**Personnel Committee Meeting**
**Tuesday, June 17, 2025 5:00 PM**
**Crete City Hall**
**243 E 13th Street**
**Crete, NE 68333**

1. **Open Meeting**

    - In accordance with Nebraska law, a copy of the Open Meetings Act can be found in the back of the Council Chambers.
    - Items listed on the agenda may be considered in any order.

2. **Roll Call**

    - Attendance of members will be recorded to determine the presence of a quorum for official actions.

3. **Items of Business**

    - The Committee may discuss or limit discussion on, hear testimony in favor of or in opposition to, or take action to provide a recommendation to the City Council on any matter presented under this title.

    3.A. Consider the HRA renewal

    3.B. Consider Assurity group application

    3.C. Consider the Principal Dental and Vision renewal application

4. **Officers' Reports**

    - Reports may be given by the Mayor, Officers, Departments, or Councilmembers concerning the current operations of the City.
    - No action can be taken on matters presented under this title except to answer any questions or to refer the matter for further action.

5. **Adjournment**

**Disclaimers & Notices**

- The Council may enter into closed session to discuss any matter on this agenda when it is determined that a closed session is clearly necessary for the protection of the public interest or the prevention of needless injury to the reputation of an individual (if such individual has not requested a public meeting) or as otherwise allowed by law. Any closed session shall be limited to the subject matter for which the closed session was called. If the motion to close passes, then immediately prior to the closed session the Mayor shall restate on the record the limitation of the subject matter of the closed session.
- The City of Crete assures that no person shall on the grounds of race, color, national origin, age, disability, handicap or sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity of the City receiving Federal financial assistance. To report discrimination, contact the City Clerk's office.
- The complete agenda with attachments is available at www.crete.ne.gov.

**POINT C**
**5310 N. 99th Street, Suite 1, Omaha NE 68134**
**402-571-6224**

# ADMINISTRATIVE SERVICES AGREEMENT

This agreement ("agreement") for administrative services is made and entered into effective **July 1, 2025**, by and between **Point C**, hereinafter referred to as the Claims Administrator and **City of Crete**, hereinafter referred to as the Plan Sponsor of the City of Crete Employee Benefit Plan (the "Plan").

IN WITNESS WHEREOF:

WHEREAS, the Plan Sponsor has established a self-funded health care plan for certain of its employees and/or their dependents (the "participants");

WHEREAS, the Plan Sponsor of the Plan has the authority, power and duty to administer the Plan according to its terms;

WHEREAS, the Plan Sponsor is authorized to engage the Claims Administrator to provide certain administrative services for the Plan; and

WHEREAS, the Claims Administrator is willing to provide such administrative services.

NOW, THEREFORE, in consideration of the mutual promises and duties set forth in this agreement, the parties, thereto, intending to be legally bound, do agree as follows:

## SECTION A: DUTIES & RESPONSIBILITIES OF CLAIMS ADMINISTRATOR

1. The Claims Administrator shall maintain adequate and necessary records from information provided by the Plan Sponsor under Section B1 herein on each Plan Participant to properly administer the Plan. These participant records shall include, but are not limited to, the following information for each Participant: Full name, date of birth, effective date of coverage and benefit elections.

2. The Claims Administrator will bond all Point C employees who handle Plan assets and will, within 30 days of a written request by the Plan Sponsor, present evidence of such bonds to the Plan Sponsor.

3. Subject to Section A4 of this agreement, the Claims Administrator agrees that Plan Participant records, and the information contained therein, shall not be disclosed, or made available to persons other than the Plan Sponsor, or its designated agents, without prior written approval of the Plan Sponsor; provided, however, the Claims Administrator may disclose such information to its subcontractors if necessary to perform its obligations under this agreement. The Claims Administrator shall comply with applicable laws and regulations regarding confidentiality or privacy of medical records and other Plan records and cooperate with the Plan Sponsor to ensure such compliance.

4. The Claims Administrator shall not disclose or use Plan records for a purpose unrelated to administration of the Plan. Absent prior written approval pursuant to Section A3 of this agreement the Claims Administrator will disclose such information only:

   (a) In response to a court order
   (b) For an examination conducted by an authorized state or federal government authority
   (c) To an issuer of a stop loss policy purchased by the Plan Sponsor
   (d) With written consent of the Plan Participant or his or her legal representative

5. The participant records maintained by the Claims Administrator shall be the property of the Plan Sponsor and shall be available for inspection by the Plan Sponsor or its designated agents, during normal business hours.

6. The Claims Administrator shall provide, subject to the Plan Sponsor's final approval, the initial Plan document, summary plan description for the Plan, and any other documents as agreed to by the Claims Administrator and the Plan Sponsor. In addition, the Claims Administrator will make available all necessary forms, ID cards, and any materials necessary for the performance of the Plan.

7. The Claims Administrator may contract with other vendors to perform services under its agreement for the benefit of the Plan. The Claims Administrator will be responsible for those services to the same extent that it would have been responsible had it performed those services directly hereunder, provided, however, professional services shall be governed by item 14 herein.

8. The Claims Administrator shall process and adjudicate all claims presented for payment according to the Plan Document.

9. The Claims Administrator shall abide by industry standards, to correctly process and pay claims for benefits in accordance with the terms of the Plan and information provided to the Claims Administrator by the Plan Sponsor.

10. The Claims Administrator shall assume no liability and shall be held harmless by the Plan and the Plan Sponsor in complying with instructions communicated by the Plan Sponsor to the Claims Administrator. Should the Claims Administrator have a question of whether a particular claim of benefits should be paid under the Plan, the Claims Administrator shall contact the Plan Sponsor for a determination of whether said claims should be paid. Thereafter, the Plan Sponsor shall provide written instructions to the Claims Administrator as to whether to pay the claim, and if said claim should be paid, the amount of the payment. The Plan Sponsor retains all final authority and responsibility for the Plan.

