### Werner Enterprises, Inc. PPO Medical Plan - 2017

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$764</td>
<td>$1,528</td>
</tr>
<tr>
<td>Family maximum</td>
<td>$1,528</td>
<td>$3,056</td>
</tr>
<tr>
<td><strong>Calendar Year Coinsurance Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,183</td>
<td>$6,366</td>
</tr>
<tr>
<td>Family maximum</td>
<td>$6,366</td>
<td>$12,732</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-Pocket Maximum (includes deductible)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,947</td>
<td>$7,894</td>
</tr>
<tr>
<td>Family maximum</td>
<td>$7,894</td>
<td>$15,788</td>
</tr>
<tr>
<td><strong>Lifetime Benefit Maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance you pay for most covered services after satisfaction of the calendar year deductible</strong></td>
<td>20% of allowable charges</td>
<td>40% of allowable charges</td>
</tr>
<tr>
<td><strong>Physician Office Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$31 Primary Care copay per visit</td>
<td>Subject to deductible and 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>$50 Specialist copay per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive/Routine Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Subject to deductible and 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Covered wellness and preventive exams and tests</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only emergency room visits that are due to non-accidents and non-medical emergencies are subject to this copay amount.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$150 copay then deductible and 20% coinsurance</td>
<td>$150 copay then deductible and 20% coinsurance</td>
</tr>
<tr>
<td><strong>Urgent Care Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 copay</td>
<td>Subject to deductible and 40% coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Mental Illness and/or Substance Abuse Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subject to deductible and 20% coinsurance</td>
<td>Subject to deductible and 40% coinsurance</td>
</tr>
<tr>
<td><strong>Outpatient Mental Illness and/or Substance Abuse Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy visits</td>
<td>$31 copay per visit</td>
<td>Subject to deductible and 40% coinsurance</td>
</tr>
<tr>
<td><strong>Other Therapies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/occupational/speech therapy/chiropractic</td>
<td>Subject to deductible and 20% coinsurance</td>
<td>Subject to deductible and 40% coinsurance</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td></td>
<td></td>
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<tr>
<td>Pulmonary rehabilitation</td>
<td></td>
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</tbody>
</table>

*See the Summary Plan Description for benefits and limitations.*

### Prescription Drugs – Prime Therapeutics

- **Retail Prescription Drugs (31-day supply)**
  - Generic - $15 copay
  - Brand Name Formulary - $40 copay
  - Brand Name Non-Formulary - $60 copay
  - Specialty - $100 copay

- **Mail Order Prescription Drugs (90-day supply)**
  - Generic - $45 copay
  - Brand Name Formulary - $120 copay
  - Brand Name Non-Formulary - $180 copay
  - Specialty - $100 copay (31-day maximum)

### Notes:
- Copays do not apply toward satisfaction of the calendar year deductible or the calendar year coinsurance maximum.
- Coinsurance is the percentage of each allowable charge you are responsible for.
- Inpatient hospital admissions require pre-certification.
- This summary is a brief overview of the deductible, coinsurance and copay amounts under your health plan. It is not a contract. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and contract limitations. Please refer to your Summary Plan Description for detailed benefit information.
Dental coverage is divided into four coverage categories, labeled A through D. Coverage B and C require satisfaction of a combined service before the coinsurance is payable. The deductible is $50 per individual and $150 per family for the calendar year. The calendar year deductible applies to coverage B and C services. Dental benefits are subject to a combined calendar year benefit maximum of $1,500 per covered person. Coverage D is limited to covered persons to age 19 and a lifetime maximum benefit of $1,500. If you do not enroll for dental coverage during the first thirty days of employment you will be considered a late enrollee. Late enrollees are only eligible for Coverage A services for the first year. Below is a brief overview of the dental services covered under each coverage category.

