AON ACTIVE
HEALTH EXCHANGE™

Make It Yours To Go

A benefits overview for you and your family.

Compare Coverage Levels

Compare Prices

Compare Insurance Carriers

Enroll

Get More From Your Benefits

Table of Contents

Eligibility

It's up to you to understand who you can cover under your medical, dental, and vision benefits. Be sure to review the information below *before* you enroll in coverage.

Am I Eligible For Benefits?

You are eligible for benefits if you work at least 30 hours per week.

You can enroll your eligible dependents for medical, dental, vision, life, and AD&PL insurance coverage.

Who Can I Cover?

You are able to cover your spouse or domestic partner and eligible child(ren) under most of the benefits offered. Eligible children can be covered up to age 26. When you enroll for benefits, you will see the available coverage level displayed for your benefits.

If you add a new dependent, you will receive a Dependent Verification form in your home mail. You must submit the documentation to validate your dependent within 31 days. Failure to provide adequate documentation of your dependents will result in a loss of their coverage.

For more information about coverage levels, log on to **NMGbenefits.com**.

Spouse/Domestic Partner Subsidy Differential

The spouse/domestic partner subsidy differential means your contribution will be $150 more per month if you cover a spouse/domestic partner who has access to medical insurance through his or her employer or another source. It costs NMG more to cover spouses/domestic partners than associates. If a spouse/domestic partner can get medical coverage through his or her employer but declines that coverage, the associate shares some of the additional cost of coverage under the NMG program through higher associate contributions.

If you choose to cover a spouse/domestic partner, you will be required to certify online at the time of enrollment, and re-certify each year during Annual Enrollment, whether your spouse/domestic partner does or does not have access to other medical coverage.

Medical Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want. If you're enrolling again, consider what changes you may be facing. Change is constant, so make sure you **do your homework** before sticking with what you had in the past.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Medical Coverage Level Options

You have several coverage levels to choose from. Each coverage level is available from different **insurance carriers** at different costs.

When you enroll, you'll find plenty of tools and resources to help you choose a coverage level.

	BRONZE	BRONZE PLUS	SILVER	GOLD
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO
Paycheck contributions	$	$	$$	$$$
		Annual Deductible		
In-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900	$1,000 / $2,000	$800 / $1,600
Out-of-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900	$2,000 / $4,000	$1,600 / $3,200
Traditional or true family?	Traditional	True family	Traditional	Traditional
		Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$6,400 / $12,800	$3,900 / $7,800	$5,300 / $10,600	$3,600 / $7,200
Out-of-network (individual / family)	$12,800 / $25,600	$11,500 / $23,000	$10,600 / $21,200	$7,200 / $14,400
Traditional or true family?	Traditional	True family	Traditional	Traditional

		In-Network Benefits		
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay 25% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	If not an office visit, you pay 25% after deductible

Prescription Drug Coverage

	BRONZE	**BRONZE PLUS**	**SILVER**	**GOLD**
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**
		30-Day Retail Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60
		90-Day Mail Order Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150

**Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to NMGbenefits.com. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on NMGbenefits.com.

California Residents: Your options will be different, depending on the insurance carrier you choose. See **what's different**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier.

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You must designate a primary care physician to coordinate your care if you:

- Choose Kaiser Permanente as your insurance carrier;
- Live in Northern California and choose Health Net as your insurance carrier; or
- Live in Southern California and choose Health Net as your insurance carrier and Gold II as your coverage level.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how the insurance carrier will cover any medications you and your covered family members need. **Get the details**.

Questions?

It's easy to find answers! Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

California Medical Coverage Level

Live In California?

Your options will be different, depending on the insurance carrier you choose.

For starters, each **insurance carrier** in California has the option to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) **or** an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer **either the standard Gold option or a Gold II option—not both**. The Gold II option offers **only** in-network benefits.

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering.

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A
Blue Cross Blue Shield of Texas	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A
Health Net	**Northern California** In-network only **Southern California** In- and out-of-network	**Northern California** In-network only **Southern California** In- and out-of-network	**Northern California** In-network only **Southern California** In- and out-of-network	N/A	In-network only
Kaiser Permanente	In-network only	In-network only	In-network only	N/A	In-network only
United Healthcare	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A

Medical Coverage Level

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO	HMO
Paycheck contributions	$	$	$$	$$$	$$$
		Annual Deductible			
In-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900†	$1,000 / $2,000	$800 / $1,600	N / A
Out-of-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900†	$2,000 / $4,000	$1,600 / $3,200	N / A
Traditional or true family?	Traditional	True family	Traditional	Traditional	N / A
		Annual Out-of-Pocket Maximum			
In-network (individual / family)	$6,400 / $12,800	$3,900 / $7,800‡	$5,300 / $10,600	$3,600 / $7,200	$5,400 / $10,800
Out-of-network (individual / family)	$12,800 / $25,600	$11,500 / $23,000‡	$10,600 / $21,200	$7,200 / $14,400	N / A
Traditional or true family?	Traditional	True family	Traditional	Traditional	Traditional
		In-Network Benefits			
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%

Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay 25% after deductible	You pay 30%
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30%
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30%
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, you pay 30%

†Under Health Net and Kaiser Permanente, if you cover dependents, no covered member pays more than $2,800 toward the family deductible. Also, these options feature a traditional annual deductible.

‡Under Health Net and Kaiser Permanente, these options feature a traditional annual out-of-pocket maximum.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
			30-Day Retail Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10	You pay $10
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40	You pay $40
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60	You pay $60

			90-Day Mail Order Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25	You pay $25
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100	You pay $100
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150	You pay $150

**Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to NMGbenefits.com. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on NMGbenefits.com.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier.

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You must designate a primary care physician to coordinate your care if you:

- Choose Kaiser Permanente as your insurance carrier;
- Live in Northern California and choose Health Net as your insurance carrier; or
- Live in Southern California and choose Health Net as your insurance carrier and Gold II as your coverage level.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how the insurance carrier will cover any medications you and your covered family members need. **Get the details**.

Questions?

It's easy to find answers! Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

How Deductibles Work

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs.

For example, let's say you break your wrist. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you reach the deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept for a particular service from the **insurance carrier.**

It Depends On Your Medical Coverage Level

Bronze, Silver, and Gold Coverage Levels
These coverage levels have a **traditional deductible.**

Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus Coverage Level
This coverage level has a **"true family deductible."** This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members.

There is no "individual deductible" in this plan(s) when you have family coverage. So even if one person in your family has a lot of expenses, you'll have to pay for it on your own until the full family deductible is met.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?

Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

How Out-of-Pocket Maximums Work

The out-of-pocket maximum is the most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance.

Here's how the out-of-pocket maximum works if you have family coverage:

It Depends On Your Medical Coverage Level

Bronze, Silver, and Gold Coverage Levels
These coverage levels have a **traditional out-of-pocket-maximum.**

Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

It doesn't include amounts taken out of your paycheck for health coverage. Also, if you choose coverage under Kaiser Permanente, copays for certain medical benefits may not apply towards the annual out-of-pocket maximum under the Silver and Gold options

Bronze Plus Coverage Level
This coverage level has a **"true family out-of-pocket maximum."** This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

There is no "individual out-of-pocket maximum" in this coverage level when you have family coverage.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?
Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Medical Price

When you make a purchase, you decide how you want to pay. Would you rather pay cash now, or use credit and pay later?

It's the same idea with the exchange. You get to decide if you'd rather **pay now or pay later.**

How much you pay out of your paycheck is one thing. You also have to consider what you'll pay throughout the year when you need care.

How much you'll pay for medical coverage depends on:

The Amount Of Your Credit From NMG

All eligible associates will receive a credit to use toward the cost of coverage.

You'll see the credit amount from NMG and your price options for coverage when you **enroll**.

The Coverage Level You Choose

The Bronze and Bronze Plus coverage levels cost less per paycheck. But they have higher deductibles that you pay before your coverage kicks in.

The Silver and Gold coverage levels cost more per paycheck because of the higher coverage they provide. You'll probably pay less out of pocket for services throughout the year.