11. The Claims Administrator shall maintain current, accurate, and complete records and files of all claim submissions and payments to each participant for a period of at least seven years after the filings of any information relating to such submissions and payments.

12. The Claims Administrator shall provide the Plan Sponsor with any reports agreed to by the parties. These reports include, but are not limited to, the following:

    (a) The "Check Register" report will be provided to the Plan Sponsor at the Plan Sponsor's requests.

13. To protect Plan Sponsor assets the Claims Administrator is hereby authorized to contract for the services of accountants, attorneys, or other professionals of the Claims Administrator's choosing to provide such services as the Claims Administrator may deem necessary. The Plan will be responsible for any reasonable costs incurred in the retaining of such professional services.

14. The Claims Administrator will, within thirty days written notice from the Plan Sponsor, allow the Plan Sponsor or its authorized agent to inspect or audit all Plan records and files maintained by the Claims Administrator at the offices of Point C during normal business hours. The Plan Sponsor will be responsible for all costs associated with the inspection or audit.

## SECTION B: DUTIES & RESPONSIBILITIES OF THE PLAN SPONSOR

1. The Plan Sponsor shall provide the Claims Administrator with the necessary records of the Plan Participants as of the effective date of this agreement. Thereafter, the Plan Sponsor shall provide the Claims Administrator with the necessary records of the Plan Participants eligible to participate in the Plan after the effective date of this agreement. The Plan Sponsor shall further provide the Claims Administrator with records relating to any change that affects any Plan Participant's benefits under the Plan, including, but not limited to changes related to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), health plan coverage changes, and elections to conform with the Health Insurance Portability and Accountability Act.

2. The Plan Sponsor shall provide the Claims Administrator with true and accurate information including, but not limited to, an accounting of all Plan Participants and changes set forth in Section B1 of this agreement. The Claims Administrator shall not be liable for any loss incurred as a result of any inaccurate information furnished to it by the Plan Sponsor. The Plan Sponsor must report all changes to the Claims Administrator within two weeks of the change. Notice of Plan Participant termination must be given within 30 days of the termination. Credit for premiums, administrative, or vendor fees will not be retroactive beyond two months.

3. The Plan Sponsor shall be solely responsible for funding, collecting, and administering all contributions to the Plan and granting the Claims Administrator drafting authority with respect to such account. The Claims Administrator shall notify the Plan Sponsor of the amount necessary to pay claims adjudicated and the Plan Sponsor shall deposit funds on a regular basis to the claim account and shall fund amounts requested within ten business days of the request to ensure prompt payment of claims as required by the United States Department of Labor or any other regulatory authority. The claim account shall be selected by and set up by the Plan Sponsor who shall execute and deliver to the Claims Administrator all documents necessary to empower the Claims Administrator or its vendor to act as signatory on such account or provide the Claims Administrator with the authorized electronic signatures to populate on the checks.

4. The Plan Sponsor shall be solely responsible for communicating to, and distributing to, Plan Participants any and all information regarding the Plan, including the summary plan description for the Plan.

5. The Plan Sponsor shall be responsible for complying with all legal requirements applicable to the Plan and shall be solely responsible for satisfying any and all reporting, notice, disclosure, and filing requirements imposed under applicable federal or state law, and all withholding, deposit and reporting requirements of federal, state and local tax laws applicable to the payment of Plan benefits.

6. The Plan Sponsor shall be responsible for any delay in the performance of the administrative and claims service caused by the failure of the Plan Sponsor to furnish any required information or funds for the payment of Plan benefits.

7. The Plan Sponsor shall be solely responsible for complying with and remitting amounts due under applicable escheat laws of any jurisdiction as such laws may be applied with respect to benefit payments under the Plan.

8. Except as provided in Section B, #9, of this agreement or as otherwise agreed to by the Plan Sponsor and Claims Administrator pursuant to a separate agreement, the Plan Sponsor will be solely responsible for complying with the requirements of COBRA and the Health Insurance Portability and Accountability Act ("HIPAA") which may apply to the Plan. The Plan Sponsor will be liable for any and all claims resulting from the failure of the Plan Sponsor to administer COBRA and/or HIPAA in accordance with this agreement and applicable laws and regulations.

9. The Plan Sponsor may elect to have the Claims Administrator provide the following COBRA nondiscretionary, ministerial recordkeeping and notification services on behalf of the Plan Sponsor. Fees for this service will be shown on Exhibit A. If no fees are indicated, the Plan Sponsor will remain solely responsible for complying with the requirements of COBRA unless otherwise agreed to by the Plan Sponsor and Claims Administrator pursuant to a separate agreement.

   (a) Generate and send initial COBRA notification to newly enrolled employees, spouses, and dependents upon notification by employer when they first become eligible for the plan(s).
   (b) Generate and send COBRA notice and election form to Qualified Beneficiaries (QB's) upon notification by the employer following a COBRA Qualifying Event.
   (c) Communicate COBRA elections made by QB's to the employer.
   (d) Collect QB COBRA premiums and remit appropriate balance to employer.
   (e) Generate and send employer a monthly bill for COBRA services.

## SECTION C: FEES

1. In consideration of the services to be provided pursuant to this agreement, the Plan Sponsor shall pay to the Claims Administrator the fees set forth in the fee schedule attached hereto as Exhibit "A", which shall not be subject to change during the first twelve months that this agreement is in effect. The Claims Administrator guarantees to pay all applicable fees received by the Claims Administrator from the Plan Sponsor to appropriate vendors.

2. The Plan Sponsor may elect to have the Claims Administrator assume responsibility for administering claims applicable to the period prior to the effective date of this agreement. If elected, there will be an additional fee for this service, and all terms of this agreement will apply to such claims.