### COVERAGE A
**Preventive and Diagnostic Dentistry**
- Two oral exams and two prophylaxis (cleaning, scaling and polishing) each calendar year
- Dental x-rays
- Sealants (once every 4 calendar years for persons under the age of 16) and Fluoride Varnishes (two per calendar year)
- Space maintainers for prematurely lost teeth for persons under age 16
- Pulp vitality tests
- Medically necessary dental consultations

**YOU PAY**
20% of allowable charges

### COVERAGE B
**Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontics and Endodontic Services**
- Silver amalgam restorations
- Temporary crowns within 72 hours of an accident
- Stainless steel or acrylic crowns; re-cementing of inlays and crowns
- Repair of dentures, bridges, crowns and cast restorations
- Simple and impacted extractions; removal of cysts and tumors
- Incisions and draining of abscesses
- Tooth replantation
- Treatment of a dislocation or fracture of the jaw required due to accidental injury not involving eating, chewing or biting
- Four periodontic cleanings each calendar year
- Gingivectomy and gingival curettage
- Osseous surgery and grafts; scaling and root planing
- Periodontal intraoral appliances
- Mucogingival plastic surgery
- Treatment of acute infection and oral lesions
- Pulp capping and vital pulpotomy
- Root canal therapy, including diagnostic x-rays, clinical procedures and follow-up care
- Medically necessary general anesthesia for covered procedures

**YOU PAY**
20% of allowable charges

### COVERAGE C
**Complex Restorative Dentistry**
- Crowns
- Installation of permanent bridges
- Installation of full and partial dentures: adjustments after six months
- One denture relining every 36 months
- Inlays when used as abutments for fixed bridgework

**YOU PAY**
40% of allowable charges

### COVERAGE D
**Orthodontic Dentistry**
- Cephalometric X-rays
- Surgical exposure to aid eruption
- Extractions
- Casts and models
- The initial and subsequent installations of orthodontic appliances, and orthodontic treatments

**YOU PAY**
50% of allowable charges

This summary contains only a partial description of the benefits, limitations and other provisions of the dental plan. Please refer to your Summary Plan Description for detailed benefit information.
LEGAL NOTICES

DISCLOSURE of GRANDFATHER STATUS

Werner Enterprises, Inc. believes that the medical coverage offered under the Werner Enterprises, Inc. Employee Benefits Plan (the “Plan”) is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Werner Enterprises Benefits Department at 1.877.856.7711. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

SPECIAL ENROLLMENT NOTICE

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that we notify you about your right to later enroll yourself and your eligible dependents for health coverage in the Werner Enterprises, Inc. Employee Benefits Plan (the “Plan”) under special enrollment provisions briefly described below.

- **Loss of Other Coverage.** If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

- **New Dependent by Marriage, Birth, Adoption or Placement for Adoption.** If you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new eligible dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.

- **Enrollment Due to Medicaid/CHIP Events.** If you or your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or a state Child Health Insurance Program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment in the plan no later than 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included with your enrollment materials.

To request special enrollment or obtain more information, contact the Werner Enterprises Benefits Department at 1.877.856.7711. Additional information regarding your rights to enroll in the Plan can be found in the applicable Summary Plan Description.

WOMEN’S HEALTH and CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under the Werner Enterprises, Inc. Employee Benefits Plan. Therefore, the deductibles and coinsurance shown in the applicable Summary Plan Description apply.

If you would like more information on WHCRA benefits, contact the Werner Enterprises Benefits Department at 1.877.856.7711.
LEGAL NOTICES

NEWBORNS’ and MOTHERS’ HEALTH PROTECTION ACT of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the group health plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).
This Notice describes the practices that the Werner Enterprises, Inc. Employee Benefits Plan (the “Plan,” “us” or “we”) will follow with regard to your “protected health information” (“PHI”).

PHI is a special term, defined by the Health Insurance Portability and Accountability Act (“HIPAA”) and its regulations (the “HIPAA Privacy Regulation”). PHI means individually identifiable health information (including demographic information) that is created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and relates to: (i) your past, present, or future physical or mental health or condition; (ii) the delivery of health care to you; or (iii) the past, present, or future payment for the delivery of health care to you. For purposes of the Plans and this Notice, PHI includes information related to the medical claims that are submitted to the Plan about you, and information about the payment of those claims. It does not include most of the information that is kept in your personnel file. For example, it does not include the doctor’s notes that you give to the Human Resources Department in order to obtain leave under the Family Medical Leave Act or to obtain a disability accommodation.

