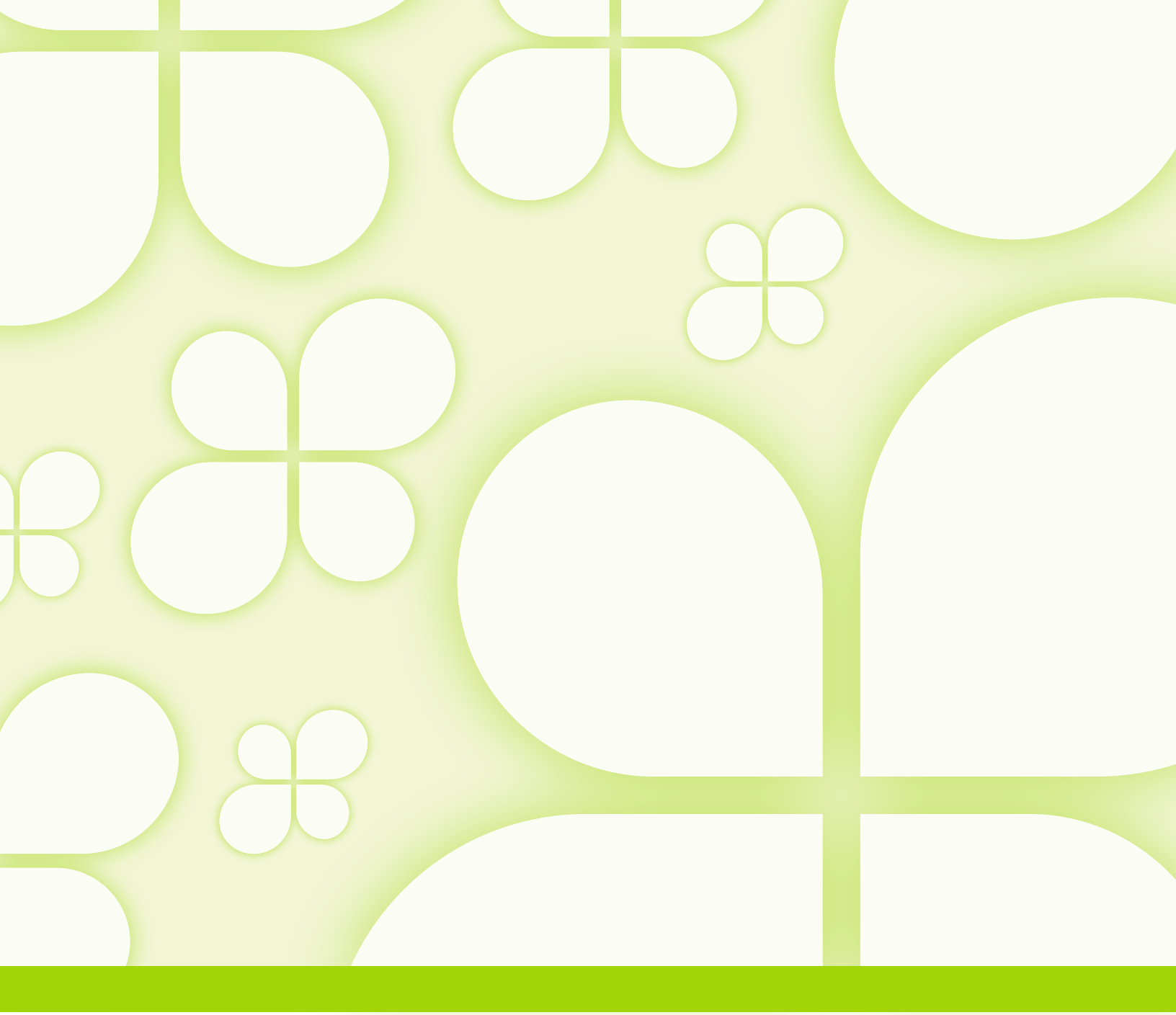

Options

benefits as individual as you

GUIDE TO 2016-2017
EMPLOYEE WELLNESS & BENEFITS PROGRAMS

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Employee Wellness & Benefits
402-471-4443 - Lincoln | 877-721-2228 - outside Lincoln
as.employeebenefits@nebraska.gov
http://das.nebraska.gov/benefits.html

Wellness & Benefits Programs

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UnitedHealthcare
877-263-0911 | www.myUHC.com

Optum Bank
866-234-8913 | www.optumbank.com

OptumRx
877-263-0911 | www.myUHC.com

HealthFitness
866-956-4285 | www.wellnessoptions.nebraska.gov

EyeMed Vision Care
877-861-3459 | www.eyemedvisioncare.com

Ameritas
800-487-5553 | www.ameritas.com

ASIFlex
800-659-3035 | www.asiflex.com

Mutual of Omaha
800-877-5176 | www.mutualofomaha.com

Aetna
800-523-5065 | www.aetnalifeessentials.com

Aetna
800-523-5065 | www.aetnalifeessentials.com

Deer Oaks EAP
866-792-3616 | www.deeroaks.com
Login/Password: SON

Employee Wellness & Benefits
402-471-4443 - Lincoln | link.nebraska.gov
877-721-2228 - outside Lincoln

NPERS
https://npers.ne.gov

Employee Wellness & Benefits
402-471-4443 - Lincoln | link.nebraska.gov
877-721-2228 - outside Lincoln

IMPORTANT INFORMATION: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official documents. If there are any inconsistencies between this summary and the official plan documents, the plan document will prevail. Please refer to the summary plan documents found on Employee Wellness & Benefits website **http://das.nebraska.gov/benefits.html** for exact benefits, exclusions and limitations.

Welcome

Dear State Employee,

We are pleased to provide you with this summary highlighting your employee benefits and wellness programs available to State of Nebraska employees for the plan year July 2016 thru June 2017. This guide contains details about each of the benefit plans offered to eligible employees and their families.

The State of Nebraska offers a comprehensive benefits package to support the health and well-being of your family, protect your income while you are working, provide financial security in the event of your disability or death, help you save for retirement, and help balance your personal responsibilities and work life balance.

We are elated by the large number of employees participating in wellness activities offered through the State's wellness program, **wellNEssoptions**. We continue to see the positive outcomes of those participating in wellness programs improve over the years. As we see employees manage their health risks, the impact is reflected in current and future costs of health care. The details of the wellness program are outlined in this options guide.

Choice is important. Please take time to read and understand the benefit programs available to make the right choices for you and your family. If you have questions, you may talk to your Human Resource representative or visit with an Employee Wellness and Benefits Specialist in State Personnel at 402-471-4443 or 877-721-2228.

Thank you for choosing the State of Nebraska as your employer. We value your commitment to delivering services that matter the most to the people of Nebraska.

Sincerely,

Crystal Meyer, PHR, SHRM-CP
Wellness & Benefits Administrator
State Personnel

Contact Information:

Employee Wellness & Benefits
1526 K Street, Suite 110
Lincoln, NE 68508

402-471-4443
877-721-2228

as.employeebenefits@nebraska.gov

OFFICE HOURS:
Monday - Friday
8:00 a.m. to 5:00 p.m.

New Hire Information

Welcome to employment with the State of Nebraska! We are pleased to provide you with this comprehensive guide to your 2016-17 State Employee Wellness & Benefits Program, referred to as our Options Guide. You have many choices to make in your first 30 days of eligibility and we want to help simplify the process.

New Hire Check List

Must complete within 30 days of date of hire or employment status change date

✓ **Review your options.**	Discuss with family members.
✓ **Prepare list of your dependents with SSN & Date of Birth**	You will need this information to enroll dependents in coverage, list as beneficiary and your emergency contact.
✓ **Medical Insurance**	Elect or waive coverage. Choose plan, tier, and covered dependents (if any).
✓ **Dental Insurance**	Elect or waive coverage. Choose plan, tier, and covered dependents (if any).
✓ **Vision Insurance**	Elect or waive coverage. Choose plan, tier, and covered dependents (if any).
✓ **Health Savings Account (HSA)**	Only available if enrolled in a Consumer Focused Health Plan. Select or waive your contributions. You can change anytime throughout the year.
✓ **FSA Healthcare**	If not contributing to HSA, enroll or waive your annual contributions. Plan wisely – unclaimed contributions are forfeited.
✓ **FSA Dependent Care**	If you pay for dependent care while you are working, select your annual contributions.
✓ **Basic Life Insurance**	Add your beneficiary. If part-time, you can waive coverage.
✓ **AD&D Life Insurance**	Elect or waive coverage. Add your beneficiary.
✓ **Supplemental Life Insurance**	Elect or waive coverage for yourself and eligible dependents and choose level of coverage. Add your beneficiary if choosing employee supplemental life.
✓ **Long Term Disability**	Elect or waive coverage. Choose level of coverage.
✓ **Wellness Programs**	Anyone on a State health plan can register at www.wellnessoptions.nebraska.gov. A welcome packet will be mailed to your home with your login information.

How to Enroll in Coverage

- Go to link.nebraska.gov
- Log in to your Employee Work Center account

Questions?

- Talk to your Agency Human Resources representative.
- Visit link.nebraska.gov and link to Wellness and Benefits Resources.
- Contact Employee Wellness & Benefits
  - Call 402-471-4443
  - Call 877-721-2228, if outside Lincoln
  - Email as.employeebenefits@nebraska.gov

Options
benefits as individual as you

About Your Benefits

The State of Nebraska is pleased to offer you a comprehensive benefits and wellness program. Administrative Services Employee Wellness & Benefits is responsible for the administration of the benefit and wellness programs described within this Options Guide.

Understanding your benefit options and making the right decisions are important steps for you and your family. Please review the content carefully and refer to our website found at link.nebraska.gov, Wellness & Benefits Resources, for additional information.

If you have any questions, your HR representative is trained to assist you. If you require additional assistance, please contact Employee Wellness & Benefits at 402-471-4443 or 877-721-2228 or email as.employeebenefits@nebraska.gov.

~ Your Wellness & Benefits Team

Employee Work Center

The benefits described in this Options Guide are administered through the Employee Work Center (EWC) found at www.link.nebraska.gov. Using the EWC, you will elect, view and make changes to your benefit plan choices. You can also update your dependent and beneficiary information, your emergency contacts, and your personal contact information. Each year you will complete Open Enrollment for benefits through EWC.

Contact Employee Wellness & Benefits

Employee Wellness & Benefits is available to assist you with your benefit questions.

