AON BENEFIT EXPERIENCE

Make It Yours To Go

make it yours

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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 their 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 their 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. 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. **Remember, the elections you choose will be in effect for five months only—from August 1 through December 31, 2025.**

	BRONZE	BRONZE PLUS	SILVER	GOLD
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO
Paycheck contributions	$	$	$$	$$$
		2025 Annual Deductible		
In-network (individual / family)	$3,300 / $6,600	$2,500 / $5,000	$1,000 / $2,000	$800 / $1,600
Out-of-network (individual / family)	$3,300 / $6,600	$2,500 / $5,000	$2,000 / $4,000	$1,600 / $3,200
Traditional or true family?	Traditional	True family	Traditional	Traditional
		2025 Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$6,400 / $12,800	$4,500 / $9,000	$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
		2025 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 30% after deductible	You pay $150, then 20% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $40
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 20% 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 20% 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 or pharmacy benefit manager. 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 Benefit Experience. 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 BenX.

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 may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

Your prescription drug coverage will be provided through your pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. associates who enroll under Aetna, Blue Cross Blue Shield of Texas, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by Optum Rx. All other carriers will manage their own prescription drug coverage.

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 your family's medications will be covered. **Get the details**.

Questions?

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 can elect 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. **Remember, the elections you choose will be in effect for five months only—from August 1 through December 31, 2025.**

	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	In- and out-of-network	In- and out-of-network	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	$	$	$$	$$$	$$$
		2025 Annual Deductible			
In-network (individual / family)	$3,300 / $6,600	$2,500 / $5,000†◆	$1,000 / $2,000	$800 / $1,600	N / A
Out-of-network (individual / family)	$3,300 / $6,600	$2,500 / $5,000†◆	$2,000 / $4,000	$1,600 / $3,200	N / A
Traditional or true family?	Traditional	True family	Traditional	Traditional	N / A
		2025 Annual Out-of-Pocket Maximum			
In-network (individual / family)	$6,400 / $12,800	$4,500 / $9,000‡	$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
		2025 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 30% after deductible	You pay $150, then 20% after deductible	You pay $150, then 30% after copay
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $40	You pay $40
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 20% 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 20% after deductible	If not an office visit, you pay 30%

†Under Health Net and Kaiser Permanente, these options feature a **traditional** annual deductible. If you cover dependents under the Bronze Plus coverage level, no covered member pays more than $3,300 toward the family deductible.

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

◆Under Health Net, if you cover dependents under the Bronze Plus coverage level, the family deductible is $4,950.

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 or pharmacy benefit manager. 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 Benefit Experience. 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 BenX.

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 may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

Your prescription drug coverage will be provided through your pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. associates who enroll under Aetna, Blue Cross Blue Shield of Texas, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by Optum Rx. All other carriers will manage their own prescription drug coverage.

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 your family's medications will be covered. **Get the details**.

Questions?

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 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 other 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 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 the Bronze Plus coverage level 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.

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.

It Depends On Your Medical Coverage Level

Bronze, Silver, and Gold 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 Bronze, Silver, and Gold options.

Bronze Plus 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 the Bronze Plus 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.

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 BenX. 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 you will pay a higher deductible before your coverage kicks in.

The Silver and Gold coverage levels cost more per paycheck, but 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 eligible spouse/domestic partner, and your children in the option you choose.

Pay Now or Later?

It's a trade-off. It's up to you to choose which option gives you the best value 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*

The Bronze and Bronze Plus coverage levels cost less per paycheck, but your deductible is higher. That means you'll pay more out of your pocket when you need care.

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 your deductible is lower. If you don't expect to 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

Now that you understand the basics, it's time to put it all together. Get confident in your choices—before you enroll—by finding answers to some really important questions.

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.

Do **not** rely on your provider's office to know the carriers' network(s). 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.
    - Check only the office location(s) you are willing to visit.
    - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

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

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

How Will My Prescription Drugs Be Covered?

Why It Matters
Each 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 covered 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 Optum Rx (if you're considering coverage under Aetna, Blue Cross Blue Shield of Texas, Cigna, or UnitedHealthcare) or the medical **insurance carrier** (for all other carriers) before

you enroll. Get a list of **prescription drug questions** to ask.

- 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:

- 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. If you also have coverage under a second medical plan, it must also be a high-deductible option for you to use an HSA.