3. The Claims Administrator may adjust its monthly and annual fees upon each anniversary date of this agreement with delivery of such adjustment to the Plan Sponsor at the renewal presentation for the coming contract year.

4. The Claims Administrator may charge the Plan Sponsor reasonable fees for the reproduction or return of Plan records requested by the Plan Sponsor or government agencies. The Plan Sponsor shall reimburse the Claims Administrator reasonable fees charged by medical providers and others for information reasonably required by the Claims Administrator to perform its duties under this agreement.

5. If, during the term of this agreement, any tax other than taxes based solely on the income of the Claims Administrator or other similar income or franchise taxes that are assessed with respect to the earnings or revenue of the Claims Administrator, or any other assessment, shall be imposed against the Claims Administrator as a result of the Claims Administrator performing its duties under this agreement, the Claims Administrator will report the payment of such tax or assessment to the Plan Sponsor and the Plan Sponsor will reimburse the Claims Administrator for the same. The Claims Administrator will be solely responsible for all withholding, deposit and reporting requirements of federal, state, and local authorities applicable to payments of benefit payments under the Plan.

6. Nothing in Section C will prohibit the Claims Administrator from performing any service not set forth in this agreement for a reasonable fee provided, however, any such service may be provided, and any such corresponding fee may be paid, only if agreed to by the parties in advance of performing such service.

7. The Claims Administrator will bill the Plan Sponsor on the first day of each month (the "Billing Date") for the current month the ("Monthly Fee") as set forth in Exhibit "A" and any other fees agreed to by the parties, regardless of the actual vendor charge, based on the number of employees enrolled in the Plan as of the billing date. The Monthly Fee, if not paid by the 15th day following the billing date, shall be subject to interest on the amount of all past due fees at a rate of ten percent per annum, or if lower, the maximum allowable rate under Nebraska state law.

8. If the Plan Sponsor, for any reason whatsoever, fails to make a required payment on a timely basis, the Claims Administrator will provide the Plan Sponsor with timely written notice of its intent to suspend the performance of services.

9. The Claims Administrator may also receive compensation from insurance carriers and vendor partners in the form of trips or other cash awards based on production, profitability, or other criteria considering all groups collectively utilizing those insurance carrier and vendor partner services and administered by the Claims Administrator. This compensation is not directly attributable as a fee or expense to the Plan and is estimated to average less than one half percent of the total Plan costs on an annual basis.

10. Some of the contracts the Claims Administrator holds with prescription benefit management companies (PBMs) may include contract incentives such as, but not limited to, discounts, allowances, incentives, rebates, adjustments, and settlements. Any contract incentives, if available, will be retained by the Claims Administrator. Any prescription claims submitted to the Plan may be processed without regard to any potential contract incentives provided to the Claims Administrator. These contract incentives are estimated to average less than one and one half percent of the total health plan costs on an annual basis. Certain PBMs may also offer the Claims Administrator member participation in their company, which may provide the Claims Administrator educational advantages and industry insights that might prove beneficial to the overall direction of the Health Plan.

## SECTION D: DURATION OF AGREEMENT

1. The agreement will have an initial term of one year and will automatically be renewed for subsequent one-year terms unless terminated pursuant to Section E of this agreement. If the parties cannot agree as to the fee structure for such subsequent term, this agreement will terminate as of its anniversary date unless the parties agree otherwise.

## SECTION E: TERMINATION OF THIS AGREEMENT

1. This agreement may be terminated by either party by written notice to the other party, to be effective as of the date set forth in said notice; provided, however, such notice must be provided no less than sixty days prior to the end of the initial term of this agreement, or any extension thereof.

2. This agreement shall, at the option of the Claims Administrator, terminate or otherwise be suspended, effective five days after providing written notice to the Plan Sponsor, if:

   (a) The Plan Sponsor fails to pay the fees provided in Section C within thirty days of their due date;
   (b) The Plan Sponsor becomes insolvent or files for bankruptcy protection;

(c) There is a merger, sale or consolidation of the Plan Sponsor, unless the Claims Administrator consents in writing to continue services under this agreement with successor Plan Sponsor in advance of such event;
(d) Any law or regulation is enacted that makes this agreement illegal or impossible to perform.

3. This agreement will, at the option of the Plan Sponsor, terminate, or otherwise be suspended, effective five days after the Plan Sponsor provides written notice to the Claims Administrator if the Claims Administrator fails to comply with the terms of this agreement. If the Plan Sponsor terminates this agreement at any time other than the anniversary date of this agreement for any reason other than the Claims Administrator failing to comply with the terms of this agreement, the Plan Sponsor will pay to the Claims Administrator the Monthly Fee as of the billing date immediately preceding the date of termination for the remaining months left in the one-year term. Within ten days of the date of termination, the Plan Sponsor will pay to the Claims Administrator all amounts owed plus any interest charges calculated.

4. Upon termination of this agreement, the Claims Administrator will process all requests for claim payments under the Plan which were received by it and which become due and payable pursuant to the terms of the Plan prior to terminating this agreement; provided, however, the Claims Administrator will have no obligation:

   (a) To process any such claim if the Plan Sponsor has failed to provide funds for payment; or
   (b) To process requests for claim payments presented after the termination date unless the parties agree otherwise.

5. Upon termination of this agreement, the Plan Sponsor will remain responsible for payment of all other claims under the Plan.

6. Upon termination of this agreement or any applicable vendor agreements, the Plan Sponsor will immediately forfeit all outstanding program incentives. These may include, but are not limited to, Administrative Performance Arrangements, Prescription Drug Rebates, Captive Distributions, and vendor partner incentives.