This Notice describes how we may use and/or disclose your PHI pursuant to HIPAA. This Notice also describes various rights you may have regarding your PHI. Many of these uses and disclosures will be made directly by our health plan administrators/service providers, and many of your rights will be handled directly by these administrators/service providers. The Plan’s service providers are listed at the end of this Notice. In this Notice, “you” refers to you, the participant, and your covered dependents.

We (and our administrators/service providers) are required by federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice about our privacy practices, our legal duties, and your rights concerning your PHI. We are also required to notify affected individuals following a breach of unsecured PHI. We must follow the privacy practices described in this Notice. These privacy practices will remain in effect until we replace or modify them.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided it is permitted by law. We reserve the right to make changes to our privacy practices for all PHI we maintain, including PHI that we received or created before such changes. When we make a material change in our privacy practices, we will revise this Notice and post it at www.wernerbenefits.com by the effective date of the material change and we will provide the revised Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing to participants.

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. Such information is not individually identifiable health information and therefore, is not PHI.

You may have additional privacy rights under state law. State laws that provide greater privacy protection or broader privacy rights will continue to apply.

You may request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us at the address or phone number listed at the end of this Notice.

1. Permitted and Required Uses and Disclosures of Protected Health Information

Uses and/or Disclosures for Treatment, Payment and Health Care Operations
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain types of activities, including payment and health care operations. Many of these activities are handled directly by other entities, such as the service provider(s) of our group health plan(s). The following is a description of how we (and our administrator/service provider) may use and/or disclose PHI about you for payment and health care operations:
Treatment: We do not provide treatment. However, we may disclose your PHI to healthcare providers who request it in connection with your treatment.

Payment: We may use and disclose your PHI for all activities that are included within the definition of “payment” as set out in the HIPAA Privacy Regulation. For example, we may use and disclose your PHI to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the health plan in which you participate. We have not listed in this Notice all of the activities included within the definition of “payment,” so please refer to the HIPAA Privacy Regulation for a complete list.

Health Care Operations: We may use and disclose your PHI for all activities that are included within the definition of “health care operations” as set out in the HIPAA Privacy Regulation. For example, we may use and disclose your PHI to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to conduct the Plan’s general administrative activities. We have not listed in this Notice all of the activities included within the definition of “health care operations,” so please refer to the HIPAA Privacy Regulation for a complete list.

If the Plan uses or discloses PHI for underwriting purposes, the Plan is prohibited from using or disclosing PHI that is genetic information for such purposes.

Uses and/or Disclosures of PHI To Other Entities
We may use and/or disclose your PHI to other entities in the following situations (as permitted by the HIPAA Privacy Regulation):

Business Associates: In connection with our payment and health care operations activities, we contract with administrators/service providers, as well as individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates are permitted to receive, create, maintain, use, or disclose PHI, but only as provided in the HIPAA Privacy Regulation and only after agreeing in writing to appropriately safeguard your information.

Providers and Other Covered Entities: In addition, we may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with their payment activities and certain other health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Uses and Disclosures for Which Your Permission May Be Sought
For purposes of this subsection only, the following conditions apply: If you are present and able to give your verbal permission, we will only use or disclose your PHI with your permission. This verbal permission will only cover a single encounter, and is not a substitute for a written authorization. If you are not present or are unable to give your permission, we will use or disclose your PHI only if we determine (based on our professional judgment) that the use or disclosure is in your best interest.

Others Involved in Your Health Care: If you provide us with an oral agreement, we may disclose your PHI to a family member, another relative, a close friend or any other individual, which you have identified as being involved in your health care. This oral agreement is valid for one encounter and is not intended as a substitute for written authorization. If you are not present or able to agree to these disclosures of your PHI due to a situation such as a medical emergency or disaster relief, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

For Limited Notification Purposes: We may use or disclose your PHI to help notify a relative or other individual who is responsible for your health care, of your location, general condition, or death.