Learn more about coverage levels.

The Insurance Carrier You Choose

You can see which insurance carrier offers the lowest paycheck amount for each coverage level. For example, if you know you want a Silver option, you can look to see how much each insurance carrier would charge you for it. **Learn more about insurance carriers.**

Important: Choose an insurance carrier whose network includes providers critical to your care. If you see an out-of-network provider, your medical insurance carrier could pay a much lower benefit—leaving you to pay the rest.

Your Dependents

You can enroll any combination of you, your spouse/domestic partner, and your children in the option you choose. Check out the **Frequently Asked Questions** (PDF) to see who's eligible.

Pay Now or Later?

It's a trade-off. It's up to you to choose which option gives you the best deal on your total health care costs.

Would you rather pay **less** now and **more** when you need care? Or pay **more** now and **less** when you need care?

Pay Less *Now*

Make sure you know **how the deductible works**. Also, make sure the deductible amount is something you could afford in the event you need a lot of health care.

TIP: You can save money by enrolling in an **HSA** when you enroll in a Bronze or Bronze Plus coverage level.

Pay Less *Later*

The Silver and Gold coverage levels cost more per paycheck but the deductibles are lower. If you don't have a lot of health care needs, you could be spending money for benefits you don't use.

How to Get the Right Medical Option

Don't wait. **Get ready** now so when it's time to enroll, you'll have answers to the following questions.

Which Providers Are In The Carrier's Network?

Why It Matters
Seeing out-of-network providers will cost you more—sometimes a lot more. For example, you will have to pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount.

What to Do
Choose an insurance carrier whose network includes providers (e.g., doctors, specialists, hospitals) critical to your care.

Want to see whether a doctor participates in a carrier's network? To search for providers:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on **NMGbenefits.com**. For the best results, search for your provider by name—not medical practice—and only the office location where you will visit the provider.

Important! Do **not** rely on your provider's office to know the carriers' network(s). If you have any uncertainty or, for instance, you will cover out-of-area dependents, you need to call the insurance carrier to confirm whether a provider participates in a **carrier's network**.

Even if you can keep your current insurance carrier, the provider network could be different and can change, so always check the provider networks before making a decision.

How Will My Prescription Drugs Be Covered?

Why It Matters
Each medical insurance carrier's pharmacy benefit manager has its own rules about how prescription drugs are covered. To avoid potentially costly surprises, you need to do your homework.

What to Do
If you or a family member regularly takes medication, make sure you're comfortable with the pharmacy benefit manager's coverage for drugs you and your covered family members need:

- Call OptumRx (if you're considering coverage under Aetna, Blue Cross and Blue Shield of Texas, Cigna, and UnitedHealthcare) or the medical carrier (for other carriers) *before* you enroll. Get a list of **prescription drug questions** to ask the insurance carriers.
- If you're currently taking a more expensive brand name prescription drug, ask your doctor (or pharmacist) if a generic is available to you.
- When it's time to enroll, you can use the prescription drug search tool to look up your medication, see how it will be classified (Tier 1, Tier 2, Tier 3), and more.

Which Medical Coverage Level Is Best For Me?

Why It Matters
You want to get the right amount of coverage for your needs at the best price. Get help choosing the right level of coverage.

What to Do
If you need help deciding, there are tools to help you:

- Get an overview of your medical **coverage levels**.
- See which coverage level could be **best for you** with the Help Me Choose tool. By answering a few questions on **NMGbenefits.com**, you can see which option could be a good fit for you and your family.
- Compare your options side by side when you enroll on **NMGbenefits.com**. Just check the boxes next to medical options you want to review and click **Compare** (under the check marks). You can quickly see which options cost more out of your paycheck and which options cost more when you get care. (You may also find Summaries of Benefits and Coverage for comparison on **NMGbenefits.com**.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price for each coverage level, and you'll be able to see all of the prices in one place on **NMGbenefits.com**. (**Note:** The benefits provided under a coverage level will be very similar across carriers, but there could be some differences.)

What to Do
If you need help deciding:

- See how other people rate their health carriers on **NMGbenefits.com** anytime. Share your own ratings and opinions with others too.
- Compare the details, when you enroll online, by checking the boxes next to medical options you want to review and clicking **Compare** (under the check marks). That makes it easy to see which carrier is offering you the best deal. (You may also find Summaries of Benefits and Coverage for comparison on **NMGbenefits.com**.)
- Browse the carrier preview sites to learn about programs, tools, and other considerations that could influence your decision.

Ready to enroll? **Find out how.**

HSA Basics

An HSA—or Health Savings Account—is a special bank account that you can use when you enroll in a Bronze or Bronze Plus coverage level.

It's a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up. Plus, it's tax-free, so you're actually getting a better deal.

You can decide if you want to enroll in an HSA when you enroll for benefits. That's a great time to **decide how much to save**.

You can change the amount you save at any time throughout the year.

Why Consider An HSA?

You'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or Bronze Plus coverage level. An HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Let's say you injure your knee playing basketball. With a high deductible, you might worry about how you're going to afford the medical bills.

Now imagine if you had already set aside money for expenses like these. That's where an HSA comes in handy! You could already have the money you need saved up.

An HSA allows you to set aside tax-free money to pay for qualified health care expenses. This includes your medical, dental, and vision copays, deductibles, and coinsurance.

It's Tax-Free—And Yours To Keep!

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside a little money in an HSA.

It's tax-free when it goes in. You can put money into your HSA on a before-tax basis through convenient payroll contributions. You'll save money on qualified health care expenses and lower your taxable income.

It's tax-free as it grows. You earn tax-free interest on your money.

It's tax-free when you spend it. When you spend your HSA on qualified health care expenses, you don't pay any taxes. That means you're saving money on your qualified medical, dental, and vision expenses.

It's always your money. You can carry over your unused HSA balance from year to year. Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical options, leave the company, or retire.

Important! Make sure you use money in your HSA only for qualified health care expenses. Otherwise, you'll pay income taxes on that distribution. You'll also pay an additional 20% penalty tax if you're under age 65.

Wondering what the difference is between an HSA and a Health Care Flexible Spending Account (FSA)? **Find out.**

Questions?

Get Answers to your questions, including eligibility rules and what happens if you already have an HSA or FSA.

If you enroll in a Bronze or Bronze Plus coverage level, learn how the HSA works in the **HSA User's Guide** (PDF).

HSA vs FSA

Wondering how an HSA is different from a Health Care Flexible Spending account (FSA)? Here's how:

	HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT
When to Use	You can use the HSA to pay for eligible medical, dental, and vision expenses under the Bronze or Bronze Plus coverage levels.	You can use the Health Care FSA to pay for eligible medical, dental, and vision expenses under any coverage level.
Contributions	You can contribute to your account before taxes. For 2021, the annual limits set by the IRS are $3,600 for individual coverage, and $7,200 for family coverage. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.	You can contribute to your account before taxes, up to the $2,750 annual limit.
Rollovers	Unused dollars roll over from year to year. The funds are always yours to keep, even if you leave the company or retire.	Unused dollars **don't** roll over from year to year.
Earning Interest	The money in your HSA earns interest.	The money in your FSA does **not** earn interest.
Debit Cards	Yes, a debit card is available.	Yes, a debit card is available.
Investment Option	You can open an investment account when your balance reaches $2,500.	You cannot invest your FSA balance.

Which Account Should I Use

If you enroll in the Bronze or Bronze Plus coverage level, you can use an HSA, a Health Care FSA, or both an HSA and Health Care FSA. If you contribute to an:

- HSA **or** Health Care FSA, you can use your account to pay for qualified medical, dental, and vision expenses.
- HSA **and** Health Care FSA, your Health Care FSA will be "limited use" and can only be used to pay for qualified dental and vision expenses. Your HSA can be used for qualified medical, dental, and vision expenses.

If you enroll in the Silver or Gold coverage level, you can use the Health Care FSA to pay for qualified medical, dental, and vision expenses.