7. The Claims Administrator will, within sixty days of the last transaction required under this Section, deliver to the Plan Sponsor a complete and final accounting and report of the financial status of the Plan, together with all books and records in its possession with respect to the Plan, all claims files, and all reports and other papers pertaining to the Plan. The Plan Sponsor will reimburse the Claims Administrator for reasonable expenses associated with complying with this Section.

8. Upon termination of this agreement, the Claims Administrator will provide reasonable assistance in transferring Plan records and related information to any successor designated by the Plan Sponsor. The Plan Sponsor will be responsible for all costs associated with such transfer including, but not limited to, non-standard reporting, ad-hoc reporting, accumulation and delivery services.

9. Upon termination of this agreement, the Plan Sponsor may agree that the Claims Administrator will retain Plan records and process claims for benefits incurred, but not processed, before the date of such termination. The fees for such run-out claims service will be as follows:

   (a) For the first month after termination, such fee will not be greater than the Monthly Fee as set forth in Exhibit “A”.
   (b) For the second month after termination, such fee will not be greater than seventy-five percent of the Monthly Fee as set for in Exhibit “A”.

(c) For the third month after termination, such fee will not be greater than fifty percent of the Monthly Fee as set forth in Exhibit "A".
(d) Any claims processed more than ninety days after the date of termination will be handled on a per claim basis at $25.00 per claim.

10. Any vendor fees for run-out processing will be passed through to the Plan Sponsor based on applicable vendor terms and conditions.

## SECTION F: INDEMNIFICATION AND LIABILITY LIMITATIONS

1. The Claims Administrator will not be liable to the Plan Sponsor, its agents, Plan Participants, or any other person whatsoever for any acts or omissions, with the exception of gross negligence, breach of contract or willful or illegal misconduct on the part of the Claims Administrator relating to services provided pursuant to this agreement.

2. The Plan Sponsor agrees to indemnify and hold harmless the Claims Administrator, its agents, and employees, from and against any and all claims, damages, losses, liabilities, penalties, fines and expenses, including court costs and reasonable attorneys' fees, arising out of or in any way connected with the performance by the Claims Administrator relating to services provided pursuant to this agreement. Such indemnification by the Plan Sponsor will include, but will not be limited to, any and all actual or threatened claims, suits, proceedings, or causes of action against the Claims Administrator by any Plan Participant or beneficiary, or any other person.

## SECTION G: AMENDMENTS

1. This agreement may be amended by the Plan Sponsor and the Claims Administrator at any time by written agreement by both parties.

## SECTION H: DISPUTE RESOLUTION

1. It is expected that any disputes or differences that may arise under this agreement will be resolved by the parties in the usual course of business. If, however, any dispute that does arise between the Claims Administrator and the Plan Sponsor which relates to or arises from this agreement, whatever its nature, the parties agree to forego litigation and proceed as follows: Either party may notify the other regarding the matter in dispute and that it wishes to begin the dispute resolution procedure. Within thirty days after such notification, a designated executive of the Claims Administrator and a designated executive of the Plan Sponsor will meet and confer in an effort to resolve the problem. The parties may agree to mediation or other voluntary form of dispute resolution. If the matter is not resolved within thirty days thereafter (or such further time as the parties may agree) either party may elect to have the dispute arbitrated in the manner provided in Section H2.

2. Any dispute or claim relating to this agreement not resolved in the manner provided under Section H1 will be resolved by final and binding arbitration before the American Arbitration Association using an independent panel of three arbitrators provided that the arbitrators selected have at least five years' experience in the health care industry. In no event may the arbitration be initiated more than one year after the date one party first gave written notice of the dispute to the other party. The arbitration will be held in Omaha, Nebraska. The arbitrators will have no power to ignore or vary the terms of this agreement and will be governed by the United States Arbitration Act. Results of the arbitration are binding and final on both parties.

## SECTION I: MISCELLANEOUS

1. Any funds deposited in the claim account received by the Claims Administrator from the Plan Sponsor will be held on the Plan Sponsor's behalf in a fiduciary capacity. The Plan Sponsor will have the final responsibility and liability for payment of claims under the Plan.

2. This agreement will be construed and enforced according to the laws of the State of Nebraska except to the extent that the agreement may be preempted by ERISA.

3. The Claims Administrator will assist the Plan Sponsor to ensure compliance with all applicable laws and regulations.

4. Failure by either party at any time to enforce or require the strict performance of any of the terms or conditions of this agreement will not constitute a waiver of such terms or conditions, modify such provisions, or in any manner a waiver of such terms or conditions or in any manner render it unenforceable as to any other time or as to any other occurrence.

   Any specific waiver by either party of any of the terms and conditions of this agreement will be considered as a one-time event and will not constitute a continuing waiver. Neither a waiver nor any failure to enforce shall in any way affect or impair the terms or conditions of the agreement or the right of either party to avail itself of its remedies.

5. If any of this agreement is deemed to be, or shall in fact be illegal, inoperative, or unenforceable, the same will not affect any other provision or provision herein to any extent whatsoever.

6. Except as provided in Section E, this agreement will be binding upon all the parties hereto, their heirs, successors, assigns, and legal representatives forever.

7. This agreement may be executed in any number of counterparts with the same effect as if all of the parties had signed the same document. All counterparts will be construed together and will constitute one agreement.

8. This agreement is the entire agreement of the parties and supersedes all prior contracts, proposals, responsibilities, and other communications between the parties.