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. 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 saved the money you need.

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, how to contribute, and more.

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

See how an HSA is different from a Health Care Flexible Spending Account (FSA) and a Limited Purpose Health Care FSA below.

	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 **Your contribution limits will be your elected annual contribution amount but prorated for the shortened plan year.**	You will elect a before-tax contribution amount based on a full calendar year (up to the 2025 IRS maximum contribution of $4,300 if you're covering just yourself, or $8,550 if you're covering yourself and family). However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 annually (or approximately $423 prorated from August 1 through December 31).	You will elect a before-tax contribution amount based on a full calendar year (up to the 2025 IRS maximum contribution of $3,300). However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31.
Fund Availability	You can use up to the total amount you have contributed to your HSA.	The total amount of your annual election is available at the beginning of the plan year.
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 purpose" 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.

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.

If you choose to enroll in an HSA, you will elect a contribution amount based on a full calendar year (up to the 2025 IRS maximum contribution of $4,300 if you're covering just yourself, or $8,550 if you're covering yourself and family). However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31.

For example, if you elect an annual amount of $4,300, your total HSA contribution from August 1 through December 31 will be approximately:

- $165.38 per pay period for 11 pay periods for bi-weekly associates
- $82.69 per pay period for 22 pay periods for weekly associates

The total contribution will be approximately $1,820 of the $4,300 election.

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 annually (or approximately $423 prorated from August 1 through December 31).

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.

Prescription Drugs

Your prescription drug coverage will be provided through your pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. associates who enroll under Aetna, Blue Cross Blue Shield of Texas, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by Optum Rx. **Note:** Optum Rx does not cover out-of-network pharmacies, and specialty drugs must be filled by a specialty pharmacy to be covered. All other carriers will manage their own prescription drug coverage.

That means your prescription drug coverage depends on the medical coverage level you choose **and** your medical **insurance carrier.**

Your Coverage Level Matters

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

Bronze or 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 or 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.

Prescription Drug Questions

Your prescription drug coverage will be provided through your **insurance carrier's** pharmacy benefit manager, which could be a separate prescription drug company. 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

Here's a list of questions to ask Optum Rx (if you're considering coverage under Aetna, Blue Cross Blue Shield of Texas, Cigna, or UnitedHealthcare) or the medical **insurance carrier** (if you're considering coverage under other carriers).

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 by using 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 pharmacy benefit managers 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?
If this applies to one of your medications, you'll need to try using the most cost-effective version first—usually the generic. A more expensive version will be covered only 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. 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.

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

Below are resources where you can find additional information and help:

- Visit **Alight Retiree Health Solutions** 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**.

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.

Wellness Benefit
This is a yearly benefit you and everyone covered on your certificate can receive by completing an eligible health screening test.

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 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, $30,000, and $40,000 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**.

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.

Wellness Benefit
This is a yearly benefit you and everyone covered on your certificate can receive by completing an eligible health screening test.

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**.

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.

Wellness Benefit
This is a yearly benefit you and everyone covered on your certificate can receive by completing an eligible health screening test.

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. 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., crowns, 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 Benefit Experience. 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 BenX.

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.

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.

You can check if your provider is part of either network on **NMGbenefits.com** or through **Your Carrier Connection**.

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 BenX.

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. 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	Varies by carrier	Varies by carrier
Tint (solid and gradient)	Discount may apply	Varies by carrier	Varies by carrier
Standard plastic scratch-resistant coating	Discount may apply	Varies by carrier	Varies by carrier
Standard anti-reflective coating	Discount may apply	Varies by carrier	Varies by carrier
Standard polycarbonate (adults)	Discount may apply	Varies by carrier	Varies by carrier
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 Benefit Experience. 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 BenX.

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 BenX.

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.

Biometric Screening Program

Save money on your medical plan premiums when you complete NMG's Biometric Screenings, designed to help associates improve their health and overall quality of life. These screenings are 100% NMG-paid and include a few simple tests—including blood pressure, height, weight, and waist circumference—at one of over 1,000 Quest Diagnostics™ Service Centers nationwide. Your results are collected by Quest Diagnostics and kept strictly confidential. NMG will not have access to your individual results.