Note: Due to the current situation with COVID-19, you will have until July 31, 2022 to use your Health Care and Dependent Care FSA funds and until October 31, 2022 to submit claims. As a result, if you enroll in a Bronze or Bronze Plus option for the new plan year and you have a Health Care FSA, you cannot contribute to the HSA.

How Much to Save?

You decide how much money you want to save in your HSA, and you can change it at any time. It's a smart idea to save enough to cover your annual deductible.

For 2021, you can save up to $3,600 if you're covering just yourself, or $7,200 if you're covering yourself and your family. If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000.

And if you don't need that much health care, your money stays in your account and earns tax-free interest. It's a great way to save for future expenses.

Note: If you want to, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit.

Prescription Drugs

This is a really big deal! Your prescription drug coverage depends on the medical coverage level you choose *and* your medical carrier. Associates who enroll under Aetna, Blue Cross and Blue Shield of Texas, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx. All other medical insurance carriers will manage their own prescription drug program.

Your Coverage Level Matters

You pay nothing for preventive drugs, as determined by your insurance carrier's pharmacy benefit manager. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze, Bronze Plus
You pay the full cost for prescription drugs until you reach the annual medical deductible. Then you pay coinsurance. Once you reach the out-of-pocket maximum, you pay nothing.

Silver, Gold
You pay a copay for all prescription drugs. Once you reach the out-of-pocket maximum, you pay nothing.

Your specific prescription coverage is based on the medical coverage level you select. **Get the details**.

Your Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—**before** choosing an insurance carrier.

Get a list of **prescription drug questions** to ask the insurance carriers' pharmacy benefit managers.

Prescription Drug Questions

Do you or a family member take medications? This could be a big deal for you!

Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager. Your prescription drug coverage depends on the insurance carrier and **medical coverage level** you choose.

However, each pharmacy benefit manager has its own rules about how prescription drugs are covered. So **you need to do your homework** to find out how your medications will be covered—**before** you choose an insurance carrier.

What To Ask

If you or a covered family member regularly takes medication, it is strongly recommended that you call OptumRx (if you're considering coverage under Aetna, Blue Cross and Blue Shield of Texas, Cigna, and UnitedHealthcare) or the medical carrier (for other carriers) before you enroll. Here's a cheat sheet of questions to ask each carrier you're considering.

Tip: You can also print out the **Prescription Drug Transition Worksheet** (PDF) and use it to take notes.

Is my drug on the formulary?
A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't listed on the formulary, you'll pay more for it.

How much will my drug cost?
It depends on how your medication is classified by your pharmacy benefit manager—Tier 1, Tier 2, or Tier 3. Typically, the higher the tier, the more you'll pay.

While generics typically cost less than brand name drugs, pharmacy benefit managers can classify higher-cost generics as Tier 2 or Tier 3 drugs. This means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can find this information on the carrier preview sites. Or you can use the prescription drug search tool when you enroll.

Will I have to pay a penalty if I choose a brand name drug?
Because many brand name drugs are so expensive, some medical insurance carriers will require you to pay the copay or coinsurance of a higher tier—*plus* the cost difference between brand and generic drugs—if you choose a brand when a generic is available.

Is my drug considered "preventive" (covered 100%)?
The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you fill them in network. But each pharmacy benefit manager determines which drugs it considers "preventive." If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

Will my doctor have to provide more information before my prescription drug can be approved?
Many pharmacy benefit managers require approval of certain medications before covering them. This may apply for costly medications that aren't considered medically necessary.

Will I have a step therapy program?
You may be required to enter a step therapy program for one or more of your medications. If so, you'll be asked to try using the most cost-effective version of your medication first—usually the generic. A more expensive version will only be covered if the first drug isn't effective in treating your condition.

Are there any quantity limits for my medication?
Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.

How do I take advantage of mail-order service?
You'll likely need a new 90-day prescription from your doctor. Mail order can take a few weeks to establish. So it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

We'll Help You Through The Transition

After you enroll, check out **things to know** before your benefits start.

Medicare Basics

Medicare is a federal medical insurance program, which includes Original Medicare. Original Medicare is a low-cost government insurance program that guarantees access to health insurance for Americans age 65 and older and younger people with certain medical disabilities. It pays for many health care expenses, but not all.

How It Works

Medicare covers its share of an approved amount and you pay the rest through deductibles and coinsurance. Original Medicare is made up of two parts:

- **Part A is hospital insurance.** It covers inpatient hospital care, skilled nursing facilities, hospice, lab tests, surgery, and home health care.
- **Part B is medical insurance.** It covers things like clinical research, ambulance services, durable medical equipment, mental health services, limited outpatient prescription drugs, and more.

You are automatically eligible for Medicare Parts A and B when you become Medicare-eligible. If you are receiving Social Security benefits, you may be enrolled in Medicare automatically.

If you have to sign up to get coverage, you can enroll starting three months before the month you turn age 65. The deadline to enroll is three months after the month you turn age 65. (Note: You can wait to enroll in Part B; however, you may have to pay a late enrollment penalty. However, in general, you can wait to enroll in Medicare Part B without facing a late enrollment penalty until your active employment ends or the date your coverage under your employer's plan ends, whichever occurs first. Consult your Medicare advisor for more details.)

Part D is optional prescription drug coverage. You can enroll in Part D if you want coverage to help pay for your prescription drug costs.

How Medicare Works With Company Coverage

If you are actively employed, your company's health plan will be your primary medical coverage, and, if you choose to enroll in Medicare, Medicare will be your secondary coverage. Please note, once you are enrolled in any part of Medicare (Parts A or B), you can no longer make contributions to an HSA, even if you are also covered by an HSA-eligible medical plan.

If you are retired and have coverage through your previous employer, Medicare will be your primary medical coverage, and your company's health plan will be your secondary coverage.

As you prepare to transition to Medicare, you will want to understand if your dependents under age 65 will be eligible for coverage under your company's health plan. To understand your options, contact Neiman Marcus Group Benefit Service Center at **1.866.673.0462** from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.

How Medicare Works With COBRA

If you are eligible for Medicare Parts A and B but you choose to not enroll in Medicare Parts A and B, you may face potentially significant out-of-pocket expenses. COBRA coverage pays secondary to Medicare Parts A and B. Therefore, the plan will pay as if Medicare has already made a payment, even if the Medicare-eligible individual did not actually enroll in Medicare.

If your Medicare benefits (Parts A or B) become effective on or before the day you elect COBRA coverage, you can have COBRA and Medicare coverage. This is true even if your Part A benefits begin before you elect COBRA coverage but you don't sign up for Part B until later.

If you become entitled to Medicare after you've signed up for COBRA coverage, your COBRA coverage may be terminated by your plan as of the day you enroll in Medicare. (But if COBRA covers your spouse and/or dependent children, their coverage may continue.)

To Learn More

Start **here** (PDF) to better understand Medicare, your options, impacts to your current coverage, and more. Below are resources where you can find additional information and help:

- Visit the **Aon Retiree Health Exchange** or call **1.833.791.0780**
- Visit the **Social Security website** or call **1.800.772.1213** (TTY **1.800.325.0778**) between 8:00 a.m. and 7:00 p.m. Monday through Friday
- Review the **Medicare & You** handbook from the Centers for Medicare & Medicaid Services

Accident Insurance

Accidents can slam your wallet too.

Even with medical coverage, your costs related to an accident can be hefty. Depending on the injury, you may be faced with copays, deductibles, hospital charges, transportation fees, and lodging expenses.

Accident insurance pays a benefit in the event you or a family member covered under this plan is in an accident. Accident insurance is not a replacement for medical coverage.

You can learn more about this coverage **here**.

Things To Consider

When deciding whether to enroll in accident insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through NMGbenefits.com at **NMGbenefits.com**.

Your and Your Family's Needs
Does your family lead an active lifestyle? Have you or an eligible family member suffered financial loss resulting from an accident? If you answered "yes" to either question, having accident insurance could give you peace of mind.

Other Coverage
Consider how accident insurance could fit in with other coverage for which you might enroll.

Critical Illness Insurance

When illness strikes, you can strike back. If you experience a serious health condition in the future, critical illness coverage can help lighten the load.

