needs

Your HR department has required tasks that must be completed.

1 Open Enrollment

You can leave anytime and we'll remember where you left off, but be sure to come back and complete the items listed below.

[Let's Begin](#)

2/2

Employee Navigator Online Enrollment Portal -- ACTION REQUIRED for all employees

Hello, Emily!

It's time for open enrollment.
You have 4 days left to complete your elections.

Open Enrollment Incomplete **Start**

Let's Begin Your Open Enrollment

You will:

1. Verify and enter some personal information for you and your dependents
2. Enter Social Security Numbers and dates of birth for eligible family members
3. Select your benefits

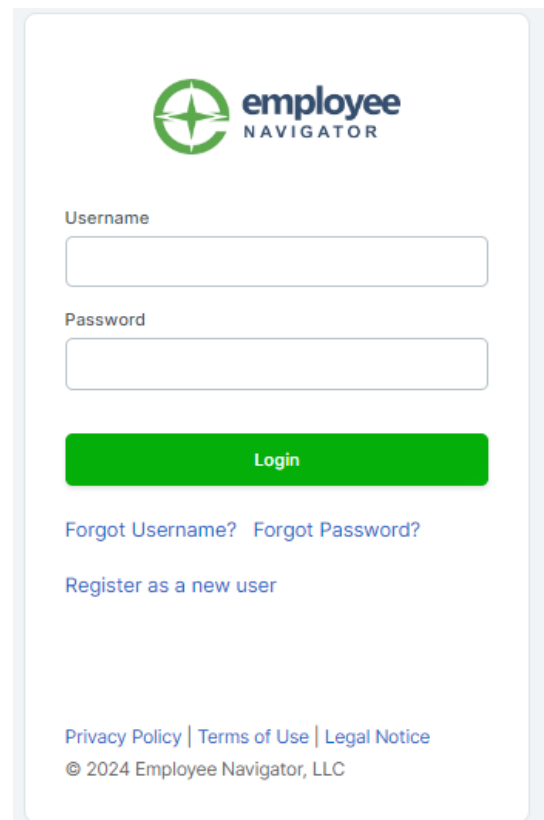
Elections will be finalized only after you sign and authorize your elections.

Get Started

Opens 11/17/2025 and you will receive an e-mail prompting you to login.

Closes 12/1/2025 and you may receive e-mail reminders until you complete your enrollment.

Your username and password are created from the initial registration email you received. Use the **Forgot Username** or **Forgot Password** link to reset credentials if needed.



The login form features the Employee Navigator logo at the top. Below the logo are two input fields: 'Username' and 'Password'. A prominent green 'Login' button is centered below the fields. Underneath the button are two blue links: 'Forgot Username?' and 'Forgot Password?'. A third blue link, 'Register as a new user', is positioned further down. At the bottom of the form, there are three small blue links: 'Privacy Policy | Terms of Use | Legal Notice' and a copyright notice '© 2024 Employee Navigator, LLC'.

Contact Information

Service	Contact
General Benefit Questions	Pat Small 402-794-4391 pats@ganatrucking.com
Enrollment Site	Employee Navigator Company Identifier: ganatrucking www.employeenavigator.com
Medical and Prescriptions	Auxiant 800-475-2232 www.auxiant.com
Dental	Ameritas 800-487-5553 www.ameritas.com
Vision	Ameritas – EyeMed Network 866-289-0614 www.eyemedvisioncare.com
Basic Life/AD&D	MetLife 800-638-5433 www.metlife.com
Accident Critical Illness Hospital Indemnity	Assurity 800-276-7619 www.assurity.com

FAQ

Whether you've lost your ID card, need help understanding your Explanation of Benefits (EOB), or have experienced a qualifying life event, this FAQ provides the guidance you need.

If you need further assistance, please reach out directly to the appropriate resource—be it your plan's customer service team, HR, or the carrier portal.

I lost my ID card. What do I do?

Login or register on your carrier's member portal website to print a replacement or request a mailed card.

I received an Explanation of Benefits (EOB) and I don't understand it or think there might be a discrepancy between this and what my provider billed me.

Review the EOB: Start by carefully reading your EOB. Pay special attention to the remark codes, which provide additional details about the charges and coverage.

Use Resources to Understand the EOB: Visit the following resources for help in understanding your EOB:

- ▶ <https://www.cms.gov/medical-bill-rights/help/guides/explanation-of-benefits>
- ▶ <https://www.cms.gov/files/document/11819-sample-explanation-benefits-508.pdf>

Get in Contact: If you feel there is a discrepancy, contact the Carrier Customer Service phone number to discuss. If you are not able to resolve, then you may reach out to HR.

I think I had a Qualifying Event, what do I do next?

Experiencing a significant life change may allow you to change your health plan and some other benefits plans outside of the annual enrollment period (also called open enrollment).

Changes due to a QE can only be completed within 30 days of the qualifying life event occurring, or you must wait until the next open enrollment period to make the change.

Check your plan materials, contact HR, and gather documentation that shows proof of the qualifying event as it will be required to make the change. Once you report the event to HR, you login to Employee Navigator to view which coverages are affected by this qualifying event and make enrollment changes.

Qualifying life events include (but are not necessarily limited to):

- ▶ Having or adopting a child
- ▶ Getting married
- ▶ Moving to a new area
- ▶ Turning 26
- ▶ Experiencing a shift in employment status in your family
- ▶ Getting divorced
- ▶ Death of someone who shares your health plan
- ▶ Earning U.S. citizenship
- ▶ Turning 65

For more information about qualifying life events and special enrollment periods, visit <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>

If you have any questions, please contact HR or your insurance carrier for more information.