Office hours:	Monday - Friday 8:00 a.m. to 5:00 p.m.
Phone:	402-471-4443 or 877-721-2228
Email:	as.employeebenefits@nebraska.gov
Location:	Administrative Services 1526 K Street, Suite 110 Lincoln, NE 68508
Website:	http://das.nebraska.gov/benefits.html

For the 2016-17 benefit year, our office will be closed on all State holidays including:

Independence Day	Monday, July 4, 2016
Labor Day	Monday, September 5, 2016
Columbus Day	Monday, October 10, 2016
Veteran's Day	Friday, November 11, 2016
Thanksgiving Day	Thursday, November 24, 2016
Day after Thanksgiving	Friday, November 25, 2016
Christmas Day	Monday, December 26, 2016
New Year's Day	Monday, January 2, 2017
Martin Luther King Jr. Day	Monday, January 16, 2017
President's Day	Monday, February 20, 2017
Arbor Day	Friday, April 28, 2017
Memorial Day	Monday, May 29, 2017

Benefit Plan Eligibility & Enrollment

Eligibility & Enrollment Coverage becomes effective the 1st of the month following 30 days of employment			
	Who is Eligible	**How/When to Enroll**	**Are Dependents Eligible**
Health Insurance *UnitedHealthcare*	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Health Savings Account *Optum Bank*	Employees enrolled in State's Consumer Focused Health Plan	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Wellness Program **wellNEssoptions** *HealthFitness*	Employees & Spouses enrolled in a State Health Insurance Plan included in this Options Guide	Follow directions in the wellness welcome packet you receive from Health Fitness about 10 days after health plan effective date	Spouses Only
Vision Insurance *EyeMed*	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Dental Insurance *Ameritas*	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Basic Life Insurance/ AD&D Insurance *Aetna*	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	No
Supplement Life Insurance *Aetna*	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Long Term Disability *Mutual of Omaha*	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	No
Employee Assistance Program *Deer Oaks EAP*	Full-time Part-time	Auto Enrollment For Participating Agencies only	Yes
FSA – Healthcare *ASI Flex*	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
FSA – Dependent Care *ASI Flex*	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes

Employment Status (ONLY for purposes of benefit eligibility)

To comply with the Affordable Care Act, part-time employees scheduled to work between 30-39 hours on average per week will pay the same for health insurance.

Full-time employees: Scheduled to work 40 hours per week

Part-time employees: Scheduled to work 20-39 hours per week

Temporary employees: Eligible for State's group health, dental, long-term disability, HSA and FSA dependent care plans if they work at least 20 hours per week and are placed in a position with a six-month assignment or longer.

Dependent Eligibility:

- **Legal Spouse**, as a result of a marriage that is valid and recognized by State of Nebraska law.
- **Children** up to age 26, including:
  - Natural child
  - Step child, if enrolled in Family coverage
  - Legally adopted child
  - Child placed with you for adoption
  - Child, or grandchild, for whom you have legal custody, legal guardianship or court ordered custody
- **Child over 26**, if disabled and dependent upon you for support
  - Child must be disabled prior to age 26
  - Child must be covered on the State health plan upon attaining age 26

Types of Coverage

- **Employee Only** - (Single Coverage)
- **Employee + Spouse** - (Two-Party Coverage)
- **Employee + Dependent Children** - (Four-Party Coverage)
- **Employee + Spouse + Dependent Children** - (Family Coverage)

Dependent (Spouse & Children) Eligibility Verification Process

The Dependent Eligibility Verification process is completed on all new dependents enrolled on the State's health insurance plan. Employees will receive a letter in the mail from Aon Hewitt, the State's third-party vendor, requesting documentation to show dependents enrolled on the State's health plan meet the Dependent Eligibility criteria. Examples of documentation include a certified birth certificate and certified marriage certificate.

All documents are sent to Aon Hewitt who will verify each dependent. You will have approximately 30 days to respond so please be prepared.

Failure to respond and provide the requested documentation by the stated deadline will result in loss of coverage in health, dental, and vision insurance for your dependent(s).

LB551 – Dependents up to Age 30

Effective January 1, 2011, an employee may elect to continue coverage to age 30 for a dependent child who would otherwise lose coverage when he/she attains an age which exceeds the plan's limiting age, provided that the following criteria are met:

- The child remains financially dependent upon the employee; and
- The child was covered as an Eligible Dependent at the time coverage would have terminated.

In order to elect continuation coverage for a child under age 30 the dependent must currently be covered under the plan and lose coverage due to the eligibility. Contact your HR representative to enroll.

The premium for continuation coverage will be equal to the plan's full, unsubsidized single adult premium. The employee will be responsible for paying the full premium each month through post tax payroll deduction.

The coverage will terminate if:

- The employee requests the termination because they no longer meet the criteria
- The employee's coverage with UnitedHealthcare terminates
- The covered dependent:
  - Marries
  - Is no longer a resident of Nebraska
  - Receives coverage under another health benefit plan or self-funded employee benefit plan
  - Attains age 30

Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage cannot be reinstated once it has been terminated.

Making Changes to Your Elections

Following your initial 30-day enrollment period for benefits, you can only change your benefit elections for health, dental, vision, and FSA plans during the State's annual Open Enrollment period or when you experience an IRS qualifying life event.

Open Enrollment

Open Enrollment for the State's benefit plans is in May of each year with coverage change effective July 1. You will make changes in the Employee Work Center (EWC).

Qualifying Life Events

You have 30 days from the date of the event, including the qualifying event, to submit your request to change your coverage through the EWC. Documentation of the status change must be provided before the change will be approved.

If adding coverage, the effective date of the change is the first day of the month following the qualifying event unless noted below. If you are removing coverage, the coverage will continue until the last day of the month and premiums will be collected accordingly. No refunds or retroactive terminations will be allowed.

Qualifying life events include:

- Change in legal marital status, including marriage, death of spouse, divorce or legal separation.
- Change in participant's number of dependents including birth, adoption of a child, or death.
  - For birth or adoption, effective date of the change is the child's date of birth or adoption.
- Dependent child reaches age 26.
- Spouse's change in employment status results in a gain or loss of coverage.
- Employee's change in employment status resulting in gain or loss of benefit eligibility, including an unpaid leave of absence.
- Employee's change in employment status resulting in an increase or decrease of 10 hours or more per week. A status change of less than 10 hours does not qualify.
- A change corresponding with a spouse's open enrollment period at his or her place of employment.
- Newly enrolled in Medicare.
- Gain or loss of coverage under a State Medicaid or CHIP program (you have 60 days to notify State).
- Health Care Market Place changes is not a qualified event.

Newborn Child

Under State Statute 44-710.19, all newborns receive 31 days of automatic coverage and the State of Nebraska will start collecting premiums for the newborn on the first of the month following the birth of a baby. For coverage to continue after the first 31 days, you must submit a change request through EWC within 30 calendar days of the child's birth. **If a request is not submitted through the EWC within 30 days of the child's birth, coverage ends at the end of the 31 days and the child cannot be added to your health plan until the next Open Enrollment period.** If you need assistance with this process, contact your HR representative or the Employee Wellness & Benefits office as soon as possible after the child's birth.

To be in compliance with HIPAA, all adopted children, regardless of age, must be enrolled using the same process as described above for newborns (in the EWC within 30 calendar days of the placement for adoption) and coverage becomes effective on the date of placement.

Legal Divorce

In the State of Nebraska, unless stated differently in the divorce decree, your divorce is considered final six months after the decree is rendered. Any requests to change your coverage due to the divorce will be effective on the first day of the month following the six-month waiting period.

If you have never had coverage with the State, you may apply for coverage when the divorce is final. You must submit the divorce decree and a certificate of creditable coverage. Your ex-spouse is not eligible to continue coverage under the State's plan once the divorce is final; however, he or she is eligible to continue coverage under COBRA if he or she was covered immediately prior to the divorce becoming final.

For more information, contact your agency HR representative.

Rehires

If you leave employment with the State of Nebraska, and return to a benefit-eligible position within 30 days, you will be required to enroll in the same benefit plans & tiers you had on your last day of employment. The waiting period is waived & coverage will begin first day of the month following your rehire date.

If you are rehired after 30 days, you will follow the same guidelines as a new hire. You will have to re-elect your benefit plans & coverage will begin the first day of the month following the 30 day waiting period before enrolling in coverage.

Rehires are NOT eligible to participate in the State's Flexible Spending Accounts (Medical or Dependent Care) until Open Enrollment for the following Plan Year (July 1).

For more information, contact your agency HR representative.

Health Insurance

Benefits are administered by UnitedHealthcare (UHC)

The State of Nebraska offers you a comprehensive health insurance program which includes both medical and pharmacy benefits. Health insurance premiums include both medical and pharmacy benefits.

You have three great plans to choose from. All health plan options are administered by UnitedHealthcare and includes both in-network and out-of-network coverage. New participants will receive an insurance card mailed to your home from UHC.

- Wellness Health Plan
- Consumer Focused Health Plan (with Health Savings Account Eligibility)
- Regular Plan

Wellness Health Plan Eligibility - July, 2017

New hires are eligible to elect the Wellness Health Plan for the 2016-17 plan year. However, employees and spouses (if enrolled) may be required to complete specific wellness activities to continue enrollment in the Wellness Health Plan for July 2017.

See Wellness section for requirements to continue eligibility for the July 2017 Wellness Health Plan.

Self-Insured Health Plan

The State of Nebraska provides health insurance for its employees through a self-funded health insurance program. In addition to deciding on the plan structure, the State pays health care claims for employees and dependents after copays and deductibles. The State contracts with UnitedHealthcare, who processes claims and provides the network of providers.

Navigating Your Health Insurance

www.myuhc.com

Once you have elected a State of Nebraska health plan, it's time to go to www.myUHC.com and register to take advantage of the many resources available to you and your covered family members.

- Print your ID card
- Search for network doctors
- Find answers to frequently asked questions
- Access your pharmacy benefit
- View Explanation of Benefits (EOBs)
- Track your out-of-pocket costs
- Look up health information
- Estimate health care costs
- Order refills for your mail order prescriptions

Difference between a Primary and a Specialty Physician

PRIMARY PHYSICIAN: A physician selected by a Covered Person to be responsible for providing or coordinating all Covered Health Services which are covered under the Plan as Network benefits. A primary physician has entered into an agreement to provide primary care health services to covered persons. His or her practice predominately includes (but may not be limited to) pediatrics, internal medicine, obstetrics/gynecology, family or general practice.