Even with medical insurance, a serious health condition could cost you. Critical illness insurance can provide you with extra cash when you need it most—if you or a family member once covered under this plan is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage renal disease).

You can learn more about this coverage **here**. Critical illness coverage has limitations and exclusions.

Choose Your Coverage Level

If you decide you want critical illness coverage, you may choose $10,000, $20,000, or $30,000 of coverage.

Things To Consider

When deciding whether to enroll in critical illness insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover, age, tobacco status, and the level of coverage you elect. You'll be able to see the cost per paycheck for all your options when you enroll through NMGbenefits.com at **NMGbenefits.com**.

Your and Your Family's Needs
Does a serious health condition run in your family? Would you need financial help to offset the cost of a serious health situation? If you answered "yes" to either question, having critical illness insurance could give you peace of mind.

Hospital Indemnity Insurance

Even with medical insurance, hospital stays can be costly. You may have copays, deductibles, and other incidental hospital charges that add up. That's why you can buy extra insurance through hospital indemnity coverage.

Hospital indemnity insurance pays you a single lump-sum benefit in the event you or a family member covered under this plan is hospitalized. The benefit is based on the type of hospital stay.

You can learn more about this coverage **here**.

Things To Consider

When deciding whether to enroll in hospital indemnity insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through NMGbenefits.com at **NMGbenefits.com**.

Your and Your Family's Needs
Does a serious health condition run in your family? Are you or an eligible family member frequently hospitalized? If you answered "yes" to either question, having hospital indemnity insurance could give you peace of mind.

Dental Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays). Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Dental Coverage Level Options

	BRONZE	SILVER	GOLD
	Annual Deductible and Plan Limits		
Annual deductible (individual / family)	$100 / $300	$100 / $300	$50 / $150
Annual maximum (excludes orthodontia)	$1,000 per person	$1,500 per person	$2,500 per person
Orthodontia lifetime maximum[1]	Not covered	$1,500 per child	$2,000 per person
	In-Network Benefits		
Preventive care	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible
Minor restorative care (e.g., root canal treatment, gum disease treatment, and oral surgery)	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Major restorative care (e.g., implants, dentures)	Not covered	You pay 40% after deductible	You pay 20% after deductible
Orthodontia	Not covered	You pay 50%, no deductible; children up to age 19 only	You pay 50%, no deductible; for children and adults

[1]If you switch insurance carriers, any orthodontic expenses you've already incurred under your current carrier will count toward your new carrier's orthodontia lifetime maximum.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to **NMGbenefits.com**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on **NMGbenefits.com**.

Considering Delta Dental? With most carriers, knowing that your dentist is in the network is a simple way to get the best deal when you need care. If you're considering Delta Dental, you need to take it one step further to get the same deal.

There are actually two Delta Dental networks—PPO and Premier. Although the benefits are the same for both, you may have to pay more if your dentist is only a part of the Premier network. You can save more by seeing a Delta Dental dentist who participates in both the PPO and Premier networks, or by using any in-network dentist if you choose another insurance carrier on the exchange.

Dental Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

When you make a purchase, you decide how you want to pay. Would you rather pay cash now or use credit and pay later? It's the same idea with the exchange.

Just like your medical coverage, your dental coverage costs will depend on a few factors:

The Coverage Level You Choose

Bronze
The Bronze coverage level generally costs less per paycheck. That's because some services aren't covered and because it has the lowest benefit maximum.

Silver
The Silver coverage level is moderately priced since most services are covered. However, the benefit maximum is lower.

Gold
The Gold coverage level costs more per paycheck since most services are covered. The benefit maximum is also higher.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your **eligible** spouse/domestic partner, and your children in the option you choose.

Vision Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care. Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Vision Coverage Level Options

	BRONZE	SILVER	GOLD
		In-Network Benefits	
Routine vision exam (once per plan year)	Covered 100%	You pay $20	You pay $10
Frames (once per plan year)	Discount may apply	$130 allowance[1]	$200 allowance[1]
		Lenses (once per plan year; premium lenses may cost more)	
Single vision	Discount may apply	You pay $20	You pay $10
Bifocal	Discount may apply	You pay $20	You pay $10
Trifocal	Discount may apply	You pay $20	You pay $10
Standard Progressive[2]	Discount may apply	You pay $20	You pay $10
Lenticular	Discount may apply	You pay $20	You pay $10
		Lens Enhancements	
UV treatment	Discount may apply	You pay $15	You pay $15

Tint (solid and gradient)	Discount may apply	You pay $15	You pay $15
Standard plastic scratch-resistant coating	Discount may apply	You pay $15	You pay $15
Standard anti-reflective coating	Discount may apply	You pay $45	You pay $45
Standard polycarbonate (adults)	Discount may apply	You pay $40	You pay $15
Standard polycarbonate (children)	Discount may apply	You pay nothing	You pay nothing
Other add-ons	Discount may apply	Discount only	Discount only
Contact Lenses			
Medically necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$130 allowance[1]	$200 allowance[1]
Fit and evaluation	Discount may apply	You pay $20	You pay $10
Laser Surgery			
Elective	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

[1]Allowance can be used for frames or elective contact lenses, but not both.

[2]Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to NMGbenefits.com. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on NMGbenefits.com.

Vision Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

When you make a purchase, you decide how you want to pay. Would you rather pay cash now or use credit and pay later? It's the same idea with the exchange.

Just like your medical coverage, your vision coverage costs will depend on a few factors:

The Coverage Level You Choose

The Bronze option will generally be less expensive per paycheck. That's because it covers only exams with some in-network discounts available. The Silver and Gold options will cost more per paycheck and provide coverage for exams as well as frames and lenses.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your **eligible** spouse/domestic partner, and your children in the option you choose.

The Living Well Program

NMG's Living Well Program helps associates improve their health and overall quality of life. You can receive a premium differential on your medical plan premiums for voluntarily completing a Biometric Screening. Biometric Screenings are 100% NMG-paid and include a few simple tests—like blood pressure, height, weight, and waist circumference—at one of over 1,000 Quest Diagnostics Patient Service Centers nationwide. Your results are collected by Quest Diagnostics and kept strictly confidential. NMG will not have access to your individual results.

You are eligible to receive up to an $800 premium differential (or $1,600 if you cover a spouse/domestic partner), pro-rated based on date of hire. New hire premium differentials will be effective from the time you are eligible for NMG benefits until the end of the plan year (July 31).

Note: If you completed a Biometric Screening by April 30 and qualified for the premium differential, you will see the credit when you enroll on **NMGbenefits.com**. The premium differential will be applied on your first paycheck following August 1.

If you (or your covered spouse/domestic partner) completed a Biometric Screening but did not qualify for the full premium differential, you will need to enroll in the LabCorp Employer Services Health Coaching program and complete 4 coaching sessions by July 31. You will see premium credits applied to your paycheck beginning in September. The first credits will include additional premium differential credits due from August 1 through September.

New Hire Eligibility

You must take your Biometric Screening within 45 days of your hire date to qualify for the medical plan premium differential. If you choose not to complete the Biometric Screening, you will not qualify for the premium differential.

To register and schedule a free Biometric Screening:*

- Log on to **NMGbenefits.com** and from the home page, click the **Schedule Your Biometric Screening** tile. Register using Registration Key: **NeimanMarcus**. Print your registration confirmation and bring it to your appointment.

- Your spouse/domestic partner can also schedule his/her screening by clicking on the Biometric Screening link on the login page of **NMGbenefits.com** and using your associate ID with the letter "s" at the end (example: 123456s) and his or her date of birth, or by calling (855) 623-9355.

- Call Quest Diagnostics Blueprint for Wellness at 1.855.623.9355, Monday through Friday from 7:00 a.m. to 8:30 p.m. CT, or Saturday from 7:30 a.m. to 4:00 p.m. CT.

*You will be eligible to register with Quest Diagnostics within two weeks of your date of hire.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) are an important accessory to your benefits. FSAs allow you to use pre-tax dollars to pay for certain health care or dependent care expenses during the year. NMG offers three types of FSAs administered by PayFlex.