You (and your covered spouse/domestic partner) can earn savings toward your medical plan premium differential by each completing a screening and any recommended health coaching. Here's how it works (savings per eligible person):

- Earn a **partial savings** of $7.69 per bi-weekly pay period (or $3.85 per weekly pay period) for completing a Biometric Screening by April 30 at a Quest Diagnostics Service Center or onsite at NMG locations. Wellness Event dates will be communicated at your work location.

- Earn a **full savings** of $30.77 per bi-weekly pay period (or $15.39 per weekly pay period) if you passed the waist circumference* and cotinine screenings. If you did not pass either or both screenings, you must enroll in the **Marquee Health Coaching program** by June 13 and complete four required coaching sessions by July 31 to receive the full premium differential.

*If you (or your covered spouse/domestic partner) are pregnant and do not pass the waist circumference screening, you can have your physician fill out and fax the **Quest Diagnostics Physician Affidavit Form** to earn the full premium differential. You will not need to complete the Health Coaching program.

Note: If you completed a Biometric Screening at a Quest Diagnostics Service Center by April 30 or at a NMG location and qualified for the full 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 screening but did not qualify for the full premium differential, review the **Health Coaching** page for more information.

New Hire Eligibility

If you take your Biometric Screening within 30 days of your hire date, regardless of your results you will qualify for the full medical plan premium differential for your entire family. Your spouse/domestic partner will be invited to take the screening the following year. If you choose not to complete the Biometric Screening, you will not qualify for the premium differential.

Register and Schedule Your Free Biometric Screening

- Log on to **NMGbenefits.com** and from the home page, click the **Schedule Your Biometric Screening** tile. If you have not previously registered on the Quest Diagnostics website, you'll need to register using the **registration key**: NeimanMarcus. Print your registration confirmation and bring it to your appointment.

- Call the Quest Diagnostics Service Center at **1.855.623.9355**, from 7:00 a.m. to 8:30 p.m. CT, Monday through Friday, and from 7:30 a.m. to 4:00 p.m. CT on Saturday.

- Your spouse/domestic partner can also schedule their screening by clicking 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 their date of birth, or by calling **1.855.623.9355**.

Please note: Before your spouse/domestic partner schedules a Biometric Screening, make sure they are listed as a dependent. Visit the NMG Benefit Service Center via **NMGbenefits.com**, click **Your Profile** at the top-right corner of the home page, and select **Dependent Summary**, or call **1.866.673.0462**. To add your spouse/domestic partner as a beneficiary, select **Manage Beneficiaries**.

Once you are at a Quest Diagnostics Service Center, here's how it works:

1. You will undergo a simple blood draw along with a measurement of blood pressure, height, weight, and waist circumference. It's required that you fast 9 to 12 hours prior to your screening. If you don't fast, you may be asked to reschedule your screening.
2. Your blood sample will be sent to a Quest Diagnostics laboratory for testing.
3. Quest Diagnostics will no longer be mailing your personal report. When your screening results are ready, you will receive an email that you can view, download, and print your personal report from their website.
4. Take your personal report to your doctor on your next visit.

Questions?

For more information, please review the **Biometric Screenings Frequently Asked Questions**.

NMG reserves the right to amend this program, with or without notice, at any time.

Health Coaching

At Neiman Marcus Group, we value the benefits of engaging in your physical, emotional, social, and community wellbeing. We encourage you to take advantage of our Marquee Health Wellness program, which is available to all associates at no cost. Our goal is to provide wellness resources to help you live a healthier, stronger, and more vibrant lifestyle!

Did You Participate in a Biometric Screening?

If you (or your covered spouse/domestic partner) completed a Biometric Screening but did not pass the waist circumference* and/or cotinine screening, you can participate in the Health Coaching program to qualify for the full premium differential.

*If you (or your covered spouse/domestic partner) are pregnant and do not pass the waist circumference screening, you can have your physician fill out and fax the **Quest Diagnostics Physician Affidavit Form** to earn the full medical plan premium differential. You will not need to complete the Health Coaching program.

Note: You (or your covered spouse/domestic partner) must schedule your first coaching session with the UBody Weight Management Program or the UBreathe Tobacco Cessation Program by June 13 and complete all four (4) sessions by July 31 to earn the full savings toward your medical plan premium differential. That's up to $30.77 per person, per bi-weekly pay period (or $15.39 per person, per weekly pay period). 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.