SPECIALTY PHYSICIAN: A physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Watch for Your Health Insurance Cards in the Mail

Start using your new card on July 1, 2016

You can also print your own card on www.myUHC.com any time after your benefits effective date.

Your On-line Resources

www.myuhc.com

Once you have elected a State of Nebraska health plan, it's time to go to www.myUHC.com and register to take advantage of the many resources available to you and your covered family members.

- Print an additional ID card
- Find a network doctor or pharmacy in your area
- Find answers to frequently asked questions
- Learn about your pharmacy benefit
- Learn about your plan details
- View Explanation of Benefits (EOBs)
- Track your out-of-pocket costs
- Look up health information
- Compare the cost of procedures among several providers
- Order refills for your mail order prescriptions
- Learn what's covered as preventive care for your age

myHealthcare Cost Estimator

Login to www.myuhc.com or Health4Me and estimate your health care costs before you see the doctor.

- Search for a condition or treatment
- Get a quick estimate based on average market costs in the area.
- Displays how that cost is impacted by your deductible, co-insurance and out-of-pocket maximum
- Select a provider

Health4Me™ mobile app

UHC strives to make it easy to get help, wherever you are. The confidential app features work best when you register at www.myUHC.com prior to using the app. It includes:

- Search for physicians or facilities
- View and share ID card information
- View claims
- Check status of deductible and out-of-pocket spending
- View benefit plan details
- Contact an experienced registered nurse 24/7

Why is UnitedHealthcare calling you or sending you mail?

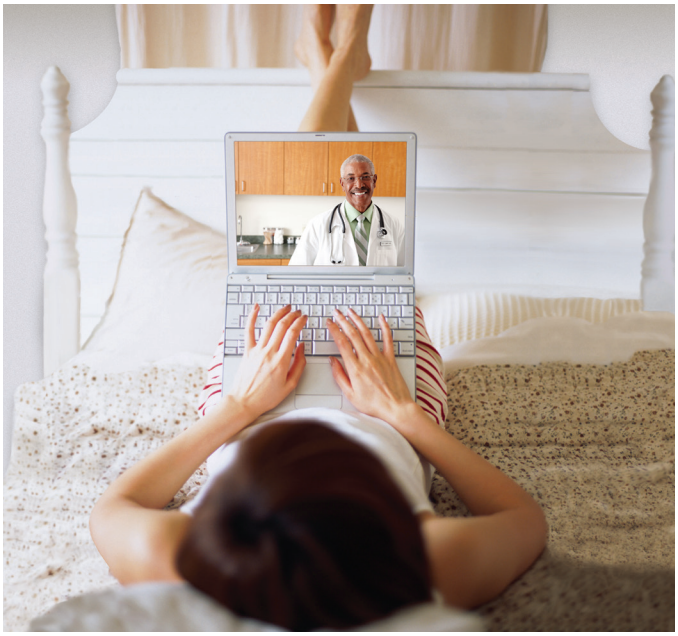
UHC may contact you by phone or mail for a variety of reasons. Here are a few:

- A Care Coordinator may call to help you with follow-up care instructions, medication, and durable medical equipment.
- Disease management staff may offer connections to needed care and resources for your health condition.
- Health Pregnancy nurses may call to offer educational services and resources.
- The mail order pharmacy may contact you about your prescription orders.
- The subrogation division may request additional information about accident-related claims.
- The claims team may request information about other coverage for your dependents.

Failure to respond may affect claims processing or your opportunity to save money on future health care costs. Therefore, it is important for you to pick up the phone or open the mail and respond to their requests and support efforts.

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. And it's part of your health benefits.



Access virtual visits

1. Log in to myuhc.com or Healt4Me App and click on Virtual Visits
2. Choose a provider group and click through to their website. Once you make that choice, you leave myuhc.com and go directly to their selected provider group's page.
3. Register - Each virtual visit provider group will require you to register – similar to "in-person" visit to a bricks and mortar clinic. Registration typically includes providing the name of the patient, health insurance, pharmacy and other general health information. You are required to pay at time of service.
4. Request a Visit - Once registered, you will request a visit and move into a virtual waiting room.
5. Connect to Physician - During their visit, you will be asked to describe your symptoms and health concern.
6. Diagnosis and Prescription - The treating physician will provide a diagnoses and likely ask about your primary care physician so any notes taken can be shared. The virtual visit physician creates an integrated medical record with full documentation. You can access this record once the visit is complete so they can email it, or print it and bring it to your primary care physician. If required the virtual visits doctor can write a prescription that is sent electronically to your chosen pharmacy, where you can pick it up.

Virtual Visits Rate

Wellness Health Plan	Regular Health Plan	Consumer Focused Health Plan
$20 copay	$20 copay	20% after deductible

Required to pay with a credit card at the time of the visit. You may use your FSA or HSA account card.

Conditions commonly treated through a virtual visit:

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Seasonal Flu
- Sore Throat
- Sinus Problems
- Bladder Infection
- Fever
- Pink Eye

myNurseLine

Receive immediate answers from nurses, backed by medical professionals who are here to help you.

- Chat with a registered nurse
- Understand your symptoms and treatment options
- Ask medication questions
- Decide if you should see a doctor, go to the ER, or try self-care
- Find a doctor, hospital, or specialist
- Make an appointment with your provider

FREE myNurseLine

877-543-4295

24 hours a day, 7 days a week
MonTTY: 711

Your Money – Your Health

You have control over how much you spend for healthcare. Here are some suggestions:

1. When you compare plans, look at both premiums and out-of-pockets costs.
2. Shop around and compare prices and quality of doctors, facilities, and pharmacies.
3. Choose generic prescriptions instead of brand name drugs.
4. Write down your questions to ask when you go to the doctor. It's easy to feel overwhelmed and forget.
5. Schedule your annual preventive exams for medical, dental, and vision.
6. Set aside money for unplanned healthcare expenses. The Health Savings Account is a great solution for this.
7. Only use the emergency room for a very serious or life threatening conditions. Consider an urgent care center or convenience care clinic if you cannot see a doctor.
8. Enter 877-543-4295 into your cell phone contact listing - it's the myNurseLine phone number and it's FREE for anyone insured under a State of Nebraska health plan.
9. Set up your www.myuhc.com account and start shopping for more ways to save money on your health!

www.myuhc.com

Once you have elected a State of Nebraska health plan, it's time to go to www.myUHC.com and register to take advantage of the many resources available to you and your covered family members.

Go to www.uhcpreventivecare.com for a list of preventive care approved procedures for your age & gender.

What is Preventive Care?

Preventive care focuses on evaluating your current health status when you are symptom free. Preventive care allows you to obtain early diagnosis and treatment, to help avoid more serious health problems. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through a preventive exam and routine health screenings, your doctor can determine your current health status and detect early warning signs of more serious problems.

Your preventive care services may include immunizations, physical exams, lab work and x-rays. During your preventive visit your doctor will determine what tests or health screenings are right for you based on your age, gender, overall health status, and current health condition.

Preventive or Diagnostic?

Certain services can be done for preventive or diagnostic reasons. If you are going in for preventive services, make sure your doctor's office codes them correctly as 'routine.'

Preventive Care is when the patient:

- Does not have symptoms or any abnormal studies indicating an abnormality.
- Has had a screening done within the recommended age and gender guidelines with the results being considered normal.
- Has had a diagnostic service with normal results, after which the physician recommends future preventive care screenings using the appropriate age and gender guidelines.
- Has a preventive service done that results in a diagnostic service being done at the same time and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), subject to benefit plan provisions.

Diagnostic Care is when:

- Abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services.
- Abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline recommendations would require.
- Services are ordered due to current symptom(s) that require further diagnosis.

Why use a network provider?

All of our health plan offerings provide benefits for both in-network and out-of-network providers. Although you can choose to visit the provider of your choice at any time, you'll generally receive a higher level of benefit when you choose providers who are part of the plan network. Network providers have agreed to provide their services at negotiated, discounted rates, which save you and the State money. Provider directories are located at http://nebraska.welcometouhc.com/physicians-facilities.

Call UHC before your procedure

Contact UnitedHealthcare to confirm treatment has been authorized any time your doctor recommends you for follow-up treatment including inpatient and outpatient hospitalizations, advanced radiology, such as MRI's and CAT scans, and rehabilitation services, such as physical therapy. Please see Summary Plan Document for details.

Specialty Centers of Excellence

Kidney Resource Services (KRS)

KRS clinical consultants are nurses who are available to help members understand their kidney disease and associated health issues. Finding the right dialysis center can be one of the most important parts of managing kidney disease. KRS can help members find one of the nation's top-performing dialysis centers so they can get the best care possible.

Transplant Resource Services

Members receive help in managing a transplant through an industry-leading transplant Centers of Excellence network and nurse consulting services.

Cancer Resource Services

Cancer Resource Services (CRS) offers information and member assistance through a team of experienced cancer nurse consultants. They are available to help individuals understand their own or a loved one's cancer diagnosis, its implications and possible treatments. They help members make an informed decision about their care and where to receive care.

Congenital Heart Disease (CHD) Resource Services

Members can better understand and manage the symptoms associated with CHD by accessing a network of industry-leading CHD Centers of Excellence facilities and nurse consulting services.

End Stage Renal Disease

ESRD provides skilled consulting services to help members understand and manage the conditions associated with End Stage Renal Disease (ESRD) and dialysis.