PayFlex offers you online tools to help you make the most of your FSA benefits. The PayFlex Mobile™ app makes it easy for you to manage your account from any smartphone while you're on-the-go. You can also simply submit claims using the Financial Center feature on the app or online at **payflex.com**. If you choose to participate in the Health Care FSA, you will receive a PayFlex MasterCard® Debit card in the mail to pay for eligible expenses at point of service.

Using Your FSA Health Care MasterCard® Debit Card

Your Health Care FSA MasterCard® Debit card can be used to pay for all eligible medical, prescription drug, dental and vision expenses directly from your Health Care FSA.

Type Of FSA

- The **Health Care FSA** (Bronze and Bronze Plus participants are **not** eligible) helps pay for eligible expenses such as medical, dental and vision expenses that are not reimbursed by any insurance plan and are not itemized on your IRS tax return. It can also cover copays, coinsurance, and certain over-the-counter products. The Health Care FSA has a contribution limit of $2,750.

- The **Limited Purpose Health Care FSA** (Bronze and Bronze Plus participants are eligible) helps pay for eligible dental and vision expenses only. The Limited Purpose Health Care FSA has a contribution limit of $2,750.

- The **Dependent Care FSA** helps pay for the care of a child under age 13 or elderly dependents while you and your spouse (if married) are working. Eligible expenses include day care centers, summer day camps, nanny services, and elder care facilities. The Dependent Care FSA has a contribution limit of $5,000.

Reminder About FSAs: Use It Or Lose It

Due to the current situation with COVID-19, you will have until July 31, 2022 to use your prior year's Health Care and Dependent Care FSA funds and until October 31, 2022 to submit claims.

Dependent Care FSA

A Dependent Care FSA may be used to reimburse yourself for qualified child and dependent care expenses. You may use this account without being enrolled in medical coverage.

The Dependent Care FSA contribution limit is $5,000 (or $2,500 if you are married and filing taxes separately). Once you set your annual contribution when you enroll, you cannot change that amount during the year (except in the case of certain qualified life events).

And, with an FSA, you lose any unused money at the end of the year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

Things To Consider

When deciding whether to enroll in FSAs, be sure to consider the following:

Tax savings
Do you have moderate to high health care or dependent care expenses? If so, an FSA could help reduce how much you pay in taxes.

Your expected expenses
Because you lose any unused FSA money at the end of the year, you need to carefully estimate your anticipated eligible expenses for the coming year. You should only set aside FSA dollars for eligible expenses you know to expect.

Long-Term Disability (LTD) Coverage

Long-term disability (LTD) coverage provides monthly income protection if you become totally disabled under the terms of the policy, and are unable to work for an extended period of time. LTD pays a monthly benefit after you have been totally disabled for six months and are approved by Reliance Standard Insurance Company. If you do not enroll when you are first eligible for LTD coverage, when you do enroll, you will be required to submit an Evidence of Insurability form and be approved for coverage. LTD coverage also allows you to participate in Reliance Standard's 24-Hour Travel Assistance Service and Identity Theft Recovery Services. More information on these bundled programs is available by contacting Reliance Standard.

LTD coverage has certain limitations. To review the Summary Plan Description, log on to **NMGbenefits.com**.

Accidental Death & Personal Loss (AD&PL) coverage

Accidental death & personal loss (AD&PL) coverage provides benefits in the event of an accidental death, dismemberment or paralysis. You can choose associate or family coverage. Please note dependents in full-time military service or age 65 and older are not eligible for AD&PL coverage. Log on to NMGbenefits.com and click on **Enroll In, Update** or **View Your Benefits** for costs of coverage.

Type Of Coverage

- **Associate coverage:** $25,000 to $1,000,000 (cannot exceed 10 times your annual earnings)

- **Family coverage:** based on the amount of coverage you choose for yourself (spouse/domestic partner only coverage 60%; child(ren) only coverage 20% for each child; spouse/domestic partner **and** child(ren) coverage: 50% spouse/domestic partner and 10% for each child)

Make Sure Your Beneficiary Designation Is Current

If you need to update your beneficiaries, log on to NMGbenefits.com and click **Enroll in, Update or View Your Benefits**.

Term Life Insurance

NMG provides $20,000 in basic life coverage to all benefits-eligible associates.

Your enrollment is automatic and there is no cost to you. You may also purchase optional term life insurance coverage for yourself, your spouse/domestic partner, and/or your child(ren).

Optional Term Life Insurance

You can choose optional term life insurance individual coverage or coverage for eligible dependents. Amounts over the guaranteed issue amount will be subject to Evidence of Insurability (EOI).

You do not have to cover yourself to choose spouse/domestic partner and/or child(ren) coverage. Log on to **NMGbenefits.com** for coverage amount options and costs.

Please note, associates eligible for the MetLife/Paragon Executive Life Program are not eligible for the basic, associate optional, and dependent optional term life insurance plans and will receive enrollment information at their home directly from MetLife.

Be Aware

Your life insurance coverage begins reducing after age 70.

What Is Evidence Of Insurability?

Evidence of Insurability (EOI) is a statement of medical history and related information, which is used to determine whether an applicant will be approved for coverage.

Any Time Benefits

NMG's Any Time Benefits are the perfect fit to complement and supplement the NMG Benefits Program. You can take advantage of these benefits any time, and you do not have to enroll during Annual Enrollment.

- Commuter Benefits
- NMG Lifestyle Solutions
- Business Travel Accident Insurance
- Travel Assistance Services
- Adoption Benefits
- Education Assistance
- Matching Gift Program
- Associate Discount
- Scholarship Program
- Active&Fit Direct™ Fitness Center Discount Program
- NMG Discount Marketplace
- PayActiv

For additional information about these benefits and contact information, log on to **NMGbenefits.com**.

How to Enroll

Log on to **NMGbenefits.com** to enroll in your benefits.

Following your enrollment, you may still need to take action. If you do, the required follow-ups will appear on a confirmation page.

There are also things you should do to set yourself up for success **after you enroll**.

Questions?

Start with the **Frequently Asked Questions** (PDF). When you enroll, customer service representatives will be available at Neiman Marcus Group Benefit Service Center from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday, to answer questions. Call **1.866.673.0462**. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

Actions After You Enroll

Now that you've enrolled, it's time to focus on the road ahead. And there are things you need to do **now** to use your benefits successfully when they take effect.

Here's your to-do list:

Know How Your Prescription Drug Plan Works

Your prescription drug coverage is provided through your medical insurance carrier's pharmacy benefits manager, who sets the rules for how medications are covered.

The pharmacy benefit manager could be a separate prescription drug company. Associates who enroll under Aetna, Blue Cross and Blue Shield of Texas, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx.

Don't be caught by surprise! Visit your pharmacy benefit manager's website for information about your medications. And, check out the **Prescription Drug Transition Worksheet** (PDF) for tips and questions you may need to ask your carrier.

Check the Formulary

A *formulary* is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. **Check with your carrier** to make sure your drug is listed on the formulary *before* you fill it. If it isn't, you'll pay more.

Go Generic

Generic drugs meet the same standards as brand name drugs, but they *typically* cost less. And, because brand name drugs are so expensive, some carriers don't cover them *at all* if a generic is available. Ask your doctor if a generic drug is available for you.

Mail-Order Setup

Mail-order service can save you a trip to the pharmacy and may reduce your costs. To set up mail order with a new pharmacy benefit manager, you'll likely need a new 90-day prescription from your doctor. Because mail-order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Track your to-dos and get organized! Print the **Prescription Drug Transition Worksheet** (PDF).

"Transition Of Care" Setup

Are you or a covered family member pregnant? Will you or your covered family member continue needing treatment for an ongoing medical condition?

If you will have a new medical insurance carrier and you answered "yes" to either question, you may be able to temporarily continue that care with your current provider once your **new** medical coverage begins. This is true even if your provider isn't in the new insurance carrier's network.