THIS CONTRACT CONTAINS AN ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Plan Sponsor and the Claims Administrator have caused this agreement to be effective July 1, 2025.

| **City of Crete** | **Point C** |
|---|---|
| |  |
| *Signature* | *Signature* |
| | Matt Wullenwaber |
| *Printed Name* | *Printed Name* |
| | President |
| *Title* | *Title* |
| | June 4, 2025 |
| *Date* | *Date* |

**ADMINISTRATIVE SERVICES AGREEMENT FEE SCHEDULE**

**EFFECTIVE: July 1, 2025**

**EXHIBIT A**

The administrative services agreement entered into by **City of Crete** and **Point C** lists below the fees as required by The Employee Retirement Income Security Act of 1974 (ERISA). The Claims Administrator will receive and pay, in accordance with the following schedule, fees, and commissions as reasonable compensation for services conducted in the ordinary course of business.

| For: | Claims Administration | Rates | Paid To: |
|---|---|---|---|
| | HRA Administration | Greater of the following:<br>$8.50/EE/MO or $75.00 per month | Claims Administrator |
| | Annual Renewal Fee | $250.00 | Claims Administrator |
| | High Dollar Rx Validation Program | 10% of Audited Claim Savings | Claims Administrator |
| | Subrogation Recovery Fee | 30% of Recovery | Subrogation Vendor |
| | Over Payment Recovery Fee | 30% of Recovery | Claims Administrator |

I certify that the above represents a true and accurate disclosure of the distribution of fees for the Plan Year beginning July 1, 2025.

| **City of Crete** | **Point C** |
|---|---|
| |  |
| *Signature* | *Signature* |
| | Matt Wullenwaber |
| *Printed Name* | *Printed Name* |
| | President |
| *Title* | *Title* |
| | June 4, 2025 |
| *Date* | *Date* |

**City of Crete**
**Health Reimbursement Arrangement Plan Document and Summary Plan Description**
**Amendment #3**
**Effective: July 1, 2025**

The following changes, clarifications, revisions, and/or updates will become part of the City of Crete Employee Health Reimbursement Arrangement Plan Document and Summary Plan Description.

**HEALTH REIMBURSEMENT ARRANGEMENT (HRA) BENEFIT SUMMARY**
**CITY OF CRETE**

**INTEGRATED GROUP HEALTH PLAN:** Embedded Out-of-Pocket
In-Network Out-of-Pocket: $6,500.00 (Single) - $13,000.00 (Family)

**HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ADMINISTERED AS:** Embedded Benefit
Single Coverage: Employee Liability $3,000.00 / Employer Liability $3,500.00
Individual Coverage Within A Family: Employee Liability $3,300.00 / Employer Liability $3,200.00 Embedded Benefit
Family Coverage: Employee Liability $6,000.00 / Employer Liability $7,000.00 Embedded Benefit
HRA benefits do not apply to out-of-network services.

**Illustration for Single Coverage**

| **$6,500.00 Out-of-Pocket** | | | |
|---|---|---|---|
| $3,500.00 Deductible | | | $3,000.00 Coinsurance |
| Employee | Employer | | Employer |
| $3,000.00 | $500.00 | | $3,000.00 |

- For single coverage, once the employee satisfies the first $3,000.00 in deductible, the next $500.00 of claims is processed at 100% being paid by the employer. At that point, the deductible that must be met before the Integrated Group Health Plan will pay claims has been fulfilled by a combination of the employee and the employer. For the coinsurance, the employer pays 20%, up to a maximum of $3,000.00. After the out-of-pocket limit has been met, the Integrated Group Health Plan pays 100%.

**Illustration for Individual Coverage within a Family**

| **$6,500.00 Out-of-Pocket** | | | |
|---|---|---|---|
| $3,500.00 Deductible | | | $3,000.00 Coinsurance |
| Individual | Employer | | Employer |
| $3,300.00 | $200.00 | | $3,000.00 |

- For individual coverage within a family, once the individual satisfies the first $3,300.00 in deductible, the next $200.00 of claims is processed at 100% being paid by the employer. At that point, the deductible that must be met before the Integrated Group Health Plan will pay claims has been fulfilled by a combination of the employee and the employer. For the coinsurance, the employer pays 20%, up to a maximum of $3,000.00. After the out-of-pocket limit has been met, the Integrated Group Health Plan pays 100%.

**Illustration for Family Coverage**

| **$13,000.00 Out-of-Pocket** | | | |
|---|---|---|---|
| $7,000.00 Deductible | | | $6,000.00 Coinsurance |
| Family | Employer | | Employer |
| $6,000.00 | $1,000.00 | | $6,000.00 |

- For family coverage, once the family satisfies the first $6,000.00 in deductible, the next $1,000.00 of claims is processed at 100% being paid by the employer. At that point, the deductible that must be met before the Integrated Group Health Plan will pay claims has been fulfilled by a combination of the family and the employer. For the coinsurance, the employer pays 20%, up to a maximum of $6,000.00. After the out-of-pocket limit has been met, the Integrated Group Health Plan pays 100%.

**The Health Reimbursement Arrangement Document will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.**

**Accepted: City of Crete**

Signature: _____

Printed Name: _____

Title: _____

Date: _____

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

For more information about your coverage, or to get a copy of the complete terms of coverage, contact your employer or Point C at 402-571-6224 or 800-364-9505. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 402-571-6224 or 800-364-9505 to request a copy.