Understanding Insurance Terminology

Deductible	The amount you must pay before the plan begins to pay for services provided.
Coinsurance	The percentage of cost you pay for services provided after the deductible is met.
Copays	A flat dollar amount you pay each time a service is provided.
Annual Out-of-Pocket Maximum	The most you pay for covered services provided in a calendar year. This includes your deductible, coinsurance, and medical plan copays.
Open Enrollment	A period of time you can make changes to your health, dental, vision, and FSA. The State of Nebraska offers Open Enrollment in May and changes become effective on July 1.
Flexible Spending Account (FSA)	FSA is an account you can contribute pre-tax dollars to and use for paying your health care (medical, dental, vision, or pharmacy) or dependent care (day care) expenses. Since your contributions are pre-tax, you save money by not paying taxes on these contributions. Employees cannot contribute to a FSA and Health Savings Account in the same plan year.
Health Savings Account (HSA)	HSA is a bank account that you own. You can use it to save money, federal income tax free, to pay for qualified medical expenses. You use the money to pay for qualified medical expenses including medical, pharmacy, dental, or vision expenses. You must be enrolled in a qualified high deductible plan like the State's Consumer Focused Health Plan to make contributions to an HSA. This money goes with you after employment and can even be used to pay for healthcare expenses during retirement.
Preferred Provider Organization (PPO)	PPO is a medical plan that allows for a higher level of coverage for eligible services when seeing providers who contract with the network. If you use providers outside of the network, you will pay higher out of pocket costs, be responsible for amounts that may exceed the contracted amount and, in most cases, file your own claims.
Premiums	The money deducted from your paycheck for the benefits coverage you elected.
Qualified Medical Expense	The Internal Revenue Service (IRS) decides which expenses can be paid and reimbursed from an HSA and FSA. See IRS Publication 502 at irs.gov for a complete listing.
Coordination of Benefits (COB)	When an individual is covered by more than one group health plan, health plans coordinate the benefits payable to ensure that the medical provider is not paid more than the allowable medical expenses. Under COB, the primary plan pays its normal plan benefits. The secondary plan pays the difference between allowable expense and amount paid by primary plan, provided this difference does not exceed the normal plan benefits. For active employees, the State's health plan is always primary. For retirees & dependents, UHC will send out COB notices once a year to dependents who file a claim on the State's health plan.

Consumer Focused Health Plan

Consumer Focused Health Plan administered by UnitedHealthcare (UHC)
HSA Provided by Optum Bank

The State of Nebraska is committed to providing our employees, retirees and their families with access to comprehensive and competitive health benefits. We want to make sure the plans we offer continue to give you the flexibility to manage your specific medical needs, improve your overall health — and help control your costs.

Why choose the Consumer Focused Health Plan and HSA?

Lower premiums

With the Consumer Focused Health Plan, you pay a lower premium, which leaves you with more money in your bank account each month. You can use these savings to make deposits into your HSA.

Annual deductible

When you receive medical care or need a prescription, you pay out of pocket for those expenses until you reach your deductible. For 2016-17, the deductible is $2,600 per individual and $5,200 max per family. After you reach the deductible, you pay 20% coinsurance until you reach your annual out-of-pocket maximum.

Preventive Drug Listing

The Consumer Focused Health Plan offers you low copays for a specific list of preventive maintenance medication. Only medication on this list has copays with no deductible or coinsurance. The types of drugs include high blood pressure, high cholesterol, diabetic, asthma, multiple sclerosis, and osteoporosis. Not all drugs in these therapeutic classes are included on this list.

How it works

- **Covers the same types of medical expenses as our other medical plans.** Once you pay the deductible, you're only responsible for 20% of your expenses – the plan will cover the other 80%. The amount you pay applies to your out-of-pocket maximum.
- **Lets you keep your current doctor.** If you have a preferred doctor, you can continue to use that doctor or choose a doctor that is in the network to save more on the cost of care.
- **Protects you if you get sick.** If you happen to need significant medical care, you're protected by an out-of-pocket maximum. It limits the amount of money you pay before the plan covers 100% of your claims. For 2016-17, the most you'll pay in a year is $4,100 for individual coverage and $8,200 for family coverage.
- **Helps you save!** You have the option of opening a Health Savings Account if you are eligible. You can make tax-free contributions to your HSA through an automatic payroll deduction – and save for the future. The money in your HSA is always yours to keep, even if you leave your job with the State of Nebraska.

Preventive Care

Under the Consumer Focused Health Plan, you don't pay anything for eligible preventive care – it's covered at 100% with no deductible, as long as you use a network doctor.

Health Savings Account (HSA)

HSA Provided by Optum Bank

With the introduction of the Consumer Focused Health Plan, the State of Nebraska is offering eligible employees the opportunity to open a Health Savings Account, managed by Optum Bank. An HSA is a personal bank account that you own, and it allows you to save money out of each paycheck on a pre-tax basis.

You can use the money you save in your HSA to pay for qualified medical, dental and vision expenses, such as doctor visits, prescriptions and hospital visits, or you can save the money for a future need – even retirement. The way you use your HSA will depend on your health care needs and your savings goals. Spend or save. The choice is yours.

Benefits of an HSA

- **You own the HSA.** Any money you deposit into your HSA is yours to keep, even if you change medical plans or leave your job.
- **There is no "use it or lose it" rule.** Your HSA balance carries over from year to year, letting you save for future health care expenses that may occur well into retirement.
- **You can grow your money.** The money you contribute to your HSA grows with interest, and once your balance reaches a certain level, you can choose to invest some of your savings in mutual funds to help your money grow further and work harder for you.
- **You get triple tax savings.** The money you contribute to your HSA is tax-free. You don't pay taxes on your contributions or the interest your account earns, as long as you use them for eligible medical expenses.

Like all good things, there's a limit on the amount that you can contribute to your HSA. Currently, the IRS limits the amount you can save during the benefit plan year depending whether or not you carry dependent coverage. You'll need to make sure your contributions don't put you over the annual maximum.

The 2016 maximum limits are:

- $3,350 for individual coverage
- $6,750 for family coverage
- If you're age 55 or older, you can contribute an additional $1,000 to your HSA during the plan year

Can You Open an HSA?

Because you don't pay taxes on HSA contributions, the interest or earnings on investments, you have to meet certain requirements to open an HSA:

- You are covered under the Consumer Focused Health Plan
- You are not covered by any other health plan, such as a spouse's non-HSA plan, or FSA Healthcare plan
- You are not enrolled in Medicare or TRICARE
- You have not received Veterans Administration (VA) benefits within the past three months
- You are not claimed as a dependent on another person's tax return

How does the HSA work?

If you enroll in the Consumer Focused Health Plan, you will authorize set up of your Optum Bank account and elect your pre-tax payroll contributions through the Employee Work Center. You'll receive additional information from Optum Bank about your account including on-line banking options to help manage your HSA.

There is a monthly bank fee of $1.00 until the balance reaches $500.00, then the fee is removed.

With the money you save in your HSA, you can:

- Use your Optum Bank HSA Debit MasterCard® to pay for qualified health care expenses at your pharmacy, doctor's office or other health care provider.
- Reimburse yourself for qualified health care expenses from your HSA.
- Pay bills on-line at no charge, or pay with checks linked to your HSA, if you choose to purchase them.
- Save for future healthcare expenses.

How is it different from a FSA Healthcare account?

- It's a bank account owned by you. It goes with you even if you change jobs or health plans.
- Like a bank account, you can only use the money you have deposited in the account.
- Higher annual contributions limits.
- Your account balance earns interest.
- You can invest your balance in mutual funds once it reaches the investment threshold.
- Anyone can deposit money in your account.
- You can use it now, or save it for the future.

What are qualified expenses?

Some examples are list below. For a complete listing, see IRS Publication 502 at irs.gov.

- Acupuncture
- Ambulance
- Artificial limbs
- Diabetic supplies
- Breast pumps
- Chiropractor
- Contact lenses and solution
- Crutches
- Dental treatments
- Doctor's office visits and procedures
- Prescriptions
- Eyeglasses and vision exams
- Fertility treatment
- Deductibles and co-payments
- Premiums for COBRA, long-term care insurance, tax-deductible health insurance
- Hearing aids
- Laboratory fees
- Laser eye surgery
- Physical therapy
- Psychiatric care
- Speech therapy
- Stop-smoking programs
- Walker
- Wheelchair

What expenses are not covered?

- Expenses reimbursed from another source
- Cosmetic surgery
- Diaper service
- Electrolysis or hair removal
- Health club dues
- Household help
- Maternity clothes
- Nutritional supplements
- OTC medicines
- Toothbrush, toothpaste
- Swimming lessons
- Teeth whitening

To Learn More...

Visit www.optumbank.com or call 866-234-8913 Monday - Friday 7:00 a.m. - 7:00 p.m. Central Time

Pharmacy Benefits

Benefits are administered by OptumRx (affiliate of UnitedHealthcare)

When you enroll in a State of Nebraska health plan, you will also be enrolled in the State of Nebraska pharmacy program. UnitedHealthcare (UHC) will send you an identification card which will be used for both medical and pharmacy claims. You will want to carry your UHC card with you at all times. Additional cards can be ordered through www.myuhc.com or by calling UHC at 877-263-0911.

The pharmacy program offers flexibility and choice in finding the right medication for you. Medications are placed on different "tiers" based on their overall value.

- Tier 1 – Your lowest cost option
- Tier 2 – Your midrange cost option
- Tier 3 – Your highest cost option

To learn more about the tiers, covered drugs, and list of network pharmacies, go to the Prescription Plan page at Employee Wellness & Benefits Resources, www.link.nebraska.gov.

Smoking Cessation Products

Effective July 1, 2016, select over the counter and prescription tobacco cessation products will be covered at $0 cost-share for eligible members on all 3 health plans. To qualify, members must be:

- Age 18 or older
- Must have a prescription for the products from their physician, even for products that are available over the counter
- Fill the prescription at a network pharmacy

Products available will include nicotine replacement gum, lozenges, patches and generic Zyban. For a complete listing, please refer to the Pharmacy Drug List "PDL" on the Employee Wellness and Benefits web site.

Choosing between brand name and generic medications

Generic medications contain the same active ingredients as brand name medications, but they often cost less. Many companies that make brand name medications also produce and market generic medications.

Are YOU getting the most out of your Pharmacy Benefit?

- **Register at www.myuhc.com**
- **Choose drugs on Tier 1, when available**
- **Use mail order**
- **Choose Generic instead of brand name medications**

Get registered at www.myuhc.com

Upon enrolling in a State of Nebraska health plan, you will receive a welcome kit from UnitedHealthcare. Go on-line at www.myuhc.com and register. Once you register, click on "Manage My Prescriptions" and you will be able to:

1. View the most current prescription drug list (also referred to as a formulary).
2. Locate a network pharmacy.
3. Compare drug prices and lower cost options.
4. Find your cost before you go to the pharmacy.
5. Refill and track your mail order prescriptions.
6. View medication limits including quantity limits, prior authorization, and step therapy.
7. View drugs not covered under your plan.