To Assist in Disaster Relief: We may disclose your PHI to an authorized public or private entity in order to assist in disaster relief efforts, or to coordinate uses and disclosures to relatives or other individuals involved in your health care.
Other Permitted Uses and/or Disclosures of Protected Health Information

We may also use and/or disclose your PHI without your authorization in the following situations:

- **Required By Law:** We may use and/or disclose your PHI when required to do so by federal, state or local law.
- **Public Health Activities:** We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose your PHI to a public health entity that is authorized by law to collect information for the purpose of reporting diseases, illnesses, births, or deaths.
- **Health Oversight Activities:** We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.
- **For Data Breach Notification Purposes:** We may use your PHI to provide legally-required notices of unauthorized acquisition, access, or disclosure of your PHI.
- **Abuse, Neglect or Domestic Violence:** We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Such disclosure will be made to the governmental entity or agency authorized to receive such information.
- **Public Health and Safety:** We may, when necessary, disclose your PHI to avert a serious or imminent threat to your health or safety or the health or safety of others.
- **Law Enforcement:** Under limited circumstances (such as required reporting laws or in response to a grand jury subpoena), we may disclose your PHI to a law enforcement official.
- **Legal Proceedings:** We may disclose your PHI in the course of a judicial or administrative proceeding.
- **Coroners, Medical Examiners, Funeral Directors, and Organ Donation:** We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- **Research:** We may disclose your PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.
- **Serious Threat to Health or Safety:** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or to the health and safety of others. Any such disclosure will be made to someone who would be able to help prevent the threat.
- **Military and National Security:** We may disclose the PHI of armed forces personnel to military authorities under certain circumstances. We may disclose your PHI to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities or to the Department of State to make medical suitability determinations.
- **Inmates:** If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.
- **Workers’ Compensation:** We may disclose your PHI to the extent necessary to comply with workers’ compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- **Reminders:** We may use and disclose your PHI by sending you a reminder for important services, such as annual checkups.
- **Plan Sponsor:** We may disclose your PHI to designated personnel at Werner Enterprises, Inc. so that they may carry out their plan-related administrative functions. These individuals will protect the privacy of your PHI and will ensure that it is only used as described in this Notice and as permitted by law. Your PHI will not be used by Werner Enterprises, Inc. for any employment-related actions or decisions or in connection with any other benefit plan offered by Werner Enterprises, Inc.
- **Additional Services:** We may use or disclose your PHI to send you information about alternative medical treatment and programs, or about health-related products and services that may be of interest to you, provided the Plan does not receive financial remuneration for making such communications.
Required Disclosures of Protected Health Information

The following is a description of disclosures that we are required by law to make:

- Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.
- Disclosures to You: We are required to provide your PHI to you upon request, as described below in the "Individual Rights" section of this Notice. We are also required to provide you with the PHI of any individual on whose behalf you are acting as a personal representative.

Uses and Disclosures of PHI with an Authorization

Your authorization is required to disclose your PHI in any situation not listed above. In addition, we are required to obtain your authorization under the following circumstances:

- Psychotherapy Notes. Most uses and discloses of psychotherapy notes will require your authorization.
- Marketing. Uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services is being marketed will require your authorization.
- Sale of PHI. Disclosures that constitute a sale of PHI will require your authorization.

If you provide an authorization, you may revoke it in writing at any time, except to the extent that action has already been taken in reliance upon the authorization. You can obtain a copy of our authorization form by contacting us at the address or phone number listed at the end of this Notice.

II. Individual Rights

The following is a brief statement of your rights with respect to your PHI. You may pursue these rights by contacting us directly (at the address indicated at the end of this Notice) or by contacting the applicable administrator/service provider referenced at the end of this Notice. In many instances, our administrator/service provider will handle these requests directly. Using the forms designated by the administrator/service provider generally will simplify the administration of your requests. For these forms, you may contact the administrator/service provider directly using the address at the end of this Notice.