**This document contains only a partial description of the benefits, limitations, exclusions, and other provisions of this health care plan. It is not a Plan document. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions, and Plan limitations. In the event there are discrepancies between this document and the Plan document, the terms and conditions of the Plan document will govern.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network<br>$3,000.00 individual<br>$3,300.00 individual within a family<br>$6,000.00 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.<br>If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |
| **Are there other deductibles for specific services?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |
| **What is the out-of-pocket limit for this plan?** | In-Network<br>$3,000.00 individual<br>$3,300.00 individual within a family<br>$6,000.00 family | The out-of-pocket limit is the most you could pay in a year for covered services.<br>If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.<br>After the HRA Out-of-Pocket limit is met, the employee is responsible for charges subject to the terms of the Integrated Group Health Plan. Refer to the SBC of the Group Health Plan. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, penalties | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |
| **Do you need a referral to see a specialist?** | Refer to the SBC of the Integrated Group Health Plan | Refer to the SBC of the Integrated Group Health Plan |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Specialist visit | Refer to the SBC of the Integrated Group Health Plan | | |
| | Preventive care/screening/ immunization | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Imaging (CT/PET scans, MRIs) | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need drugs to treat your illness or condition** | Generic drugs | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Preferred brand drugs | Refer to the SBC of the Integrated Group Health Plan | | |
| | Non-preferred brand drugs | Refer to the SBC of the Integrated Group Health Plan | | |
| | Specialty drugs | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Physician/surgeon fees | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need immediate medical attention** | Emergency room care | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Emergency medical transportation | Refer to the SBC of the Integrated Group Health Plan | | |
| | Urgent care | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Physician/surgeon fees | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Inpatient services | Refer to the SBC of the Integrated Group Health Plan | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Childbirth/delivery professional services | Refer to the SBC of the Integrated Group Health Plan | | |
| | Childbirth/delivery facility services | Refer to the SBC of the Integrated Group Health Plan | | |
| **If you need help recovering or have other special health needs** | Home health care | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Rehabilitation services | Refer to the SBC of the Integrated Group Health Plan | | |
| | Habilitation services | Refer to the SBC of the Integrated Group Health Plan | | |
| | Skilled nursing care | Refer to the SBC of the Integrated Group Health Plan | | |
| | Durable medical equipment | Refer to the SBC of the Integrated Group Health Plan | | |
| | Hospice services | Refer to the SBC of the Integrated Group Health Plan | | |
| **If your child needs dental or eye care** | Children's eye exam | Refer to the SBC of the Integrated Group Health Plan | | Refer to the SBC of the Integrated Group Health Plan |
| | Children's glasses | Refer to the SBC of the Integrated Group Health Plan | | |
| | Children's dental check-up | Refer to the SBC of the Integrated Group Health Plan | | |

**Excluded Services & Other Covered Services:**

| **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** |
|---|
| • Please check the terms of the Summary Plan Description of the Integrated Group Health Plan |

| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** |
|---|
| • Please check the terms of the Summary Plan Description of the Integrated Group Health Plan |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x-61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your employer or Point C at 402-571-6224 or 1-800-364-9505 or visit us at www.pointchealth.com/tpaM1.

**Does this plan provide Minimum Essential Coverage? No**

**This HRA plan, by itself, does not provide minimum essential coverage. These requirements may be satisfied in coordination with the major medical plan of which this HRA is a component piece. Please refer to the SBC of the Integrated Group Health Plan.**

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

**Does this plan meet the Minimum Value Standards? No**

**This HRA plan, by itself, does not meet minimum value standards. These requirements may be satisfied in coordination with the major medical plan of which this HRA is a component piece. Please refer to the SBC of the Integrated Group Health Plan.**

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

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

**About these Coverage Examples:**

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

## Peg is Having a Baby

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

**Refer to the Integrated Group Health Plan for Specialist, Hospital (facility) and Other information.**

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$**
- **Hospital (facility) *[cost sharing]*** **$**
- **Other *[cost sharing]*** **$**

**This EXAMPLE event includes services like:**

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

## Managing Joe's Type 2 Diabetes

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

**Refer to the Integrated Group Health Plan for Specialist, Hospital (facility) and Other information.**

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$**
- **Hospital (facility) *[cost sharing]*** **$**
- **Other *[cost sharing]*** **$**

**This EXAMPLE event includes services like:**

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,200 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,200** |

## Mia's Simple Fracture

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

**Refer to the Integrated Group Health Plan for Specialist, Hospital (facility) and Other information.**

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$**
- **Hospital (facility) *[cost sharing]*** **$**
- **Other *[cost sharing]*** **$**

**This EXAMPLE event includes services like:**

Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

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

The plan and/or the Integrated Group Health plan would be responsible for the other costs of these EXAMPLE covered services.

Assurity®

**Assurity® Life Insurance Company**
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

# GROUP POLICYHOLDER APPLICATION

**PLEASE PRINT WITH BLACK INK**

## POLICYHOLDER INFORMATION

| | | |
|---|---|---|
| Group Name City of Crete | | Group's Tax I.D. No. 47-6006154 |
| Address 243 East 13th St PO Box 86 (Street Address) Crete (City) NE (State) (ZIP+4) | | Type of Group ☒ Employer ☐ Association/Union |
| Contact Name Jody Fiehtner | | Contact Title Human Resources |
| Contact Phone No. ( 402 ) 826-4312 | Contact Fax No. ( ) | Contact Email jody.fiehtner@crete.ne.gov |

1. Details of any subsidiaries or affiliates to be insured no
2. What is the group's industry? 911102 , Executive offices, state and local
3. Waiting period for current participants: no waiting period Waiting period for new participants: first of the month following date of hire
4. Total number of actively-at-work benefit-eligible employees? (do not include those on leave of absence) 63
5. How many hours are required for benefit eligibility? 30
6. Do you allow benefit changes or cancellations throughout the year? ☒ Yes ☐ No
   If YES, what type of changes/cancellations: ☐ Any ☒ Only life-changing events ☒ Only cancellations ☐ Other *(Specify)* _____
7. Does this insurance replace existing insurance with any company? If YES, provide details below.

| Company Name | Group/Policy Number | Termination Date *(MM/DD/YYYY)* |
|---|---|---|
| Mutual of Omaha | G000AXNG | 06 / 30 / 2025 |
| | | / / |

8. Requested effective date of insurance 07 / 01 / 2025 *(MMDDYYYY)*
9. Mail policies to: ☒ Insured ☐ Other (Specify)

**NOTE:** There is an "actively employed" requirement for coverage to be in force. Any employee unable to perform the material and substantial duties of their regular occupation will not be insured until this requirement is satisfied.