Diabetic Supplies

Diabetic supplies covered under the prescription drug benefit include syringes, needles, lancets, blood monitor kits, test strips, blood glucose calibration solutions, urine tests, and blood test strips. Blood glucose monitors are also covered under the pharmacy benefit, but continuous blood glucose monitors are currently excluded. Insulin pumps and sensors are covered under the medical benefit as Durable Medical Equipment. If you have any questions, call customer service at 877-263-0911.

Mail Order – Save money & time!

For medications you take on a regular basis, you can fill a 90-day supply through the OptumRx™ Mail Service Pharmacy. Mail order offers the convenience of home delivery and saves you money. You will also be able to get a 90 day prescription from your local pharmacy.

To start using mail order:

1. **Tell your physician you would like to start mail service**
   Once you and your physician are confident you will continue taking a medication on an ongoing basis, have your physician write a prescription for a 90-day supply, plus up to three refills. Prescriptions with more than three refills will not be processed as it will exceed a one year maximum supply as required by law.

2. **Contact OptumRx™** at 800-562-6223, 24 hours a day, seven days a week and have your prescription label available when you call.
   You can mail the order form - include with the original prescription(s). Write the member ID and date of birth on each prescription and mail with completed order form. Please fill out one order form per member. You can download an order form from link.nebraska.gov - link to Employee Wellness & Benefit Resources.

Your Prescription Medication Options

Your PDL is a list of commonly prescribed medications and their cost levels or tiers, which define the amount you pay for each medication under your benefit. Tier placements on the PDL are reviewed and may change throughout the year. For a current list of your PDL, contact OptumRx at 877-263-0911 or visit www.myUHC.com.

Specialty Pharmacy Program

BriovaRx Specialty Pharmacy

Certain prescriptions on our prescription drug listing require that you use the BriovaRx Specialty Pharmacy to refill your prescriptions. Specialty pharmacies have experience in storing, handling, and distributing these unique medications and typically provide a higher level of customized care for specialty medications than traditional retail pharmacies. Specialty pharmacists and nurses also have additional clinical expertise surrounding these medications and complex diseases.

What is a specialty medication?

An injectable, oral, or inhaled medication is most often considered specialty medication if it:

- Is used to treat a chronic or complex condition
- Requires extra, on-going clinical oversight and additional education for best management
- Has unique storage or shipping requirements
- Typically is not available at retail pharmacies

How does the program work?

Your first fill:

When you are first prescribed a specialty medication, you can receive a 30-day supply from your local pharmacy. Your pharmacist will let you know when you are prescribed a specialty medication. Also, you will receive a welcome packet from OptumRx with instructions on how to refill your medication.

Follow-up refills:

Contact the BriovaRx Specialty Pharmacy at 855-242-2241 and speak with a Patient Care Coordinator to help set up your account, order refills, and answer questions about your prescription.

Your Pharmacy Benefits

	Wellness Health Plan	Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
RETAIL - 30 DAY SUPPLY			
Tier 1	$5 copay	$5 copay	20% after deductible
Tier 2	$30 copay	$30 copay	20% after deductible
Tier 3	$50 copay	$50 copay	20% after deductible
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)			
Tier 1	$10 copay	$10 copay	20% after deductible
Tier 2	$60 copay	$60 copay	20% after deductible
Tier 3	$100 copay	$100 copay	20% after deductible
Pharmacy Out-of-Pocket Maximum	$2,000 - individual $4,000 - family	$2,000 - individual $4,000 - family	Included in the medical out-of-pocket maximum

Wellness Health Plan ONLY

DIABETIC, HYPERTENSION AND HIGH CHOLESTEROL PRESCRIPTIONS

RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	$15 copay
Tier 3	$30 copay
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)	
Tier 1	2 Times the 30-day supply
Tier 2	
Tier 3	

Consumer Focused Health Plan ONLY

UHC PREVENTIVE DRUG LIST (FORMULARY)
Go to link.nebraska.gov; Wellness & Benefits Resources page for list

RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	$25 copay
Tier 3	$50 copay
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)	
Tier 1	2 Times the 30-day supply
Tier 2	
Tier 3	

Pay the Difference

If a generic equivalent is available, and you choose brand, you will pay the difference in cost between the generic cost and brand cost, in addition to the appropriate copay. Penalty does not apply if physician does not allow substitution.

Wellness and Regular Health Plans Pharmacy Out-Of-Pocket Maximums

The pharmacy out-of-pocket maximum limits are in addition to the medical out-of-pocket maximums on page 28-29. Once the out-of-pocket maximum has been met for pharmacy co-pays, all prescriptions covered under the plan will be paid 100% by the plan.

Consumer Focused Health Plan

1. If your medication is on the UHC Preventive Drug List, you pay the copay. Your copay will apply towards your annual out-of-pocket maximum. After your limit is met, the plan pays 100% of your costs. Go to http://das.nebraska.gov/benefits.html.

2. For all other covered prescriptions, the full cost of the prescription is applied towards your deductible. Once you meet your deductible, then you pay 20% coinsurance until your annual out-of-pocket limit is met. Then all costs are paid 100% by the plan.

Your Health Insurance Benefits

	Wellness Health Plan	
	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	$600 individual $1,200 family	$1,200 individual $2,400 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	$2,400 individual $4,800 family	$4,800 individual $9,600 family
Annual Pharmacy Out-of-Pocket Maximum	$2,000 individual $4,000 family	
PHYSICIAN OFFICE VISITS		
Primary Care Physician Office visit	$30 copay	30% after deductible
Specialty Office visit	$45 copay	
Virtual Visits - NEW July 2016	$20 copay	
Allergy testing / serum	Plan pays 100%	
Allergy shots	Plan pays 100%	
Pathology Services	Paid at 100% up to $500; then 20% after deductible	
Radiology and Chemotherapy/Radiation Therapy	20% after deductible	
Routine Vision Exam plus Refraction	$35 copay	Not covered
PREVENTIVE EXAMS		
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. **See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.**	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% per Patient Protection and Affordable Care Act (PPACA) guidelines.
Prostate cancer screening	Plan pays 100%	30% after deductible
EMERGENCY CARE		
Ambulance	Plan pays 100%	
Urgent care center	$45 copay	30% after deductible
Hospital emergency room	20% after deductible	
HOSPITAL SERVICES		
Inpatient and outpatient hospital services **Approved skilled nursing facility** **Home health care, Hospice care**	20% after deductible	30% after deductible
BEHAVIORAL HEALTH SERVICES		
Inpatient	20% after deductible	30% after deductible
Outpatient	$30 copay	
OTHER SERVICES		
Chiropractic Office visit (Limit 60 sessions per year)	$45 copay	30% after deductible
Therapy - Occupational, Physical, Speech (Limit 60 sessions per year)	$30 copay	
Hearing aids & exam (Limit $3,000 every 3 years)	20% after deductible	
Durable Medical Equipment		

Regular Health Plan		Consumer Focused Health Plan (HSA Eligible)	
In-Network	Out-of-Network	In-Network	Out-of-Network
$1,200 individual $2,400 family	$2,400 individual $4,800 family	$2,600 individual $5,200 family	$5,200 individual $10,400 family
$4,000 individual $8,000 family	$8,000 individual $16,000 family	$4,100 individual $8,200 family	$8,200 individual $16,400 family
$2,000 individual $4,000 family		Included in the medical out-of-pocket maximum	
$35 copay	40% after deductible	20% after deductible	40% after deductible
$50 copay			
$20 copay			
20% after deductible			
Not covered		Not covered	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines.
Not covered		Not covered	
20%; deductible waived		20% after deductible	
$50 copay	40% after deductible	20% after deductible	40% after deductible
20% after deductible		20% after deductible	
20% after deductible	40% after deductible	20% after deductible	40% after deductible
20% after deductible	40% after deductible	20% after deductible	40% after deductible
$35 copay			
20% after deductible	40% after deductible	20% after deductible	40% after deductible

IMPORTANT INFORMATION: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official documents. If there are any inconsistencies between this summary and the official plan documents, the plan document will prevail. Please refer to the summary plan documents found on Employee Wellness & Benefits website **http://das.nebraska.gov/benefits.html** for exact benefits, exclusions and limitations.

NOTES:

Medical, Dental & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2016 through June 30, 2017 are shown below.

The State contributes 79% of the total cost of your health care benefits for full-time employees.

Premiums are deducted from your paycheck pre-tax. That means the premiums are deducted from your pay before taxes are withheld and thus, you do not pay taxes on these premiums.

It is your responsibility to review your pay stub to ensure that the proper deductions are taken. You are responsible for the cost of the proper employee share of your elected benefits. A payroll error does not absolve you of responsibility for payment of the proper share of the cost.

NOTE: For employees who are paid bi-weekly, your deduction will be half of the total shown here and deductions are only taken 24 times per year.

Monthly Medical Plan Premiums

Full-Time: 30-40 hours
Part-Time: 20-29 hours

		Wellness Health Plan		Regular Health Plan		Consumer Focused Health Plan	
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only (Single Coverage)	**Your Cost:**	**$116.10**	**$190.34**	**$139.24**	**$228.28**	**$79.30**	**$130.02**
	State Cost:	$436.78	$362.54	$523.84	$434.80	$298.36	$247.64
	Total:	$552.88	$552.88	$663.08	$663.08	$377.66	$377.66
Employee + Spouse (Two-Party Coverage)	**Your Cost:**	**$307.68**	**$504.44**	**$369.00**	**$604.98**	**$210.16**	**$344.56**
	State Cost:	$1,157.46	$960.70	$1,388.16	$1,152.18	$790.64	$656.24
	Total:	$1,465.14	$1,465.14	$1,757.16	$1,757.16	$1,000.80	$1,000.80
Employee + Dependent Children (Four-Party Coverage)	**Your Cost:**	**$238.02**	**$390.22**	**$285.46**	**$468.02**	**$162.58**	**$266.56**
	State Cost:	$895.38	$743.18	$1,073.86	$891.30	$611.64	$507.66
	Total:	$1,133.40	$1,133.40	$1,359.32	$1,359.32	$774.22	$774.22
Employee + Spouse + Dependent Children (Family Coverage)	**Your Cost:**	**$412.18**	**$675.76**	**$494.32**	**$810.46**	**$281.54**	**$461.60**
	State Cost:	$1,550.54	$1,286.96	$1,859.62	$1,543.48	$1,059.16	$879.10
	Total:	$1,962.72	$1,962.72	$2,353.94	$2,353.94	$1,340.70	$1,340.70

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$23.12	$27.00
Employee + Spouse (Two-Party Coverage)	$46.28	$54.04
Employee + Dependent Children (Four-Party Coverage)	$66.68	$77.92
Employee + Spouse + Dependent Children (Family Coverage)	$72.44	$84.60

Monthly Vision Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$5.30	$8.20
Employee + Spouse (Two-Party Coverage)	$8.50	$13.16
Employee + Dependent Children (Four-Party Coverage)	$8.68	$13.40
Employee + Spouse + Dependent Children (Family Coverage)	$13.96	$21.64

Wellness

Benefits are provided by HealthFitness™

The State of Nebraska wellness program, **wellNEssoptions**, launched in 2009 and has become integral in our efforts to:

1. Create a healthier workforce by encouraging healthy behaviors and the use of preventive care benefits.
2. Control health care costs.