- Right to Request Restrictions: You have the right to request that we place additional restrictions on our use and/or disclosure of your PHI for treatment, payment or health care operations. You also have the right to request a limit on the PHI about you that we disclose to someone who is involved in your care or the payment of your care, such as a family member or friend. We are not required to agree to any additional restrictions; however, if we do, we will abide by those restrictions (except in emergency situations). All requests must be in writing. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply. Request forms are available from and must be submitted to the Benefits Manager or applicable administrator/service provider at the address or phone number listed at the end of this Notice.
- Right to Receive Confidential Communications: You have the right to request that we communicate with you confidentially about your PHI by alternative means and/or to an alternative location. We will not ask you the reason for your request. Your request must provide the alternative means and/or location for communicating your PHI with you. All requests must be in writing. Request forms are available from and must be submitted to the Benefits Manager or applicable administrator/service provider at the address or phone number listed at the end of this Notice.
- Right to Inspect and Copy: Subject to the following exceptions, you have the right to inspect and/or obtain copies of your PHI that we maintain. If the Plan maintains an electronic health record containing your health information, you have the right to request that we send a copy of your health information in an electronic format. All requests must be in writing. You are not entitled to inspect and/or copy:
  - any psychotherapy notes;
  - any information compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding;
  - any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a);
  - certain other records as specified in the HIPAA Privacy Regulation.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The
person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. In this event, we will inform you that the decision is not reviewable. We reserve the right to charge a reasonable copying fee for the cost of producing and mailing the documents. For more information on our fee structure (or any fees imposed by our administrator/service provider) and to obtain the designated form for your request, please contact us or the applicable administrator/service provider at the address or phone number listed at the end of this Notice.

- **Right to Request Amendment of PHI:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the PHI. You have the right to request an amendment for as long as the PHI is kept by or for the Plan. Your request must be in writing and must clearly state the information to be amended and the reasons for doing so. We may deny your request if:
  - we did not create the PHI;
  - we do not maintain the PHI;
  - the PHI is not available for inspection; or
  - we believe the PHI is accurate and complete.

All denials to amend will be made in writing. You may respond to our denial by filing a written statement of disagreement. We then have the right to rebut that statement. The denial, statement of disagreement, and rebuttal will be included in any future disclosures of the relevant PHI. If we approve your request to amend the information, we will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of the relevant PHI. A request form can be obtained by contacting us at the address or phone number listed at the end of this Notice.

- **Right to Receive an Accounting of Certain Disclosures:** You have the right to receive a summary of all instances in which we disclosed your PHI. If the PHI disclosed is an “electronic health record,” the accounting will include disclosures up to three years before the date of your request. If the PHI disclosed is not an “electronic health record,” the accounting will include disclosures up to six years before the date of your request. In this case, the accounting is not required to include all disclosures. For example, the accounting will not include disclosures relating to treatment, payment, health care operations and certain other activities. The accounting also will not include any disclosures we made before April 14, 2004. All requests must be in writing. Your request must include the time frame that you would like us to cover (this may be no more than 6 years before the date of the request). Request forms are available from and must be submitted to the Benefits Manager or applicable administrator/service provider at the address or phone number listed at the end of this Notice. If you make a request more than once in a 12-month period, we may charge a reasonable, cost-based fee for additional copies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Receive a Paper Copy:** You are entitled to receive this Notice in paper form at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To request a paper copy, please contact the Benefits Manager at the address or phone number listed at the end of this Notice.

### III. Complaints

If you believe your privacy rights have been violated, you may file a written complaint by contacting the Company Privacy Officer at the address listed below. You may also file a written complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint. You can receive a copy of our complaint form by notifying our Privacy Officer at the address or phone number listed at the end of this Notice. We will respond to your complaint within 60 days of receipt of the form.

### IV. Contact Information

For Questions:
Attention: Benefits Manager
P.O. Box 45308
Omaha, NE 68145-0308
Telephone Number: (402) 895-6640

For Complaints:
Attention: Company Privacy Officer (Legal)
P.O. Box 45308
Omaha, NE 68145-0308
Telephone Number: (402) 895-6640
Or you may contact the following administrators/service providers directly with respect to information maintained by them.