How to Get Started—connect to Marquee Health in the following ways:

- Phone: **1.800.882.2109**
- Web portal: **mymarqueehealth.com** (access code: **nmg**)
- Email: **coaching@marqueehealth.com**

New Hire Eligibility

You must take your **Biometric Screening** within 30 days of your hire date to qualify for the full medical plan premium differential for your entire family. Regardless of your screening results, you will not be required to participate in the health coaching, this is a special exception for new hires only. If you choose not to complete the Biometric Screening you will not qualify for the premium differential.

Additional Services

Marquee Health provides access to health and wellbeing resources right at your fingertips! Programs include:

- Unlimited health coaching
- Fun wellness challenges
- On-demand wellness videos
- Online health improvement modules

- Wellbeing place blog
- Monthly wellness webinars
- Access to gym membership discounts

Whether you are completing health coaching to qualify for your medical premium differential or interested in building a stronger mind, body, and spirit, Marquee Health is your gateway to better health and wellbeing.

NMG reserves the right to amend this program, with or without notice, at any time.

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 Inspira Financial.

Inspira Financial offers you online tools to help you make the most of your FSA benefits. The Inspira 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 **inspirafinancial.com**. If you choose to participate in the Health Care FSA, you will receive a 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.

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.

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. You will elect a before-tax contribution amount based on a full calendar year up to the 2025 IRS maximum contribution of $3,300. However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31.

- The **Limited Purpose Health Care FSA** (Bronze and Bronze Plus participants are eligible) helps pay for eligible dental and vision expenses only. You will elect a before-tax contribution amount based on a full calendar year up to the 2025 IRS maximum contribution of $3,300. However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31.

- 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. You will elect a before-tax contribution amount based on a full calendar year up to the 2025 IRS maximum contribution of $5,000 (or $2,500 if you are married and filing taxes separately). However, due to the shortened plan year, you will only receive the contributions made that were from August 1 through December 31.

Limited Purpose Health Care FSA

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 purpose" 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.

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.

You will elect a before-tax contribution amount based on a full calendar year up to the 2025 IRS maximum contribution of $5,000 (or $2,500 if you are married and filing taxes separately). However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31. 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 the Dependent Care 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.

Note: Your Dependent Care FSA annual contribution may be reduced by Plan or IRS limitations.

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
Carefully estimate your anticipated eligible expenses for the coming year. You should only set aside FSA dollars you know you will be able to use on eligible expenses.

Short-Term Disability (STD) Coverage

NMG provides short-term disability (STD) coverage to all benefits-eligible associates. Your enrollment is automatic and there is no cost to you.

STD coverage provides weekly or bi-weekly income protection if you become disabled under the terms of the policy, and are unable to work. STD pays a weekly or bi-weekly benefit after you have been disabled for seven calendar days and are approved by Reliance Standard Insurance Company.

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

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 (**English**/**Spanish**) 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 the **Health & Insurance** tab, then on **Coverage Details** 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 go to the **Quick Actions** section, then click on **Manage Beneficiaries**.

Legal Services

You don't want to spend a fortune to get legal advice when you need it. Legal Services coverage offers a network of attorneys who can help with creating or updating a will, real estate matters, tax audits, document preparation, and more.

If you use a network attorney, you don't pay any fees, deductibles, or copays. For a complete list of network attorneys and covered services, go to **https://www.metlife.com/info/NeimanMarcusGroup/benefits/legal-plans/**.

Legal Services is a voluntary benefit administered by MetLife. The plan covers associates and eligible family members.

Things To Consider

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

Cost per Paycheck
If you expect to need Legal Services, the cost of coverage could be less than if you paid an in-network attorney directly. You'll be able to see the cost per paycheck when you enroll through **NMGbenefits.com**.

Your Personal Situation
Consider your expected legal needs and access to network attorneys. Do you plan to purchase, sell, or refinance a home? Do you need help preparing a will or trust? If you answered "yes" to either question, having Legal Services coverage could give you peace of mind.

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.

Make Sure Your Beneficiary Designation Is Current

If you need to update your beneficiaries, log on to **NMGbenefits.com** and go to the **Quick Actions** section, then click on **Manage Beneficiaries**.

Identity Theft Protection

Victims of identity theft spend countless hours trying to sort out the damage.

Identity theft protection could help you catch fraud in its early stages through 24/7 monitoring of your personal and financial information. It can also help you act quickly to limit damage if your personal or financial information is stolen.

For more information, you can click **here**.

