WageWorks

IMPORTANT OPEN ENROLLMENT INFORMATION FOR:

- ***Individuals ENROLLED in the University of Nebraska COBRA benefits plan***
- ***Individuals ELIGIBLE FOR the University of Nebraska COBRA benefits plan***

Don't Miss the 11/13/2026 Deadline!

You MUST respond if making changes to your coverage(s) or if you are a pending COBRA participant and have not enrolled and would like to.

University of Nebraska
WageWorks, Inc.
P.O. Box 14709
Lexington, KY 40512

October 16, 2026

University of Nebraska is conducting Open Enrollment for their Benefit Plans that are effective 01/01/2027. You can change your Blue Cross and Blue Shield of Nebraska medical option, add or drop dependents, or cancel medical insurance coverage during this time. You may also enroll or cancel dental and vision coverage. Alternatively, you may wish to explore coverage through the Health Insurance Marketplace.

If you do not want to make changes to your coverage, no action is required.

Health Insurance Marketplace
There may be other coverage options for you and your family. The Health Insurance Marketplace provides you with another opportunity to buy health insurance. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You may obtain information about the Marketplace at www.healthcare.gov.

Enclosed are materials designed to assist you and/or your eligible dependents in making a COBRA Open Enrollment selection that will be effective from **01/01/2027** through **12/31/2027**, or until your COBRA expires, whichever occurs first. To view your current benefit elections or other pertinent information regarding your COBRA account, you can access our secure website by going to mybenefits.wageworks.com.

ACTION REQUIRED BY YOU

Refer to the COBRA Open Enrollment Election Form for the new plan year benefit options and monthly premium rates*.*

- **If you are NOT making changes to your coverage, no action is required.**

  Note: If you are not making changes, your existing coverage will continue or automatically be renewed.

- **If you are** making changes to your coverage, you can add qualified dependents to your plan(s), add or change plans or discontinue coverage and you **MUST complete and return** the enclosed Open Enrollment Form postmarked on or before ***11/13/2026***.

  *Note: Your requested benefit changes cannot be processed without this form. If your requested changes are not returned by the postmarked date **11/13/2026**, your existing coverage will continue or automatically be renewed*.

  If you are making any changes, the election form should be faxed or mailed to:

  WageWorks, Inc.
  PO Box 14709
  Lexington, KY 40512

  FAX: (866) 450-5641

IMPORTANT INFORMATION REGARDING PAYMENT COUPONS
Payment coupons for the new plan year will be mailed prior to 01/01/2027 or after the completion of your Open Enrollment period, whichever is later. If you or any of your qualified beneficiaries are current COBRA participants, you must continue to remit all required premium payments by their due date in order to maintain coverage, including the first month of the new plan year, even if Open Enrollment period continues beyond the new plan year or new coupons have not been mailed yet.

ARE YOU A PENDING COBRA PARTICIPANT?
If you have received this letter and are not currently enrolled in COBRA, our records indicate that you are still within your 60-day election period. Refer to your original COBRA notification letter packet for enrollment information and deadlines. **You must respond within the 60-day election period to enroll for the current plan year.** If you wish to also make an election for the new plan year, be sure to ALSO respond back to WageWorks, Inc. with your COBRA Open Enrollment Election Form by **11/13/2026** by submitting the enclosed COBRA Election Form.

QUESTIONS?
If you have any questions, please call WageWorks, Inc. at (888) 678-4881. We will be glad to assist you.

REMEMBER – If making changes, you MUST return the enclosed form by 11/13/2026

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WageWorks

University of Nebraska
COBRA Open Enrollment Election Form
Benefits Effective 01/01/2027

THIS FORM <u>MUST BE RETURNED NO LATER THAN 11/13/2026</u> IF YOU WISH TO ADD, CHANGE OR DISCONTINUE YOUR COBRA COVERAGE FOR THE NEW PLAN YEAR.
<u>ALL CHANGES WILL BE EFFECTIVE 01/01/2027</u>.

List all eligible persons electing coverage below. Failure to complete in full and sign this form may result in a delay of benefit enrollment updates.

Name	DOB	Gender	Soc. Sec. #	Med	Den	Vis
_____ SELF	_____	_____	_____	____	____	____
_____ SPOUSE	_____	_____	_____	____	____	____
_____ CHILD #1	_____	_____	_____	____	____	____
_____ CHILD #2	_____	_____	_____	____	____	____
_____ CHILD #3	_____	_____	_____	____	____	____

Please **<u>CHECK</u>** the Accept or Decline box for each benefit plan and then **<u>CIRCLE</u>** the coverage level for each plan that you are electing below:

[ ]Accept [ ]Decline – Blue Cross Low w/Rx

Individual Only	Indiv+Spouse	Indiv+Child(ren)	Family
$ 847.62	$1,854.36	$ 1,393.32	$ 2,543.88

[ ]Accept [ ]Decline – Blue Cross Basic w/Rx

Individual Only	Indiv+Spouse	Indiv+Child(ren)	Family
$ 961.86	$ 2,086.92	$ 1,596.30	$ 2,871.30

[ ]Accept [ ]Decline – Blue Cross High w/Rx

Individual Only	Indiv+Spouse	Indiv+Child(ren)	Family
$ 1,101.60	$ 2,388.84	$ 1,926.78	$ 3,286.44

[ ]Accept [ ]Decline – Blue Cross High Deductible w/Rx

Individual Only	Indiv+Spouse	Indiv+Child(ren)	Family
$ 847.62	$ 1,854.36	$ 1,408.62	$ 2,543.88

[ ]Accept [ ]Decline - Blue Cross Bronze Health Plan

Individual Only	Indiv+Child(ren)
$ 561.45	$ 982.54

[ ]Accept [ ]Decline – Blue Cross Dental

Individual Only	Indiv+Spouse	Indiv+Child(ren)	Family
$ 38.76	$ 71.40	$ 79.56	$ 121.38

[ ]Accept [ ]Decline - EyeMed Vision

Individual Only	Indiv+Spouse	Indiv+Child(ren)	Family
$ 8.63	$ 18.95	$ 18.95	$ 23.77

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Statement of Understanding and Election: I hereby apply for benefits under the terms and conditions of the benefits program, and I agree to pay the premium as required. I understand that continuation coverage may terminate under several circumstances, including: the date I become entitled to Medicare, or on the date on which the group health/dental plan coverage offered by my former employer ends. I understand that if I was disabled at the time of my qualifying event, I may be eligible for extended continuation. I also understand that payments are due on the 1st of each month and that failure to remit payments within the grace period specified under federal COBRA legislation will result in termination of coverage. I understand and agree that any omission or incorrect statements knowingly made by me on this application may invalidate my coverage and the benefits under this plan.

_____ _____
Signature of Participant Date

_____
Email Address

(Election Forms received without a signature will be rejected and potentially cause delay in your COBRA coverage.)

Return all pages of this Open Enrollment Election Form to:

WageWorks, Inc.
PO Box 14709
Lexington, KY 40512

FAX: (866) 450-5641