Medical, Dental and Prescription Drug Plans: Blue Cross and Blue Shield of Nebraska
Attention: Privacy Officer
P.O. Box 247040
Omaha, NE 68124-7040
Telephone Number: (402) 343-3521
Toll Free Number: (877) 258-3999

PayFlex Systems USA, Inc.
Jeff Protextor, Privacy Officer
10802 Farnam Drive, Suite 100
Omaha, NE 68154
Telephone Number: 402-231-8705

Employee Assistance Program
Bob Thome, Privacy Officer
Best Care EAP
9239 W. Center Road
Omaha, NE 68124

Superior Vision Services
Kimberley Hess
Vice President, Operations
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

Effective Date: September 23, 2013
Revised October 6, 2016
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Werner Enterprises Benefits Department at 1.877.856.7711.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Werner Enterprises, Inc.</td>
<td>47-0648386</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>14507 Frontier Road</td>
<td>800-228-2240</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omaha</td>
<td>NE</td>
<td>68138</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Troia, Human Resources Manager - Employee Benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Phone number (if different from above)</th>
<th>12. Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>877-856-7711</td>
<td><a href="mailto:benefits@werner.com">benefits@werner.com</a></td>
</tr>
</tbody>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  Employees of Werner Enterprises, Inc. and its subsidiaries who are not working in a temporary status and who are regularly scheduled to work a minimum of 30 hours per week.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Employees' legal spouse and children to age 26. Children include biological or adopted children, step children (son or daughter of current spouse), and grandchild(ren) for whom the employee is the court ordered guardian. The term "children" does not include foster children.

  - ☐ We do not offer coverage.

  ☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

  ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
   - [ ] Yes (Continue)
     - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ____________ (mm/dd/yyyy) (Continue)
   - [ ] No (STOP and return this form to employee)

14. **Does the employer offer a health plan that meets the minimum value standard?**
   - [ ] Yes (Go to question 15)
   - [ ] No (STOP and return form to employee)

15. **For the lowest-cost plan that meets the minimum value standard offered only to the employee (don’t include family plans):**
   - If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn’t receive any other discounts based on wellness programs.
   - a. How much would the employee have to pay in premiums for this plan? $ ____________

16. **What change will the employer make for the new plan year?**
   - [ ] Employer won’t offer health coverage
   - [ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
   - a. How much would the employee have to pay in premiums for this plan? $ ____________

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* An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Phone: 1-855-692-5447</td>
<td></td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td></td>
</tr>
<tr>
<td>ARKANSAS – Medicaid</td>
<td>Website: <a href="http://myarhhipp.com/">http://myarhhipp.com/</a></td>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
</tr>
<tr>
<td>COLORADO – Medicaid</td>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td>Medicaid Customer Contact Center: 1-800-221-3943</td>
<td></td>
</tr>
<tr>
<td>FLORIDA – Medicaid</td>
<td>Website: <a href="http://flmedicaidtprecovery.com/hipp/">http://flmedicaidtprecovery.com/hipp/</a></td>
<td>Phone: 1-877-357-3268</td>
<td></td>
</tr>
<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
<td>- Click on Health Insurance Premium Payment (HIPP)</td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>INDIANA – Medicaid</td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
<td>Website: <a href="http://www.IndianaMedicaid.com">http://www.IndianaMedicaid.com</a></td>
<td>Phone: 1-800-403-0864</td>
</tr>
<tr>
<td>IOWA – Medicaid</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a></td>
<td>Phone: 1-888-346-9562</td>
<td></td>
</tr>
<tr>
<td>KANSAS – Medicaid</td>
<td>Medicaid Website: <a href="http://www.kdheks.gov/hcp">http://www.kdheks.gov/hcp</a></td>
<td>Medicaid Phone: 603-271-5218</td>
<td></td>
</tr>
<tr>
<td>KENTUCKY – Medicaid</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>Phone: 1-800-635-2570</td>
<td></td>
</tr>
<tr>
<td>LOUISIANA – Medicaid</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmaha/clients/medicaid/">http://www.state.nj.us/humanservices/dmaha/clients/medicaid/</a></td>
<td>Medicaid Phone: 609-631-2392</td>
<td>CHIP Website: <a href="http://www.nifamilycare.com/index.html">http://www.nifamilycare.com/index.html</a> CHIP Phone: 1-800-701-0710</td>
</tr>
<tr>
<td>MAINE – Medicaid</td>
<td>Website: <a href="http://www.maine.gov/dhhs/oif/public-assistance/index.html">http://www.maine.gov/dhhs/oif/public-assistance/index.html</a></td>
<td>TTY: Maine relay 711</td>
<td></td>
</tr>
<tr>
<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>Phone: 1-800-462-1120</td>
<td></td>
</tr>
<tr>
<td>MINNESOTA – Medicaid</td>
<td>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a></td>
<td>Phone: 1-800-657-3739</td>
<td></td>
</tr>
<tr>
<td>NORTH CAROLINA – Medicaid</td>
<td>Website: <a href="http://www.myhealth.gov/health_care/medicaid/">http://www.myhealth.gov/health_care/medicaid/</a></td>
<td>Phone: 1-800-541-2831</td>
<td></td>
</tr>
<tr>
<td>NORTH DAKOTA – Medicaid</td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>Phone: 1-844-854-4825</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Medicaid and CHIP include low-income families and individuals below the federal poverty level, children, pregnant women, families with disabilities, and those with special health care needs.
- The Healthy Indiana Plan is for low-income adults 19-64.
- All other Medicaid programs are available for those with limited income and resources.
- The Medicaid Customer Contact Center is available to assist with Medicaid applications and eligibility determinations.
- Medicaid and CHIP websites provide information on eligibility, enrollment, and coverage options.