If you think this applies to you, **call customer service** at your **new** medical insurance carrier as soon as possible to ask for help with "transition of care."

Give your new insurance carrier information about your treatment and the providers you use today.

Will you have a new dental plan? Will you or your child(ren) continue receiving ongoing orthodontic treatment? **Call customer service** at your **new** dental insurance carrier as soon as possible to ask for help with "transition of care."

Track your to-dos and get organized! Print the **Transition of Care Worksheet** (PDF).

Avoid Unexpected Out-Of-Network Costs

It's very important to know whether your doctor participates in your medical insurance carrier's network.

You Could Pay a Lot More for Out-of-Network Care

Your medical insurance carrier could pay a much lower benefit if you see an out-of-network doctor—leaving you to pay the rest.

For instance, you will pay more through a higher out-of-network deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare-based calculation to determine the maximum allowed amount.

Example
For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 40% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 40% of $2,000 and 100% of the remaining $3,000, for a total of $3,800.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 40% of $3,000 and 100% of the remaining $2,000, for a total of $3,200.

Take These Steps to Protect Yourself

If you *didn't* check your doctor's status before you enrolled or you want to look up a different doctor, do it *now*—before making an appointment with that doctor.

You can check the provider directory through **NMGbenefits.com** or your medical insurance carrier's website.

Important! Do **not** rely on your provider's office to know the carriers' network(s). If you have any uncertainty or, for instance, you will cover out-of-area dependents, you need to call the insurance carrier to confirm whether a provider participates in a **carrier's network**.

Even if you're keeping the same insurance carrier, the provider network could be different. *Always* check the provider directories before making a decision.

If your doctor is out-of-network and you still want to see him or her, check the cost with your doctor *before* you get care. Then ask your doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you'll be responsible. That way you'll be prepared for any potentially significant costs.

When To Expect New Cards

If you enroll in medical coverage with Aetna, Blue Cross and Blue Shield of Texas, Cigna, or UnitedHealthcare, you will receive a medical ID card and a separate prescription drug ID card from OptumRx. If you enroll in medical coverage with another insurance carrier, your medical and prescription drug ID card will be combined.

If you don't receive your ID card, **contact the insurance carrier** to request one be mailed to you.

Need an ID card and can't wait for it through the mail? You can go to your insurance carrier's website, register online, and print a temporary ID card.

Note: Many dental insurance carriers also issue ID cards. If you receive one, simply present it when you get dental care during the new plan year.

Contributing To An HSA?

If you enrolled in the Bronze or Bronze Plus option, you had the option to elect to contribute to an HSA.

If you decided to put money in an HSA for the first time, you'll receive a welcome letter and HSA debit card in the mail. You must activate your HSA before you can use it. If you decided to put money in your HSA and you've previously contributed to the HSA, you'll continue to use your existing debit card. New money added to your account will be accessible through your current debit card.

HSA vs. FSA: Which One Should You Use?
Heads up: If you enrolled in an HSA *and* a Health Care Flexible Spending Account (FSA), you must follow IRS guidelines on how to use each account:

Your HSA can be used for medical, dental, and vision expenses.

Your Health Care FSA will be "limited purpose" and can only be used to pay for eligible dental and vision expenses.

How to Get Care

When you get care, it helps to know what you can expect:

Getting Care At The Doctor's Office

Present your medical ID card at your doctor's office to get discounted rates. Ask your doctor to file a claim with your insurance carrier and bill you after the carrier processes the claim.

Have an HSA?
You don't have to present your HSA debit card at the doctor's office—just your medical ID card! You can **use your HSA** or pay another way—it's your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your ID card each time you drop off a prescription. If payment is due, you pay out of pocket. Or you can **pay with your HSA** or FSA if you have one.

Know When You'll Owe

If your doctor bills services as preventive care or your medication is listed as preventive on the formulary, you'll owe nothing. For other types of covered services or non-preventive prescription drugs, you could owe a deductible, copay, and/or coinsurance.

Remember: You'll Pay Less With In-Network Providers

You can check the provider directory on NMGbenefits.com **NMGbenefits.com** or refer to your **insurance carrier's website**.

If a doctor is out-of-network and you still want to see him or her, check the cost with the doctor before you get care.

Then, ask the doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you will be responsible.

That way, you'll be prepared for any potentially significant costs.

Remember: Not all options cover out-of-network care.

Paying for Care

When you receive medical care, you choose how to pay your share of the cost. Follow these easy steps when it's time to get care:

Step 1: Meet With Your Provider

Don't forget, you'll probably pay **a lot** less when you see in-network providers. You can check the provider directory on NMGbenefits.com NMGbenefits.com or refer to your **insurance carrier's website**.

Remember: Not all options cover out-of-network care.

Step 2: Present Your Medical ID Card

When you visit your doctor, hospital, or other health care provider, remember to show them your ID card so they know how to bill for the services they are providing you.

Step 3: Review The Explanation Of Benefits (EOB)

An EOB is **not** a bill. It's simply a statement from your insurance carrier that shows when you got care and how much it cost.

It will show your provider's charges, the negotiated amount your insurance carrier agreed to pay, how much is covered (if any), and your payment responsibility.

Remember, if you haven't met your deductible, you could owe the entire negotiated amount. Keep the EOB for your records because you'll need it for the next step.

Step 4: Review Your Provider's Bill

A provider's bill typically arrives in your mailbox after the EOB arrives. The amount you owe on your provider's bill should match what's on the EOB.

Step 5: Pay Your Provider

You can pay your provider out of pocket. Or, if you have an **HSA** or FSA, you can use it to pay for eligible health care expenses.

Paying With Your HSA

You can open an HSA if you enrolled in a Bronze or Bronze Plus coverage level. When it's time for you to pay for care or prescription drugs, your HSA gives you options:

Use Your HSA Debit Card

Just use it when you're ready to pay for qualified medical expenses. The funds will be taken directly from your account.

Make sure you only use the card for eligible expenses, and that you have enough money in your HSA to cover it.

Log on to Optum Bank's website through **NMGbenefits.com** to check your balance beforehand.

Pay Out Of Pocket

If you prefer, you can pay for your expenses up front and pay yourself back through your HSA later. You'll log on to Optum Bank's website through **NMGbenefits.com** to transfer money from your HSA to your regular bank account. If you need help with this, contact Optum Bank at **1.877.470.1771**.

Set Up Direct Payments

Another option is to have Optum Bank make direct payments to your provider from your HSA. Log on to **NMGbenefits.com** to set up direct payments.

Eligible Expenses

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

Don't forget! If you use money from your HSA to pay for nonqualified expenses, you'll pay taxes on that money. You'll also pay an additional 20% penalty tax if you're under age 65. This applies to expenses such as child care, cosmetic surgery, health club fees, teeth whitening products, and vitamins.

Keep Your Receipts!

Always remember to save your receipts when you make payments from your HSA, in case you need to provide proof of your eligible expenses to the IRS.

Questions?

Learn more in the **HSA User's Guide** (PDF).

Your Carrier Connection

Check out your health care insurance carrier choices—and see all the unique features and services they have to offer YOU. Discover what each provides, see the doctors included in their network—then decide for yourself.

Medical

Carrier Name: Aetna

Areas We Serve: Offered in all states except AK, ID, MT, WY, and SD. Availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/si/2021

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm local time

Phone Number: 1.855.496.6289

Pharmacy Contact (OptumRx): 1.844.579.7775

Who We Are: At Aetna, we're not just a health insurance company. We're a health company that understands that your health is about more than just coverage and costs.

Learn More

Carrier Name: Blue Cross Blue Shield

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.bcbstx.com/aonsi

Once you're a member (website): https://www.bcbstx.com/member/register

Customer Service Hours: Monday - Friday 8:00 a.m. - 6:00 p.m. CT

Phone Number: 1.855.212.1617

Pharmacy Contact (OptumRx): 1.844.579.7775

Who We Are: Find out why nearly one in three Americans choose a Blue Cross and Blue Shield Plan. Access to a large, national provider network, wellness resources, discount and points programs, and great service are just a few of the features you get when you sign up with Blue Cross and Blue Shield of Texas.