Identity theft protection is a voluntary benefit administered by ID Watchdog. The plan covers all eligible family members. And you can drop coverage at any time during the year.

Things To Consider

When deciding whether to enroll in identity theft protection, be sure to consider the following:

Cost per Paycheck
You'll be able to see the cost per paycheck when you enroll.

Your Risk Factors
While everyone has risk, some people are at greater risk than others. Have you used credit cards on unsecure websites? Do you make online purchases regularly? If you answered "yes" to either question, having identity theft protection could give you peace of mind.

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.

- Active&Fit Direct™ Fitness Center Discount Program
- Adoption Benefits
- All Heart Programs
- Associate Discount
- **Auto and Home Insurance**
- Business Travel Accident Insurance
- Commuter Benefits
- Education Assistance
- NMG Credit Union
- NMG Discount Marketplace
- NMG Lifestyle Solutions EAP
- NMG Retirement Savings Plan
- PayActiv
- **Pet Insurance**
- Scholarship Program
- Travel Assistance Services
- **Wellness Benefit** – Included with Accident, Critical Illness, and/or Hospital Indemnity Insurance coverage

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

Auto and Home Insurance

It's your stuff. Keep it safe.

You can get special group rates and policy discounts on many types of insurance—including auto, home, condominium, renter's, and recreational vehicle insurance. Auto and home insurance is a voluntary benefit administered by Farmers Insurance, Liberty Mutual, and Travelers Insurance. You can sign up for coverage directly with the insurance carrier for your choice.

You can learn more through **NMGbenefits.com**.

Paying For Coverage

You'll pay your premiums by credit or debit card.

Things To Consider

When deciding whether to enroll in auto and home insurance, be sure to consider the following:

Cost
The cost for coverage depends on the insurance carrier, the type of policy you choose, and your location. You can get a personalized quote before you enroll.

Your Personal Situation
Auto and home insurance offers policies to cover your possessions against damage and theft. And you may be eligible for additional discounts if you buy more than one policy from the same insurance carrier.

Flexibility
Since you can add or drop coverage at any time, it's easy to make a change if the need arises.

Pet Insurance

Pet insurance allows you to focus on your pet's health—not how to pay for it.

Pet insurance can help pay veterinary expenses for a sick or injured dog or cat. It covers a wide range of services with no annual or lifetime limits. There is not a network of providers—you can use any licensed veterinarian. Go **here** for a complete list of covered services.

You can learn more through **NMGbenefits.com**.

Paying For Coverage

You'll pay your premiums by credit or debit card.

Things To Consider

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

Cost
Your cost of coverage is based on the type of pet, breed, and age. Coverage is provided by pet. So if you have more than one, you can get a personalized quote for each.

Your Pet's Needs
Does your pet need regular veterinary care? Are you paying a lot of money out of your pocket for veterinary care? If you answered "yes" to either question, having pet insurance could give you peace of mind.

Flexibility
Since you can add or drop coverage at any time, it's easy to make a change if the need arises.

How to Enroll

Log on to **NMGbenefits.com** or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to enroll in your benefits for 2025.

Logging on for the first time? From NMGbenefits.com, register as a new user and follow the prompts to provide requested information and set up your username and password.

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?

Once logged on to **NMGbenefits.com**, look for the "Need Help?" icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through NMGbenefits.com. You can also call Neiman Marcus Group Benefit Service Center at **1.866.673.0462** from 8:00 a.m. to 8:00 p.m. ET. English- and Spanish-speaking representatives are 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 pharmacy benefit manager, who sets the rules for how medications are covered. The pharmacy benefit manager could be a separate prescription drug company. associates who enrolled under Aetna, Blue Cross Blue Shield of Texas, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by Optum Rx. All other carriers will manage their own prescription drug coverage.

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 pharmacy benefit manager** 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 can be expensive, some pharmacy benefit managers 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**, your medical insurance carrier's website, or get assistance with your **Health Pro**.

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 Blue Shield of Texas, Cigna, or UnitedHealthcare, you will have a medical ID card and separate prescription drug ID card from Optum Rx. If you enroll in medical coverage with another insurance carrier, you will have one ID for both medical and prescription drugs.

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.

For questions about ID cards, **contact the insurance carrier**. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Contributing To An HSA?

If you enrolled in the Bronze or Bronze Plus coverage levels, 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. 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?