## ENROLLMENT INFORMATION

Open enrollment period 6/1-6/30 What is the enrollment timeframe for new hires? ☐ Continuously ☐ Quarterly ☒ Annually

## BILLING INFORMATION

1. Refund money to? ☐ Policyholder ☐ Participant
2. What is the billing method? ☒ Payroll deduction ☐ Other (Specify) _____

   How would you like to be billed? ☐ Ahead ☐ Arrears

   What is the payroll deduction frequency?

   ☐ Weekly (52) ☐ Bi-weekly (26) ☐ Semi-Monthly (24) ☒ Monthly (12) ☐ 9thly ☐ 10thly ☐ 13thly ☐ Other _____

   Do you want your monthly bill to reflect your premiums based on your payroll deduction frequency? ☐ Yes ☐ No

   If NO, how would you like them to appear? _____
3. Do you need the billing split up by location or employee class? ☐ Yes ☐ No
   if YES, please provide details _____
4. Where are the billings sent? ☒ Group ☐ TPA ☐ Other (Specify) _____
5. If billing information is different from what is listed in Group Address, please provide

## BILLING INFORMATION – Continued

Third party administration (TPA) must be approved by and under contract with Assurity. If a TPA is involved, please provide the information below

Name _____

Address _____
*Street Address* *City* *State* *Zip Code*

Additional information or details _____

## PRODUCT INFORMATION – Policy and rider availability, features and rates may vary by state

### CRITICAL ILLNESS

| Policy Type | Benefit Packages | Benefit Amount Options | Optional Riders | Paid By |
|---|---|---|---|---|
| ☒ Critical Illness | See worksite proposal ID #256077 for benefit and rider details. | | | ☐ Participant Paid<br>☐ Group Paid<br>☐ Other (Specify) |

### ACCIDENT EXPENSE

| Policy Type | Benefit Packages | Optional Riders | Paid By |
|---|---|---|---|
| ☒ 24-hour Accident Expense<br>☐ Off-the-job Accident Expense<br>Premium paid by:<br>☐ pre-tax deduction<br>☐ after-tax deduction | See worksite proposal ID #256077 for benefit and rider details. | | ☐ Participant Paid<br>☐ Group Paid<br>☐ Other (Specify) |

### SHORT-TERM DISABILITY INCOME

| Policy Type | Benefit Packages | Industry Class | Optional Riders | Paid By |
|---|---|---|---|---|
| ☐ Off-the-job Accident and Sickness Disability Income<br>☐ 24-Hour Accident and Sickness Disability Income<br>☐ Off-the-job Accident-only Disability Income<br>☐ 24-Hour Accident-only Disability Income | | | | ☐ Participant Paid<br>☐ Group Paid<br>☐ Other (Specify) |

### HOSPITAL INDEMNITY

| Benefit Packages | Policy Type | Benefit Options | Optional Riders | Paid By |
|---|---|---|---|---|
| ☐ Tier 1<br>☐ Tier 2<br>☐ Tier 3<br>☐ Basic Care<br>☐ Prime<br>☐ Flexible | | | | ☐ Participant Paid<br>☐ Group Paid<br>☐ Other (Specify) |

## TERM LIFE

| Policy Type | Optional Riders | Paid By |
|---|---|---|
| ☐ 10-Year<br>☐ 20-Year<br>☐ To Age 70 | | ☐ Participant Paid<br>☐ Group Paid<br>☐ Other (Specify) |

## WHOLE LIFE

| Policy Type | Optional Riders | Paid By |
|---|---|---|
| ☐ Whole Life Employee/Member<br>☐ Whole Life Spouse<br>☐ Whole Life Child | | ☐ Participant Paid<br>☐ Group Paid<br>☐ Other (Specify) |

## SERVICING AGENT INFORMATION

Agent Name _____ Agent No. _____
*First* *Middle* *Last*

Phone No. _(_____)_____ Fax No. _(_____)_____ Email Address _____

## BROKER OF RECORD

Agent or Agency Name _____ Agent or Agency ID No. _____

## ENROLLMENT FIRM

Enrollment Firm being used (if applicable) _____

## AUTHORIZATION AND AGREEMENT

The undersigned policyholder and/or authorized representative: 1) understands and represents to the best of their knowledge and belief that the statements made in this application, are true and complete; and 2) further agrees by payment of the required premium, if approved for coverage to the following:

1. The policyholder will: a) make the insurance coverage available to all eligible employees/members and their eligible dependents and to distribute information and documents to employees/members as needed to facilitate such coverage and b) provide notice of applicable continuation rights, if any, to eligible employees/members and dependents.
2. The policyholder will deduct premiums as necessary from the wages of participating employees/members and remit them to Assurity Life Insurance Company.
3. All employees/members applying for coverage are: a) employees of the employer; b) receive salary or wages documented on state and/or federal payroll reports; and c) meet any other eligibility requirements for coverage.

The undersigned policyholder and/or authorized representative acknowledges that the plan for which they are applying includes minimum participation requirements. If a sufficient number or percentage of eligible employees/members fails to enroll and the minimum participation requirements for the plan are not met, the insurance may not become effective. The undersigned policyholder and/or authorized representative acknowledges that compliance with federal and state employment laws is solely the responsibility of the policyholder.