Eligibility & Participation

All employees and spouses enrolled in a State of Nebraska health plan can participate in **wellNEssoptions**.

To Get Started

Around the time your health plan coverage begins, you and your spouse (if enrolled) will receive a welcome letter from HealthFitness with information about the **wellNEssoptions** program and how to register on www.wellnessoptions.nebraska.gov. On the **wellNEssoptions** website, you can register for your biometric health screening (April-May), complete your on-line health assessment, and enroll in a wellness program designed to help you achieve and maintain a healthy lifestyle.

Follow Your Progress On-line

Track the completion of your progress at www.wellnessoptions.nebraska.gov. After you register and set up your personal settings, you can review your progress on your Rewards tab located in your **wellNEssoptions** website account.

Confidentiality is a Top Priority

Privacy of personal information is our top priority. HealthFitness™ maintains the confidentiality of all personal health information in accordance with federal regulations. This means your personal health information, which is obtained by HealthFitness™, will not be released to the State of Nebraska, except in aggregate form.

What is allowed during work hours?

The following items are allowed for participation during work hours:

- Open Enrollment
- Health assessment
- On-site biometric health screening
- Email HealthFitness using your work e-mail

NOTE: Submitting activities are allowed on a State computer, but are to be done on personal time (lunch time or break). Participation is in no way to be considered part of or arising out of employment for the purposes of workers' compensation or for any other purpose.

The following items are not allowed during work hours:

- Health Advising calls
- Lifestyle Management and Condition Management Coaching calls
- Walk This Way participation - pedometers can be worn during the workday on company time; however, physical activities outside of normal work requirements (example: going for a walk) must be done on personal time (lunch time or break)

If in doubt, refer to your personnel policy, or ask your supervisor.

No Penalties for Poor Health

The Wellness Health Plan qualification criteria is based on active participation and completion of specific wellness programs, and is not based on your individual health factors, health assessment answers or biometric screening results. This means you will not be penalized for having or reporting poor health behaviors, lifestyle risks or conditions. Federal regulations prohibit a group health plan from discriminating among individuals based on their health status. Because the State of Nebraska does not condition eligibility for the Wellness Health Plan upon a participant's ability to meet a health standard, the program meets the nondiscrimination requirements under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Your health plan is committed to helping you achieve your best health. Incentives for participating in the **wellNEssoptions** program are available to all employees. If you think you may be unable to meet a requirement under the **wellNEssoptions** program, you may qualify in a different manner. Please contact a Wellness Specialist at 402-471-4110 or 402-471-4703 and we will work with you and with your doctor to find a wellness program that is right for you in light of your health status.

Wellness Incentives

Employees and spouses who complete the required qualifying steps between April 2016 and March 2017 will be eligible to enroll in the Wellness Health Plan beginning July 1, 2017.

Wellness Health Plan Advantages

- Plan with lowest deductible and annual out-of-pocket maximums
- All blood work is covered up to $500
- No age restrictions for preventive screenings
- Thyroid testing
- Bone density testing (no age restriction)
- Routine and follow-up mammograms covered at 100%
- Routine and follow-up colonoscopies covered at 100%
- Cholesterol, hypertension, and diabetic medications at a reduced copay or no cost
- Routine prostate cancer screening
- Vision exam with a copay

WellNEssoptions website log-in support call:

866-956-4285 option 1

Qualifying for Wellness Health Plan - July 2017

Group 1: Insurance Effective Prior to 4/1/2016	Due Dates
Complete Biometric Screening Option	4/1/2016 - 5/31/2016
Complete Health Assessment	4/1/2016 - 5/31/2016
Enroll & Complete a Wellness Program • Coaching • Colorful Choices • Cardio/Strength Tracker • Walk This Way	Enroll by 11/30/2016 Complete by 3/31/2017
Group 2: Insurance Effective 4/1/2016 - 11/1/2016	**Due Dates**
Complete Health Assessment	11/30/2016
Enroll & Complete a Wellness Program • Coaching • Colorful Choices • Cardio/Strength Tracker • Walk This Way	Enroll by 11/30/2016 Complete by 3/31/2017
Group 3: Insurance Effective 12/1/2016 - 3/1/2017	**Due Dates**
No requirements	11/30/2016

2016-17 Wellness Health Plan Premium Savings

Plan Name	Single	Two-Party	Four-Party	Family
Regular Health Plan	$1,670.88	$4,428.00	$3,425.52	$5,931.84
Wellness Health Plan	$1393.20	$3,692.16	$2,856.24	$4,946.16
You Save:	**$277.68**	**$735.84**	**$569.28**	**$985.68**

Wellness Programs

Colorful Choices

- Focus on nutrition by tracking your daily fruits & vegetables
- Log a minimum of 600 points on-line
- Enroll on-line by November 30, 2016
- All points must be entered on-line by March 31, 2017

Cardio/Strength Tracker

- Maintain or improve your health by being physically active
- Log 60 workouts of at least 30 minutes per day; one credit given per day
- Enroll and log one qualifying workout on-line by November 30, 2016
- All workouts must be entered on-line by March 31, 2017

Walk This Way®

- Boost your activity level by wearing a pedometer and tracking your steps on-line
- Log a minimum of 1,000,000 steps on-line and join the Million Step Club!
- Enroll on-line by November 30, 2016
- All steps must be entered on-line by March 31, 2017

Coaching

- Work with a coach to support and guide you in making lifestyle changes
- Complete and track 10 or more goals with your coach
- All goals must be tracked by March 31, 2017

Lifestyle Management -
choose from over 19 focus areas to improve your health including:

- Tobacco Cessation
- Stress Management
- Unhealthy Fats
- Whole Grains
- Sleep
- Flexibility
- Portion Control

Condition Management - Professional Health Coaches
available to participants who have been diagnosed with any of the following:

- Asthma
- Congestive Heart Failure
- Depression
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Certain diagnoses of back and neck pain

Enroll by calling 866-956-4285, option 2, by Nov. 30, 2016

Wellness Program Results

Congratulations Wellness Program Participants!

Over 11,000 employees and spouses participated in **wellNEssoptions** health screenings and health risk assessments offered during April and May 2015.

See how our health and wellness programs are improving the lives of State of Nebraska employees through preventive check-ups, screenings, and increased activity levels:

- Wellness Health Plan participation increased **16%**.
- Over **4,000** employees received a flu shot at a State on-site clinic.
- Over **11,000** participants participated in a wellNEssoptions program.
- Overall Wellness Score increased **1.8%** for 2-year participants.Healthy eating and physical activity are top coaching goals.
- **5,793** participants enrolled in wellNEssoptions coaching programs.
- Wellness & Benefits traveled statewide hosting education meetings and help desks about health plans and wellness.

A Culture of Health & Wellness

Participants walked over 8.5 billion steps. 3,923 participants walked 1 million steps or more.

As a result of our wellness program efforts and outcomes, the State of Nebraska is among the leaders across the country in wellness. The State's **wellNEssoptions** program has received several prestigious national awards including the 2010 and 2012 Gold Well Workplace by the Wellness Council of America, the Innovations Award from The Council of State Governments, and the coveted 2012 C. Everett Koop National Health Award.

Wellness Champions

Employee Wellness & Benefits partners with Wellness Champions from several agencies across the state to provide feedback and help with promoting and supporting a culture of wellness. There are over 140 volunteers who serve as State of Nebraska Wellness Champions! Wellness Champions encourage their co-workers to adopt healthy behaviors in order to positively impact their quality of life. They are also instrumental in providing input on several Wellness Health Plan design enhancements. If you have a strong desire to help others, model a healthy lifestyle and want to help build a culture of wellness within your work area, speak with a Wellness & Benefits Specialist on the Employee Wellness & Benefits team.

Wellness Recognition

Periodically, we learn about success stories from participants who have or are taking control of their lives and are making some pretty amazing lifestyle changes resulting in significant health improvements. For many, it is a life changing experience – almost a second outlook on life. The purpose of the wellness recognition is to encourage, recognize, educate and create a standard of excellence for promoting healthy lifestyles by encouraging active living and healthy choices that shape the future of a culture of wellness within the State of Nebraska workforce.

Annual Wellness Award Banquet

The State continues to enthusiastically support and promote wellness initiatives for its employees. Each year, the State recognizes individuals and agencies for going above and beyond in promoting and establishing a healthy lifestyle during the Annual Wellness Awards Banquet. The wellness recognition recipients, State of Nebraska Agency Wellness Champions, and Agency Directors (for those agencies with objective measures of health improvements, high wellness program participation percentage and participation growth) are recognized each year at the banquet.

Vision Benefits

Benefits are provided by EyeMed Vision Care

Employees choose from two vision plans – Basic or Premium. All premiums are paid through pre-tax, payroll deductions. New participants will receive an insurance ID card from Eyemed upon enrollment.

State of Nebraska employees who elect vision benefits get EyeMed's Access vision plan, which allows you to take advantage of America's largest vision care network, comprised of independent providers and top optical retailers. This means that you get access to more convenient evening and weekend hours to fit anyone's schedule - or you can use your in-network benefits at one of EyeMed's online providers.

Accessing your vision care benefit is easy:

- Find a provider near you at eyemed.com, then schedule an appointment with a simple phone call or stop by one of the many providers who offer walk-in appointments.
- Register for EyeMed's member portal to maximize your membership through alerts about your vision health and benefits. You may also download the EyeMed Member App at iTunes or the Google Play Store for easy access on the go.