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.

If you currently have money in a Health Care FSA, use it before you begin contributing to your HSA. This includes any "grace period" that applies during a new plan year (generally before April).

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. If you're enrolled in the Bronze or Bronze Plus coverage levels, you can wait to pay until your insurance carrier processes the claim and you get your doctor's bill.

When it's time to pay, you can **pay with your HSA**, FSA, or pay another way—it's your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your medical or prescription drug 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** 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** 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 you can **pay with your HSA** or FSA 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 Financial's website at **optum.com/financial** 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 Financial's website at **optum.com/financial** to transfer money from your HSA to your regular bank account. If you need help with this, contact Optum Financial at **1.877.470.1771**.

Set Up Direct Payments

Another option is to have Optum Financial make direct payments to your provider from your HSA. Log on to **optum.com/financial** 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).

Transparency in Coverage

Your employer is subject to the Affordable Care Act's requirements to make certain information available to the public. These links lead to the machine-readable files that are published in response to the federal Transparency in Coverage Rule and include negotiated service rates and out-of-network allowed amounts between health plans and health care providers. The machine-readable files are formatted to allow researchers, regulators, and application developers to more easily access and analyze data.

- **Aetna:** https://health1.aetna.com/app/public/#/one/insurerCode=AETNACVS_I&brandCode=ALICSI/machine-readable-transparency-in-coverage?searchTerm=189910&lock=true
- **Cigna:** https://www.cigna.com/legal/compliance/machine-readable-files
- **Dean/Prevea360:**
    - https://www.Deancare.com/transparencyincoverage
    - https://www.Prevea360.com/transparencyincoverage
- **Geisinger:** https://www.geisinger.org/health-plan/nosurprisesact
- **HCSC:** https://bcbstx.com/asomrf?EIN=954119509
- **HealthNet:** https://www.centene.com/price-transparency-files.html
- **HMSA:** http://www.hmsa.com/transparencymrf
- **Kaiser:** https://healthy.kaiserpermanente.org/front-door/machine-readable
- **Med Mutual of OH:** https://medmutual.healthsparq.com/healthsparq/public/#/one/insurerCode=MMO_I&brandCode=MMO&productCode=MRF/machine-readable-transparency-in-coverage
- **Priority Health:** www.priorityhealth.com/landing/transparency
- **United Healthcare:** https://transparency-in-coverage.uhc.com
- **UPMC:** https://www.upmchealthplan.com/transparency-in-coverage/mrf/

Your Carrier Connection

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

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 (Optum Rx): 1.844.579.7775

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: 24 hours a day/7 days a week/365 days a year, except for major holidays

Phone Number: 1-877-325-2996

Pharmacy Contact (Optum Rx): 1.844.579.7775

Learn More

Carrier Name: **Cigna**

Areas We Serve: Available nationally with the exception of MN and ND.

Before you're a member (preview site): https://connections.cigna.com/carrierbenefits-aso2025/

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

Customer Service Hours: Cigna Support is available 24/7/365

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

Pharmacy Contact (Optum Rx): 1.844.579.7775

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

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

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): https://www.kp.org

Customer Service Hours: CA: 24/7 except major holidays
CO: Mon - Fri: 8:00 a.m. - 6:00 p.m. MST
GA: Mon - Fri: 7:00 a.m. - 7:00 p.m. EST
DC, MD, VA: Mon - Fri: 7:30 a.m. - 9:00 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: 1.800.632.9700 (Gold II & Platinum); 1.855.364.3184 (All other metallics)
GA Post-enrollment: 1-888-865-5813 (Gold II & Platinum); 1-855-364-3185 (All other metallics)
DC, MD, VA Post-enrollment: 1.888.225.7202 (All metallics)
Southwest WA Post-enrollment: 1.800.813.2000 (Kaiser & Platinum); 1.866.616.0047 (All other metallics)

Pre-enrollment Phone Number: 1.877.580.6125

Learn More

Carrier Name: **Kaiser Permanente**

Areas We Serve: Generally available in WA

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

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

Customer Service Hours: Monday - Friday: 8:00 a.m. - 5:00 p.m. PST

Phone Number: 1.855.407.0900

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

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

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://www.whyuhc.com/aon10

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

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. local time zone

Phone Number: 1.888.297.0878

Pharmacy Contact (Optum Rx): 1.844.579.7775

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: 8:00 a.m. - 6:00 p.m. EST
Saturday: 8:00 a.m. - 12:00 p.m. EST

Saturday: 8:00 a.m. - 12:00 p.m. EST

Phone Number: 1.844.252.0690

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/si

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

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

Phone Number: 1.855.496.6289

Learn More

Carrier Name: **Cigna**

Areas We Serve: Available nationally with the exception of MN and ND.