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If you have questions or need assistance, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov for more information.
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td><a href="http://www.dss.mo.gov/mlhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mlhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
</tr>
<tr>
<td>MONTANA</td>
<td>Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>1-800-694-3084</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>Medicaid</td>
<td><a href="http://dhhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dhhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a></td>
<td>1-855-632-7633</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td><a href="http://www.eohhs.ri.gov">http://www.eohhs.ri.gov</a></td>
<td>401-462-5300</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>Medicaid</td>
<td><a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
<td>1-800-562-3022 ext. 15473</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>Medicaid</td>
<td><a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>1-888-828-0059</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a></td>
<td>1-877-598-5820, HMS Third Party Liability</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebwa](http://www.dol.gov/ebwa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)
Important Notice from the Werner Enterprises, Inc. Employee Benefits Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Werner Enterprises, Inc. Employee Benefits Plan (the “Plan”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Werner Enterprises, Inc. has determined that the prescription drug coverage offered by the Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) because you lost creditable coverage to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected. In this case, the Plan will continue to pay primary (or secondary) as it had before you joined a Medicare drug plan. If you decide to enroll in a Medicare drug plan and waive or drop your current Plan coverage, Medicare will be your only payer. In addition, if you waive or drop your current Plan coverage, you and your dependents will be able to re-enroll in the Plan at Open Enrollment or if you have a special enrollment event as defined by the Plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage under the Plan and you don't join a Medicare drug plan within 63 continuous days after your current Plan coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be a least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join a Medicare drug plan.

For More Information About this Notice or Your Current Prescription Drug Coverage:

Contact the Benefits Department for further information at 1-877-856-7711. NOTE: You will receive this notice each year. In addition, you will receive this notice at other times in the future such as before the next period you can join a Medicare drug plan, and if the Plan’s coverage changes. You may also request a copy of this notice at any time.

For More Information About Your Options under a Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information about Medicare Prescription Drug Coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you enroll to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2016
Name of Entity/Sender: Werner Enterprises, Inc.
Contact – Position/Office: Benefits Department
Address: P.O. Box 45308, Omaha, NE 68145
Phone Number: 1-877-856-7711
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.nebraskablue.com or by calling 1-888-592-8963.

Important Questions Answers Why this Matters:

What is the overall deductible? $764 single / $1,528 family Doesn’t apply to preventive care You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.

Are there other deductibles for specific services? No. You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

Is there an out-of-pocket limit on my expenses? Yes, Participating providers: $3,185 single / $6,366 family Non-participating providers: $6,366 single / $12,733 family The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit? Premiums, balance-billed charges, and health care this plan does not cover. Even though you pay these expenses, they don’t count towards the out-of-pocket limit.