Learn More

Carrier Name: Cigna

Areas We Serve: Generally offered in most states, except MN, ND. Limited availability in MI.

Before you're a member (preview site): https://connections.cigna.com/aonactivehealth-withyou-2021/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna One Guide® personal guides are available Monday - Friday: 8:00 a.m. - 9:00 p.m. EST.

Outside of the standard hours, customer service advocates are available 24 hours a day, 7 days a week.

Phone Number: 1.855.694.9638, For Cigna company names and product disclosures, visit Cigna.com/product-disclosure

Pharmacy Contact (OptumRx): 1.844.579.7775

Who We Are: For over 225 years, Cigna has made it our mission to improve the health, well-being, and peace of mind for our customers - delivering quality care at an affordable price. Especially in times of uncertainty, you can count on us to work hard and help you safeguard your health and financial stability.

Learn More

Carrier Name: Dean/Prevea360

Areas We Serve: South Central and Northeastern Wisconsin

Before you're a member (preview site): http://aon.deanhealthplan.com/

Once you're a member (website): http://aon.deanhealthplan.com/

Customer Service Hours: Mon - Thurs: 7:30 a.m. - 5:00 p.m. CST
Friday: 8:00 a.m. - 4:30 p.m. CST

Phone Number: 1.877.232.9375

Who We Are: With access to more than 4,000 practitioners and close to 200 primary care sites and 28 hospitals, Dean Health Plan connects a strong network of health care providers, innovative hospitals, and comprehensive insurance coverage into one integrated health care system working for you.

Learn More

Carrier Name: Geisinger Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://geisinger.org/aon

Once you're a member (website): https://www.geisinger.org/member-portal

Customer Service Hours: Monday - Friday: 7:00 a.m. - 7:00 p.m. EST
Saturday: 8:00 a.m. - 2:00 p.m EST

Phone Number: 1.844.390.8332

Who We Are: Choosing a good health insurance plan is more important than ever. With Geisinger Health Plan, we cover the services you need and help you stay healthy by better managing your healthcare needs.

Learn More

Carrier Name: Health Net
Areas We Serve: Oregon and select markets in California

Before you're a member (preview site): https://www.healthnet.com/myaon

Once you're a member (website): https://www.healthnet.com/myaon

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m. PT

Phone Number: 1.888.926.1692

Who We Are: Health Net.... Coverage for every stage of life™

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in CA, CO, DC, GA, MD, VA, OR, and southwest WA

Before you're a member (preview site): http://kp.org/aon

Once you're a member (website): http://www.kp.org

Customer Service Hours:
CA: 24/7 except major holidays
CO: Mon - Fri: 8:00 a.m. - 5:00 p.m. MST
GA: Mon - Fri: 7:00 a.m. - 7:00 p.m. EST
DC, MD, VA: Fri: 7:30 a.m. - 5:30 p.m. EST
OR and WA (Vancouver/Longview area): Mon - Fri: 8:00 a.m. - 6:00 p.m. PST

Phone Number:
1.877.580.6125, CA Post-enrollment: 1.800.464.4000
CO Post-enrollment: 1.303.338.3800
GA Post-enrollment: 1.404.261.2590
DC, MD, VA Post-enrollment: 1.800.777.7902
OR and southwest WA Post-enrollment: 1.800.813.2000

Pre-enrollment Phone Number: 1.877.580.6125

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in WA

Before you're a member (preview site): https://kp.org/wa/aonactivehealth

Once you're a member (website): https://wa-member.kaiserpermanente.org

Customer Service Hours: WA (outside Vancouver/Longview area): Mon - Fri: 8:00 a.m. - 6:00 p.m. PST

Phone Number: 1.855.407.0900

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Medical Mutual

Areas We Serve: Generally available in OH

Before you're a member (preview site): http://www.medmutual.com/aon

Once you're a member (website): https://member.medmutual.com

Customer Service Hours: Monday- Thursday: 7:30 a.m. - 7:30 p.m. EST Friday: 7:30 a.m. - 6:00 p.m. EST
Saturday: 9:00 a.m. - 1:00 p.m. EST

Phone Number: 1.800.541.2770

Pre-enrollment Phone Number: 1.800.677.8028

Who We Are: We care about the health and wellbeing of Ohioans. That's why we offer high-quality health insurance plans with access to the doctors and hospitals you know and trust. Plus, prescription drug coverage, personalized wellness programs and more.

Learn More

Carrier Name: Priority Health

Areas We Serve: Available in the lower peninsula of MI

Before you're a member (preview site): https://www.priorityhealth.com/aon

Once you're a member (website): https://member.priorityhealth.com/

Customer Service Hours: Monday -Thursday 7:30 a.m. -7:00 p.m. EST
Friday 9:00 a.m. - 5:00 p.m. EST
Saturday 8:30 a.m. - noon EST

Phone Number: 1.833.207.3211

Who We Are: Looking for a health plan that fits with your lifestyle? We work hard to create health insurance plans that work for you, your family, your health status and your budget. From cost cutting tools to nationally-recognized customer service, Priority Health delivers a better experience.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://welcometouhc.com/aon6

Once you're a member (website): http://myuhc.com

Customer Service Hours: Customer Care Center:
Monday - Friday: 7:00 a.m. - 7:00 p.m. EST

Transaction Center: Monday - Friday: 8:00 a.m. - 5:00 p.m. PT

Phone Number: 1.888.297.0878

Pharmacy Contact (OptumRx): 1.844.579.7775

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Carrier Name: UPMC Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://www.upmchealthplan.com/aon/

Once you're a member (website): https://www.upmchealthplan.com/members/

Customer Service Hours: Monday-Friday: 7:00 a.m. - 7:00 p.m. EST Saturday: 8:00 a.m. - 3:00 p.m. EST

Phone Number: 1.844.252.0690

Who We Are: Here's the plan for getting the high-quality care you and your family deserve: Choose UPMC Health Plan. When you do, you can expect the best.

Learn More

Dental

Carrier Name: Aetna

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/fi/2021

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm local time

Phone Number: 1.855.496.6289

Who We Are: As a member, enjoy dental care that focuses on ease, simplicity and service. You can choose from a selection of affordable plans and programs.

Learn More

Carrier Name: Cigna

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://connections.cigna.com/aonactivehealth-2021/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Customer service advocates are available 24 hours a day, 7 days a week.

Phone Number: 1.855.694.9638

Who We Are: A healthy partnership starts here. Cigna provides affordable, predictable, and simple health and wellness solutions for real life. Regardless of your unique needs, we have a plan for you, at a price you can afford. Offered by Cigna Health and Life Insurance Company or its affiliates.

Learn More

Carrier Name: Delta Dental (Bronze, Silver, and Gold)

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): http://ddca.deltadentalexchange.com/

Once you're a member (website): http://www.deltadentalins.com

Customer Service Hours: PPO - Mon - Fri: 7:15 a.m. - 8:00 p.m. EST

Customer Service Hours: DHMO - Mon - Fri: 8:00 a.m. - 9:00 p.m. EST

Phone Number: 1.800.471.7614

Pre-enrollment Phone Number: 1.800.503.4162

Who We Are: Delta Dental protects more smiles than anyone. As the nation's leading dental insurance provider, we make it easy to keep your smile healthy with specialized expertise and the largest network of dentists.

Learn More

Carrier Name: MetLife

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-exchange

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday - Friday: 8:00 a.m. - 11:00 p.m. EST

Phone Number: 1.888.309.5526

Who We Are: MetLife is among the largest global providers of insurance, annuities, and employee benefit programs, with 90 million customers in over 60 countries. We are also the largest commercial dental insurance carrier in the U.S. and offer both dental and vision benefits on the Aon Active Health Exchange.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://welcometouhc.com/aon5

Once you're a member (website): https://www.myuhc.com

Customer Service Hours: Monday - Friday: 7:00 a.m. - 10:00 p.m. EST

Phone Number: 1.888.571.5218

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Vision

Carrier Name: EyeMed

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.eyemedexchange.com/aon/

Once you're a member (website): https://www.eyemedvisioncare.com/member/public/login.emvc

Customer Service Hours: Mon - Sat: 7:30 a.m. - 11:00 p.m. EST
Sundays: 11:00 a.m. - 8:00 p.m. EST
Closed: Easter, Thanksgiving and Christmas

Phone Number: 1.844.739.9837

Who We Are: Driven to become the nation's first choice for vision benefits, EyeMed seeks to give you choice and to make using your benefits easy. We're focused on developing innovative benefit solutions and the networks you want. Visit eyemed.com.