Vision benefits are available once every Plan Year

Example of Premium Progressive Glasses Purchase:

Retail Cost of Lens	$400
20% Discount	- $80
	$320
Less Lens Allowance	- $120
	$200
Member Copay	+ $75
Total Member Out-of-Pocket	**$275**

Monthly Vision Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$5.30	$8.20
Employee + Spouse (Two-Party Coverage)	$8.50	$13.16
Employee + Dependent Children (Four-Party Coverage)	$8.68	$13.40
Employee + Spouse + Dependent Children (Family Coverage)	$13.96	$21.64

EyeMed Vision Care Summary of In-Network Coverage (Member Cost)

	Basic Option	Premium Option
Exam	$10 copay Every 12 months	$10 copay Every 12 months
Frames	80% over $105 Every 24 months	80% over $120 Every 12 months
Benefits: You can choose from prescription lenses **OR** contact lenses each 12 or 24 months depending on the frequency of your chosen plan option.		
Prescription Lenses	**Every 24 months**	**Every 12 months**
• Single, Bifocal, Trifocal	$10 copay	$10 copay
• Standard Progressive Lens	$75 copay	$75 copay
• Premium Progressive Lens	$75 copay plus (80% of charge less $120)	$75 copay plus (80% of charge less $120)
Contact Lenses	**Every 24 Months**	**Every 12 months**
• Conventional	85% over $105	85% over $130
• Disposable	100% over $105	100% over $130

LEGAL DISCLAIMER: Member will receive a 20% discount on items not covered by the plan at network Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Allowances are one-time use benefits; no remaining balance. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. The plan design is offered with the EyeMed Access panel of providers. Limitations and exclusions apply. Insured plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri except in New York. Fidelity Security Life ºPolicy Number VC-19/VC-20 form number M-9083.

Dental Benefits

Benefits are provided by Ameritas

The State of Nebraska offers dental insurance to all full-time and part-time employees. All of the premiums are paid by the employee and collected through pre-tax payroll deductions. For new plan participants, dental ID cards will be mailed to your home.

Our dental program promotes routine dental care as part of our wellness culture for you and your family. Whether or not you elect health coverage, you can choose dental coverage for yourself and your eligible dependents. The dental plan is a participating provider organization (PPO) with a network of participating providers. You have the option of selecting dental care in- or out-of-network each time you receive dental care, but the plan pays the greatest benefit for care received from a provider in the Ameritas network.

Dental Rewards®

Dental Rewards® is a program offered by Ameritas and encourages good dental habits through regular dental check-ups. It is available to all family members who participate on the dental plan. If you file at least one dental claim during the plan year and total benefits paid are less than $500, your annual maximum for the following year will be increased by $250 ($350 if using a PPO dentist). This continues until you reach a total reward of $1,000. The Dental Rewards amount is available to use in future years in addition to your annual maximum. It can only be reduced if you have claims totaling more than $1,000 or if you fail to submit at least one claim during any given year.

Penalty for Late Entrants

A late entrant is any participant on the plan who does not elect coverage during your initial 30 days of eligibility, or, any participant who re-enrolls in the dental plan after dropping coverage. It applies to both you and your dependents.

As late entrants, your benefits will be limited to only preventive procedures for the first 12 months that you are covered. After 12 months, you will have access to all of the plan's benefits.

NOTE: Orthodontia and TMJ procedures are excluded from Dental Rewards as they have their own maximum benefit.

Find a Participating Provider

At www.ameritas.com or call 800-487-5553.

Ameritas Dental Plan Benefits

	Basic Option		Premium Option	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Basic & Major Procedures Only	$50 per individual $150 per family	$50 per individual $150 per family	$50 per individual $150 per family	$50 per individual $150 per family
Type 1 - Preventive	Plan covers 100%	Plan covers 50%	Plan covers 100%	Plan covers 50-60-70%**
Type 2 - Basic	Plan covers 80%	Plan covers 50%	Plan covers 80%	Plan covers 50-60-70%**
Type 3 - Major	Plan covers 50%	Plan covers 25%	Plan covers 50%	Plan covers 30%
Benefit Year Maximum	$1,000	$1,000	$1,500	$1,000
Dental Rewards®	Included	Included	Included	Included
ORTHODONTICS & TMJ				
Coinsurance (No Deductible)	Plan covers 50% (To age 19)	Plan covers 25% (To age 19)	Plan covers 50% (Adults & Children)	Plan covers 30% (Adults & Children)
Lifetime Maximum (per person)	$2,000	$2,000	$2,000	$2,000
Dental Rewards®	Excluded	Excluded	Excluded	Excluded

Type 1 - Preventive Procedures

Exam & cleanings (**2 per year - does not have to be at exactly 6 month intervals**), x-rays, sealants

Type 2 - Basic Procedures

Fillings, root canals, gum disease treatment, extractions

Type 3 - Major Procedures

Initial and replacement crowns, dentures, bridges

**Premium Plan ONLY

**Premium Plan ONLY - Type 1 and 2 procedures for out of network providers will be reimbursed on an incentive basis that progressively increases each plan year. New plan members begin at 50% coinsurance. As long as plan members visit the dentist and have at least one covered procedure performed each plan year, they advance one coinsurance level the following plan year until they reach 70%. If a plan member fails to have at least one dental procedure performed during any benefit year, he or she will revert back to the beginning coinsurance level to begin advancing through the levels.

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$23.12	$27.00
Employee + Spouse (Two-Party Coverage)	$46.28	$54.04
Employee + Dependent Children (Four-Party Coverage)	$66.68	$77.92
Employee + Spouse + Dependent Children (Family Coverage)	$72.44	$84.60

Flexible Spending Accounts (FSA)

Benefits are offered through ASIFlex

Flexible Spending Accounts (FSA) offer you a way to save money on your health care and/or dependent care (daycare) expenses. The money you deposit into the spending accounts is deducted pre-tax from your paycheck in equal amounts 24 times throughout the year (12 times for monthly payroll). Most people save at least 25% on each dollar that is set aside through the FSA program. The State of Nebraska offers you two flexible spending accounts: the Health Care FSA and the Dependent Care FSA. You must enroll each year to participate in the flexible spending accounts.

Important Facts about FSA's

- You can participate in the Health Care FSA, the Dependent Care FSA, or both.
- You can only enroll during your first 30 days of eligible employment or during Open Enrollment.
- You cannot enroll or change your FSA election mid-year unless you experience a qualifying life event that affects your FSA contribution.
- You must re-elect your FSA contribution every year during Open Enrollment.
- Estimate your expenses carefully — any money left in your account after end of plan year will be forfeited.
- Money cannot be transferred from the Health Care FSA to the Dependent Care (Daycare) FSA and vice versa.
- ASI Flex will send all new participants a welcome letter to your home address on record.
- Cannot contribute to an FSA Healthcare and an HSA during the same plan year.
- To learn more about FSA's and eligible expenses, go to ASI Flex website at www.ASIFlex.com or visit the Employee Wellness & Benefits Resources, www.link.nebraska.gov.

Save Money with an FSA

Here's how you can save money when you use an FSA. As you can see, an employee who earns $30,000 annually and uses the plan to cover $1,500 in eligible expenses would save $415 by using the FSA plan.

Let's assume...	With FSA	Without FSA
Annual Base Pay	$30,000	$30,000
Total Annual Contribution	$1,500	$0
Taxable Income	$28,500	$30,000
Federal Income Tax (20%)	$5,700	$6,000
Social Security(FICA) Tax (7.65%)	$2,180	$2,295
Total Tax	$7,880	$8,295
After-tax Eligible FSA Expenses	$0	$1,500
Take Home Pay	$20,620	$20,205
Annual Tax Savings	**$415**	$0

Additional FSA Tools

Visit www.ASIFlex.com today!

- **FlexMinder** - Monitor your UHC health plan to identify carrier claims with qualified out-of-pocket health care expenses that can be reimbursed from your health care FSA. You can direct FlexMinder, with just a click, to prepare and submit FSA claims. To learn more and to sign up, login to your ASI Flex account and click on the FlexMinder icon.
- **ASI Flex Mobile App** - Check your FSA balance and file claims from your mobile device. Available on-line or from Google Play Store or the App Store.
- **ASI Flex Card** - Visit the ASI website at ASIFlex.com/debitcards for more information on use of the card and to view a list of merchants where you can use your ASI Flex Card.

Dependent Care FSA (Daycare)

The Dependent Care FSA allows you to use tax free money to pay for dependent care expenses that enable you to work. This includes eligible day care, before and after- school expenses for a child under age 13, or an older dependent who lives with you at least 8 hours per day and requires someone to assist with day-to-day living.

How it works:

- IRS maximum annual contribution is $5,000 per household for the calendar year.
- You can use your dependent care FSA for eligible expenses incurred from July 1, 2016 to June 30, 2017.
- You have until October 31, 2017 to file a claim for reimbursement. Any balance left in your account after October 31, 2017, will be forfeited.
- You are only reimbursed up to the amount you have contributed at the time your claim is processed.
- Amounts requested above your account balance will automatically be reimbursed as subsequent contributions from your paycheck become available.

Eligible Dependent Care Expenses include day care, baby-sitting, and general purpose day camps.

Ineligible Dependent Care Expenses include overnight camps, care provided by your spouse or your child under the age of 19, and care provided while you are not at work.

Dependent Care FSA vs. Dependent Care Tax Credit

The money you contribute to the Dependent Care FSA reduces the amount of dependent care expenses you can claim on your federal income tax. You may want to talk with a tax professional to determine if the Dependent Care FSA or the federal tax credit provides you with the greatest savings.

Go Green!

Save paper and time. Sign up for account notices to be sent through email and/or text messaging. You may also receive all reimbursements via direct deposit.

Health Care FSA

The Health Care FSA reimburses you for eligible out-of-pocket health care expenses not covered by any health, dental or vision care plan you may have.

How it works:

- Your maximum annual contribution is $2,550 for the plan year.
- Your minimum annual contribution is $120.00.
- You will receive a debit card. If you do not want the card, contact ASI to cancel.
- Claims must be incurred between July 1, 2016 and June 30, 2017.
- You have until October 31, 2017 to file a claim for reimbursement. Any balance left in your account after October 31, 2017, will be forfeited.

SAVE YOUR ITEMIZED RECEIPTS
From your FSA Healthcare debit card transactions.

Eligible Health Care Expenses –

Go to www.asiflex.com and click on the FSA Store icon and the Eligible Expenses tab to learn more.