Is there an overall annual limit on what the plan pays? No. The chart starting on page 2 describes any limits on what the plan will pay for people covered services, such as office visits.

Does this plan use a network of providers? Yes. See www.nebraskablue.com or call 1-888-592-8963 for a list of participating providers.

Do I need a referral to see a specialist? No. You don’t need a referral to see a specialist. You can see the specialist you choose without permission from the plan.

Are there services this plan doesn’t cover? Yes. Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Co-payments are fixed dollar amounts (for example, $1) you pay for covered health care, usually when you receive the service. Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount of $1,000, your co-insurance payment of 20% would be $200. This may change if you haven’t met your deductible.

1. The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

2. This plan may encourage you to use in-network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event Services You May Need Your cost if you use an In-network Provider Out-of-network Provider Limitations & Exceptions

If you visit a health care provider’s office or clinic
Primary care visit to treat an injury or illness $31 copay / visit $40 copay / visit 40% coinsurance None
Specialist visit $50 copay / visit $60 copay / visit 40% coinsurance None
Other practitioner office visit 20% coinsurance 40% coinsurance Chiropractic manipulation treatment
Preventive care/screening/vaccination 40% coinsurance None

If you have a test
Diagnostic test (x-ray, blood work) 20% coinsurance 40% coinsurance None
Imaging (CT/PET scans, MRIs) 20% coinsurance 40% coinsurance None

If you need drugs to treat your illness or condition
Generic drugs $15 copay (tablet) $25 copay (oral liquid) Copay + 25% penalty Mail order out-of-network is not covered
Preferred brand drugs $40 copay (tablet) $60 copay (oral liquid) Copay + 25% penalty Mail order out-of-network is not covered
Non-preferred brand drugs $60 copay (tablet) $100 copay (oral liquid) Copay + 25% penalty Mail order out-of-network is not covered
Specialty drugs $100 copay Not Covered Cover up to a 30 day supply (retail or mail order)

If you need outpatient surgery
Facility fee (e.g., ambulatory surgery center) 20% coinsurance 40% coinsurance None
Physician/surgeon fees 20% coinsurance 40% coinsurance None

If you need urgent medical care
Emergency room services 20% coinsurance 40% coinsurance None
Emergency medical transportation 20% coinsurance 40% coinsurance None

Questions: Call 1-888-592-8963 or visit us at www.nebraskablue.com.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.ecco.cms.gov/CCIO/Programs-and-Initiatives/Consumer-Support-and-Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html or call 1-888-592-8963 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network Provider</td>
<td>Out-of-network Provider</td>
</tr>
<tr>
<td>attention</td>
<td>Urgent care</td>
<td>$30 copay / visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$31 copay / office visit and 20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This is not a complete list. Check your policy or plan document for other excluded services.):

- Aromatherapy
- Infertility treatment
- Routine eye care
- Cosmetic surgery
- Long-term care
- Routine foot care
- Private-duty nursing
- Weight loss programs or weight reduction surgeries
- Routine dental care
- Therapy
- Experimental or investigatory services
- Screening radiological tests

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.):

- Cardiac rehabilitation
- Chiropractic care
- Diabetic education
- Physical, occupational, speech therapy
- Pulmonary rehabilitation
- Most coverage provided outside the United States. See www.nebraskahealth.com

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-592-8963. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-888-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Blue Cross and Blue Shield of Nebraska at 1-888-592-8963.
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan provides minimum essential coverage.

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage meets the minimum value standard for the benefits it provides.

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

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**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,240
- **Patient pays:** $2,300

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

**Patient pays:**

| Deductibles                    | $764    |
| Co-pays                        | $31     |
| Co-insurance                   | $1,355  |
| Limits or exclusions           | $150    |
| **Total**                      | $2,300  |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,686
- **Patient pays:** $1,714

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

**Patient pays:**

| Deductibles                    | $764    |
| Co-pays                        | $600    |
| Co-insurance                   | $300    |
| Limits or exclusions           | $40     |
| **Total**                      | $1,714  |
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?
- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.