Learn More

Carrier Name: MetLife

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-exchange

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday - Friday 8:00 a.m. - 11:00 p.m., ET
Saturday 10:00 a.m. - 11:00 p.m., ET
Sunday 10:00 a.m. - 11:00 p.m., ET

Phone Number: 1.888.309.5526

Who We Are: MetLife is among the largest global providers of insurance, annuities, and employee benefit programs, with 90 million customers in over 60 countries. We are also the largest commercial dental insurance carrier in the U.S. and offer both dental and vision benefits on the Aon Active Health Exchange.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://welcometouhc.com/aon5

Once you're a member (website): https://www.myuhcvision.com

Customer Service Hours: Monday - Friday: 7:00 a.m. - 10:00 p.m. CT Saturday: 8:00 a.m. - 5:30 p.m. CT
IVR and website is available 24 hours a day, seven days a week.

Phone Number: 1.888.571.5216

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Carrier Name: VSP Vision Care

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): http://aon.vspexchange.com

Once you're a member (website): https://www.vsp.com/login

Customer Service Hours: Monday - Friday: 5:00 a.m. - 8:00 p.m. PT
Saturday: 7:00 a.m. - 8:00 p.m. PT
Sunday: 7:00 a.m. - 8:00 p.m. PT

Phone Number: 1.877.478.7559

Who We Are: Your well-being is at the core of everything we do. VSP® Vision Care gives you access to

quality eye care from VSP network doctors with low out-of-pocket costs. Get the most out of your vision plan with up to 98K provider access points including independent doctors, popular retailers, and online.

Learn More

Get Carrier Ratings

See how others have rated their health carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and specific comments are available at **NMGbenefits.com** during enrollment and throughout the year.

* Your specific medical options are based on where you live. You'll be able to see the options available to you when you enroll. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: Coverage may be slightly different than the Silver option on this site. Refer to **NMGbenefits.com** for details.)

Contacts

Customer service representatives at Neiman Marcus Group Benefit Service Center are available from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday, to answer questions. Call **1.866.673.0462**. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

Health Pros are also available to assist with tough issues like claims and billing disputes.

Questions About Coverage?
Start by contacting the **insurance carrier** directly. They know their coverage rules best.

If you enrolled in a Bronze or Bronze Plus medical coverage level, check out the **HSA User's Guide** (PDF) for additional contacts during the year.

Contact a Health Pro

Have questions about your claims or coverage? Start by contacting your **insurance carrier** directly. They know their coverage rules best and have the final say on all claims and billing disputes.

Sometimes you need more help than your insurance carrier can provide. If you have a billing issue, such as your provider charging you more than the amount your EOB says you owe, or you believe your plan covers more than what your EOB shows, Alight Advocacy Services is available. Alight Health Pros are experts in handling claims and billing disputes and can work with you on your behalf to resolve issues. Find more information about Health Pros **here**.

If you aren't satisfied with the resolution of a claim or billing dispute, you can file an appeal through your insurance carrier, who will be able to direct you through that process. NMG doesn't have any influence on the outcome. The insurance carrier—not NMG—is responsible for the cost of claims.

Questions?

Don't worry. You have backups. When you face a billing issue:

1. Start with your insurance carrier.
2. Email a Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530** if you need help.
3. File an appeal if you're unhappy with the final outcome.

Get the Answers

Have a question? We've got you covered.

Start with the **Frequently Asked Questions** (PDF).

Wondering what something means? Check out the **Glossary**.

Just want to talk to a real person? No sweat! Here's who to **contact**.

Glossary

Wondering what a term means? Find it here!

Brand Name
A more expensive prescription drug for which there is an active patent. (A patent is a time-sensitive right to market a drug under a certain name.)

Coinsurance
The percentage of costs you pay for eligible expenses after you meet the deductible.

Copay
A fixed dollar amount (not a percentage of the cost) you pay for some services under certain coverage levels.

Coverage Level
A benefit level that determines how services are covered.

Deductible
What you pay out of your own pocket before your insurance begins to pay a share of your costs. **How the deductible works** depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual deductible. They only count toward your out-of-network deductible.

EOB
Also known as an Explanation of Benefits. An EOB shows the claim filed by your health care professional, what was paid, and what your portion of the payment was or will be. Your insurance carrier provides the EOB. It's not a bill.

Formulary
A list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. You should make sure your medication is on the formulary of the medical insurance carrier you choose.

Generic
Medications that have been approved by the FDA as safe and effective. These medications contain the same active ingredients in the same amounts as brand name products. Generics may be different in color, shape, or size from their brand name counterparts. Your physician may substitute a generic for a brand name drug to save you money.

Health Savings Account (HSA)
A special bank account that allows you to set aside tax-free money to pay for qualified health care expenses. These include your medical, dental, and vision copays, deductibles, and coinsurance.

HMO
Health Maintenance Organization (HMO) options offer care through a network of doctors and hospitals. All of your care generally must be provided through the HMO network and coordinated through the HMO primary care physician (PCP) you select when you enroll. Except in emergencies, your care is usually covered only if it's coordinated by your PCP. There's no coverage for out-of-network care.

Insurance Carrier
An insurance company who manages and pays benefits on behalf of the plan.

Network
A group of health care providers that offer services to participants in a health plan at a negotiated, discounted cost. You'll save money if you use doctors inside your carrier's network.

Out-of-Pocket Maximum
The most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance. **How the out-of-pocket maximum works** depends on your coverage level.

Out-of-network charges do **not** count toward your in-network annual out-of-pocket maximum. They only count toward your out-of-network out-of-pocket maximum.

Payroll Contribution
The amount deducted from your paycheck on a pre-tax basis to cover your share of health care benefit costs.

PPO
A Preferred Provider Organization, or PPO, is a type of medical plan that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

Preventive Care
Annual physicals, wellness screenings, immunizations, well-woman exams, well-baby exams, and more. In-network preventive care is 100% covered without having to pay your deductible.

Reasonable and Customary
The normal charge made by a licensed practitioner in a specific area for a specific service. It doesn't exceed the normal charge made by most providers in the area where the service is provided.

Traditional Deductible
Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Traditional Out-of-Pocket Maximum
Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

True Family Deductible
The entire family deductible must be met before your insurance will pay benefits for any covered family member.

True Family Out-of-Pocket Maximum
The entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

Newly Eligible for Benefits?

Welcome!

Being new to the company, you have a lot on your plate. Enrolling in NMG benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2021/2022 benefits, you can start here:

- Quick Guide
- Enrollment Checklist (PDF)
- Medical
- Dental
- Vision

Make It Yours

Once you’ve done your homework, if you want coverage through NMG, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug, dental, or vision coverage through NMG for you and your family.

Enroll now

Questions?

Check out the Frequently Asked Questions (PDF) for more details.

Helpful Documents

- 2021 NMG Legal Notices

COBRA Coverage Options

If you have left the company, your COBRA enrollment notice has details regarding your options.

If you choose not to enroll by your COBRA enrollment deadline, you will not be able to enroll in COBRA coverage in the future. Also, once enrolled, you can make changes to your elections only during enrollment or following a qualified change in status.

You will receive additional information—including prices—once you lose access to health benefits through the company.

Your COBRA Coverage Options

You can start by reviewing your **medical**, **dental**, and **vision** coverage level options.

You'll also want to review your **insurance carrier** options.

How To Enroll

To enroll in COBRA coverage when eligible, follow the instructions on the COBRA enrollment notice mailed to you.