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.**

Signed at _____ on _____/_____/_____

*City* *State* *Date (MM/DD/YYYY)*

_____ _____

*Group Representative Signature* *Title*

_____ _____

*Signature of Licensed Agent* *Print Agent Name* *Agent No.*

Assurity Life Insurance Company
P.O. Box 82533 | Lincoln, NE 68501-2533

800-869-0355 | assurity.com

# ELECTRONIC DELIVERY OF GROUP MASTER POLICY AND CERTIFICATES OF INSURANCE

The certificate of insurance and its accompanying notices (the "Certificate") provides important information to employees or members about their coverage under the Assurity Group Master Policy. Because of its responsibility for delivering the Certificate(s) to the employees or members, the Group Policyholder has the right to receive a paper copy of the Certificate(s) and the Group Master Policy. However, as a service to the Group Policyholder, Assurity will provide the following electronic delivery service in place of such paper copies:

- Assurity will provide the Group Master Policy to the Group Policyholder by email address provided by the Group Policyholder and/or to a secure group policyholder web portal designated by Assurity.
- On behalf of the Group Policyholder, Assurity will deliver the Certificate(s) electronically to the employees or members on its customer portal, MyAssurity.com (or other website address, as Assurity may designate). To access their individual Certificate, the employees or members will be required to create a MyAssurity account. The employees or members will receive instructions from Assurity via the email address provided at enrollment on how to access their Certificate, and will need a personal computer with internet access, appropriate browser software, and Adobe Acrobat, to do so. If no email address for an employee or member is provided, or if Assurity receives notice the email to the employee or member was undeliverable, Assurity will mail the Certificate to the address of the employee or member on file.

Electronic delivery may be limited in some states and/or by product.

By checking 'No' and signing below, you do not consent to electronic delivery, and Assurity will mail the Group Master Policy to you and the Certificate(s) to the employees or members on your behalf.

By checking 'Yes' and signing below, you are authorizing and affirmatively consenting to electronic delivery as described above in place of receiving paper versions of the Certificate(s) and Group Master Policy.

☐ Yes, I consent to electronic delivery.
☐ No, I do not consent to electronic delivery.

If you do not check either box, your signature below serves as your consent to electronic delivery as described above and in place of receiving paper versions of the Certificate(s) and Group Master Policy.

_____ _____ / / _____

*Employer Signature* *Date (MM/DD/YYYY)*

Account Number: 1047409

Anniversary Date: July 1, 2025

May 20, 2025

CITY OF CRETE
ATTN: WENDY THOMAS
243 E 13TH STREET
PO BOX 86
CRETE, NE 68333

OCI INSURANCE AND FINANCIAL SERVICES, INC.
4221 N 203RD ST STE 200
ELKHORN, NE 68022-3474

As you approach your upcoming renewal with Principal Life Insurance Company®, we would like to thank you for your continued business over the past year. Our goal is to offer competitive benefit solutions supported with exceptional service. Your business is very important to us and we look forward to supporting your business needs in the coming years!

## Your renewal

Your renewal rates are on the following pages. Your coverage will renew on your policy anniversary date (July 1, 2025).

Help your renewal go smoothly by reviewing this checklist: principal.com/groupinsurancerenewal

## How to renew your coverage

To renew coverage, please notify your agent and your payment of the premium due is your acceptance of the rates. We look forward to continuing our relationship with you.

## Available discounts

You may be able to take advantage of the Principal Life **Multiple Product Discount** when you're paying for at least three qualifying coverages. A strong and competitive benefit offering will help you retain excellent employees.

## Contact Us

If you have questions about this renewal or exploring alternate benefit designs, contact your broker or local Principal Life Insurance Company® sales office at 515-223-4931.

Sincerely,

Group Benefits Underwriting
Specialty Benefits Division

## Renewal rates
## Effective July 1, 2025

### Dental

| MEMBERS ELECTING HIGH PLAN | | | | | |
|---|---|---|---|---|---|
| | **Lives** | **Current rates** | **Renewal rates** | **Current monthly premium** | **Renewal monthly premium** |
| Employee | 2 | $34.12 | $36.44 | $68.24 | $72.88 |
| Employee & spouse | 2 | $66.79 | $71.33 | $133.58 | $142.66 |
| Employee & child(ren) | 3 | $83.39 | $89.06 | $250.17 | $267.18 |
| Family | 3 | $121.94 | $130.23 | $365.82 | $390.69 |
| **Total** | | | | $817.81 | $873.41 |
| Renewal rates are guaranteed through June 30, 2026. | | | | | |

| MEMBERS ELECTING LOW PLAN | | | | | |
|---|---|---|---|---|---|
| | **Lives** | **Current rates** | **Renewal rates** | **Current monthly premium** | **Renewal monthly premium** |
| Employee | 21 | $27.53 | $29.40 | $578.13 | $617.40 |
| Employee & spouse | 9 | $53.89 | $57.55 | $485.01 | $517.95 |
| Employee & child(ren) | 5 | $59.05 | $63.06 | $295.25 | $315.30 |
| Family | 9 | $89.17 | $95.23 | $802.53 | $857.07 |
| **Total** | | | | $2,160.92 | $2,307.72 |
| Renewal rates are guaranteed through June 30, 2026. | | | | | |

### Vision

| ALL MEMBERS | | | | | |
|---|---|---|---|---|---|
| | **Lives** | **Current rates** | **Renewal rates** | **Current monthly premium** | **Renewal monthly premium** |
| Employee | 17 | $9.54 | $9.54 | $162.18 | $162.18 |
| Employee & spouse | 7 | $14.19 | $14.19 | $99.33 | $99.33 |
| Employee & child(ren) | 8 | $14.19 | $14.19 | $113.52 | $113.52 |
| Family | 10 | $23.97 | $23.97 | $239.70 | $239.70 |
| **Total** | | | | $614.73 | $614.73 |
| Renewal rates are guaranteed through June 30, 2026. | | | | | |
| Your rates aren't changing. | | | | | |

**Principal Life Insurance Company**
Des Moines, Iowa 50392
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