Before you're a member (preview site): https://connections.cigna.com/carrierbenefits-aso2025/

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

Customer Service Hours: Cigna Support is available 24/7/365

Phone Number: 1.855.694.9638

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): https://www.deltadental.com/us/en/aon/california.html

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

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

Phone Number: 1.800.471.7614

Pre-enrollment Phone Number: 1.800.503.4162

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-benefit-experience

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

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://www.whyuhc.com/aon10

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

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. local time zone

Phone Number: 1.888.571.5218

Learn More

Vision

Carrier Name: EyeMed

Areas We Serve: Available nationally

Before you're a member (preview site): https://eyemed.com/en-us/benx-aon

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

Customer Service Hours: Monday - Friday: 7:30 a.m. - 11:00 p.m. EST
Saturday: 8:00 a.m. - 11:00 p.m. EST
Sunday: 11:00 a.m. - 8:00 p.m. EST

Phone Number: 1.844.739.9837

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-benefit-experience

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

Customer Service Hours: Monday-Saturday 9:00am-8:00pm EST

Phone Number: 1.888.309.5526

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://www.whyuhc.com/aon10

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

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. local time zone

Phone Number: 1.888.571.5218

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): https://www.vsp.com/aon

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

Customer Service Hours: Monday – Saturday: 6AM-5PM PT
Sunday: Closed (IVR available 24/7)

Phone Number: 1.877.478.7559

Learn More

Contacts

Once logged on to **NMGbenefits.com**, look for the “Need Help?” icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through NMGbenefits.com. You can also call Neiman Marcus Group Benefit Service Center at **1.866.673.0462** from 8:00 a.m. to 8:00 p.m. ET. English- and Spanish-speaking representatives are available.

Health Pros are also available to assist with tough issues like claims and billing disputes through July 31, 2025.

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

Health care benefits can be difficult to understand. Medical costs are rising and finding the right care can be time consuming. For your convenience, you have a personal **Health Pro** consultant at your fingertips to simplify your health care experience and steer you towards the most cost-effective, high-quality providers, so you can spend more time on what matters most. Health Pros can help you:

- **Understand your benefits**—clear up any confusion about your health plan
- **Save money on health care**—compare prices and choose more cost-effective options
- **Find great doctors**—locate highly rated doctors, dental providers, and eye care professionals
- **Pay less for prescriptions**—get recommendations for lowering the cost of your medications
- **Schedule appointments**—have your appointments scheduled at times most convenient for you
- **Resolve billing errors**—avoid paying more than you owe

Health Pros can continue to simplify your health care experience through Annual Enrollment. **Beginning August 1, associates will no longer have access to Health Pros.** However, any active inquiries as of July 31 will be completed.

Questions?

Email a Health Pro at **nmgHealthPro@alight.com** or call **1.866.279.2719** from 9:00 a.m. to 9:00 p.m. ET, Monday through Friday if you need help.

Get Answers

Have a question? Start with the **Frequently Asked Questions** (PDF).

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

Want to talk with someone? 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 benefits during the shortened plan year of August 1 through December 31, 2025, you can start here:

- Quick Guide
- Enrollment Checklist
- Medical
- Dental
- Vision

Need To Enroll For Two Benefits Plan Years?

For your benefits effective now through July 31, 2025, you can start here:

- Benefits Guide (PDF)
- What's Changing (PDF) (see what’s different from the current plan year ending July 31 and the shortened plan year of August 1 through December 31, 2025)

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

Optum Rx Program Information

- **CVS90 Program**
- **Diabetes Care - Blood Glucose Meter**
- **Generic Medications**
- **Optum Rx Mobile App**
- **Prior Authorizations**
- **Specialty Medications**

Other

- **NMG Legal Notices**
- **Quest Diagnostics Physician Affidavit Form**
- **Feel Your Best**

COBRA Coverage Options

If you leave the company or lose coverage due to a status change, 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 and enroll at **NMGbenefits.com**.