- Deductibles, copays and coinsurance for health care, prescription drugs, dental and vision care
- Out-of-pocket dental expenses - exams, fillings, crowns, implants, dentures, orthodontics, denture cleansers and adhesives
- Over-the-counter products - bandages, family planning, braces/supports, first aid supplies, etc.
- Over-the-counter medicine eligible with a prescription include pain relief, allergy relief, cold/cough/flu remedies, antibiotics, anti-gas products, etc.

Ineligible Health Care Expenses –

See website for detailed listing

Examples of expenses not reimbursable under the Health Care FSA:

- Insurance premiums
- Cosmetic procedures (i.e., facelifts, teeth whitening, veneers)
- Clip-on or nonprescription sunglasses
- Toiletries
- Long-term care expenses
- Drugs, herbs or vitamins for general health and not used to treat a medical condition

Long-Term Disability Benefits

Benefits are offered through Mutual of Omaha (aka United of Omaha)

Long-Term Disability (LTD) provides a tax-free monthly income benefit if you become disabled and are unable to work due to illness or injury. This benefit provides financial protection when you need it most. For all elimination periods, the LTD benefit will be 60%. Once you decide to enroll in the plan, your only decision will be to choose the length of the elimination period. There are four choices for the elimination period; 2, 3, 6 or 9 months.

Newly eligible employees can elect LTD coverage within the first 30 days of eligible employment. You are not required to submit evidence of good health if you enroll during your initial eligibility period.

If you do not elect LTD during the first 30 days, you will need to complete the Evidence of Insurability form. Coverage will not be in effect until you have been approved by Mutual of Omaha.

Your cost for coverage is based on the elimination period you choose, as well as your age and salary as of July 1 of each year.

2016–17 Voluntary Long-Term Disability Rates

Elimination Periods & Monthly Rates
(Rates Per $100 of Monthly Covered Payroll)

Age	2 Months	3 Months	6 Months	9 Months
19 & Under	$0.14	$0.08	$0.06	$0.06
20 - 24	$0.16	$0.08	$0.06	$0.06
25 - 29	$0.26	$0.12	$0.10	$0.10
30 - 34	$0.34	$0.16	$0.14	$0.12
35 - 39	$0.38	$0.20	$0.16	$0.14
40 - 44	$0.46	$0.26	$0.20	$0.18
45 - 49	$0.60	$0.36	$0.28	$0.24
50 - 54	$0.88	$0.54	$0.42	$0.36
55 - 59	$1.04	$0.64	$0.50	$0.44
60 - 64	$1.10	$0.66	$0.52	$0.46
65 - 69	$1.14	$0.70	$0.54	$0.48
70 & Over	$1.20	$0. 74	$0.58	$0.50

How to Submit a Claim for Long Term Disability

The Long Term Disability claim form must be completed and sent to: State of Nebraska, Administrative Services/ Employee Wellness & Benefits. There are three statements that will need to be complete before the claim can be sent to the insurance company for processing: (1) The Employee's Statement; (2) The Employer's Statement; and (3) The Physician's Statement.

You will be responsible for any fees charged by your physician for completing the claim form.

Your human resource partner will be able to assist you in initiating the claims process.

Calculating LTD Monthly Cost

Your cost for coverage is based on the option you choose, your age and your salary. Follow the simple steps below to determine your exact monthly cost.

1. Enter your basic gross monthly pay (not including overtime): $ _____
2. Monthly divided by 100 /100 = _____
   Rate per $100
3. Enter the rate for your age and the option you select: x _____
4. Multiply #2 x #3: (This is your monthly cost) $ _____

Evidence of Insurability (EOI)

Evidence of Insurability is a statement or proof of a person's physical condition. Any increase to your long-term disability will require EOI.

Life and AD&D Insurance Benefits

Benefits are provided by Aetna

The State of Nebraska offers both life and accidental death and dismemberment (AD&D) insurance coverage to employees. Newly hired employees may elect any supplemental coverage amount within the first 30 days of employment without having to provide evidence of insurability.

Open Enrollment Only

If you are currently enrolled in supplemental life insurance coverage, you may increase your coverage level by one increment without providing evidence of insurability.

Basic Life Insurance

The State provides eligible full-time employees with a basic life insurance benefit of $20,000 at no cost. Part-time employees are eligible for the $20,000 insurance benefit and pay 50% of the monthly rate. The part-time rate is $0.48 per month.

Accidental Death & Dismemberment Insurance(AD&D) – Employee Only

AD&D insurance pays benefits if you die or suffer certain serious injuries as a result of an accident. The AD&D benefit is paid based upon the type of loss you suffer.

AD&D Information	
Rate	$0.10/month
Coverage	Up to $5,200
* Dependent coverage is not available.	

Supplemental Employee Life Insurance

You may elect to purchase additional life insurance coverage for yourself. Coverage can be purchased in increments of one-half, 1, 1.5, 2, 3, 4, or 5 times your annual salary. Amounts will be rounded to the next highest $1,000. Employees pay the entire cost for supplemental life insurance through a payroll deduction. **Employee supplemental life rates are based on your age and salary as of July 1 of each year.**

During open enrollment, employees currently enrolled in Supplemental Life may increase one increment of coverage without approval by the carrier. Any increases outside of the Open Enrollment period, or any increases greater than one increment, will require evidence of insurability and approval by the carrier

Supplemental Life Coverage - Monthly Rates	
Age	**Rate/$1,000**
Under 25	$0.024
25-29	$0.024
30-34	$0.032
35-39	$0.049
40-44	$0.073
45-49	$0.105
50-54	$0.178
55-59	$0.381
60-64	$0.729
65-69	$1.191
70-74	$1.620
75-79	$3.677
80 and over	$7.444

Supplemental Life Insurance – Dependent

You may also purchase optional life insurance for your spouse and dependent child(ren) up to age 26. There are two dependent life options to choose from and both include coverage for spouse and your child(ren) but vary by spouse's age.

Dependent Supplemental Life Insurance Monthly Rates		
	Option 1 (Low) Spouse &/or Child(ren) $5,000 Policy	**Option 2 (High) Spouse &/or Child(ren) $10,000 Policy**
If Spouse under age 70	$1.54	$3.00
If Spouse 70 or older	$4.10	$8.22

NOTE: If both husband and wife are employed by the State, only one may cover the children on the State's supplemental dependent life coverage. Also, they cannot elect dependent life coverage on each other.

Accelerated Death Benefit

The voluntary group life insurance plan offers an "Accelerated Death Benefit" that allows you to receive a partial life insurance benefit if you are:

- Diagnosed with a terminal illness and not expected to survive more than 24 months; or
- Diagnosed with one of the following medical conditions:
  - Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
  - End stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate;
  - A medical condition requiring artificial life support, without which you would die; or
  - A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a hospital or skilled nursing facility.

The Amount of Accelerated Death Benefit

You can request up to the Accelerated Death Benefit percentage or 75% of the life insurance that is currently in effect however not:

- Less than $5,000 or
- More than $500,000

Requesting an Accelerated Death Benefit

To request the Accelerated Death Benefit, you must complete and submit a request form to Aetna. The request form must include:

- A statement of the amount requested; and
- A **physician's** statement verifying that you are suffering from a non-correctable terminal illness, or, are suffering from one of the listed medical conditions that is expected to result in a drastically limited life span. The statement must also provide the following information:
  - All medical test results;
  - Laboratory reports; and
  - All supporting documentation and information on which the physician's statement is based.

Your human resource partner will be able to assist with the completion/submission of the "Accelerated Death Benefit" claim form.

NOTES:

Employee Assistance Program (EAP)

Benefits are offered through Deer Oaks Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for employees and their household members by the State of Nebraska. The EAP is designed to help you and your family manage life's challenges.

Through this program, you and your family members may access a wide variety of counseling, referral, and consultation services to help you deal with personal and work-related issues that may be affecting your job performance or personal well-being. Whether you seek mental health counseling, work and life consultation services, legal and financial resources, assistance with locating child and elder care facilities, or you have uncertainty about retirement, Deer Oaks is there to assist with these, and other requests, 24 hours per day, 7 days per week.

NOTE: Not all State agencies have elected to provide EAP coverage for their employees. Please contact your agency Human Resources office to determine whether your agency is participating in the Deer Oaks EAP.

Deer Oaks offers a multidisciplinary team of professional counselors and work/life consultants trained to assist with such issues as:

- Work/Life Balance
- Depression/Anxiety
- Substance Abuse
- Preparing for Retirement
- Emotional & Psychological Issues
- Life Changes & Transitions
- Stress & Time Management
- Legal & Financial Difficulties
- Family & Marital Problems
- Child/Elder/Adult Care Issues
- Healthy Lifestyles
- Loss & Grief

These services are completely confidential and may be easily accessed 24/7 by calling the toll-free Helpline listed above. You may also visit us on-line at www.deeroaks.com to browse articles, interactive assessments, audio and video files, and to participate in monthly webinars and live chat sessions.

Contact Us

Helpline: **(866) 792-3616**
Website: **www.deeroaks.com**
Login/Password: **SON**

Termination/Retirement

Upon leaving employment with the State of Nebraska, it is important for you to know the following information about your benefits.

Address & Phone Number Changes

Please keep State of Nebraska informed of any changes to your address and/or phone number. State of Nebraska needs this information in order to send you a W-2 and 1095-C in January following the year in which you terminate or retire.

Medical, Dental and Vision

Medical, dental, and/or vision coverage ends on the last day of the month in which you terminate. You have the option to temporarily continue your coverage under COBRA. You will receive information regarding continuation of these benefits from the State's third-party COBRA administrator, ASI COBRA. If you require a faster enrollment process, contact Employee Wellness & Benefits at 402-471-4443.

If you have any questions about COBRA, please contact ASI COBRA at 877-388-8331.

See page 38 for COBRA/Retiree Premiums.

Early Retiree Insurance Program

This program was created for State employees who meet the qualifications and retire from employment between ages 55 to 64. Retirees age 65 or older at the time of Retirement and their spouse will only be offered 18 months of COBRA continuation.

The Early Retiree Insurance Program allows a retiree and enrolled dependents to continue coverage on the State's health, dental, vision, healthcare FSA, and EAP coverage at your own expense. The health insurance premiums include both State and active employee costs. The employee and dependent must be actively enrolled in the benefit on their last day of employment to continue coverage. Unlike COBRA, a dependent cannot continue coverage through the Early Retiree Insurance Program unless the employee/retiree is also enrolled.

When Retiree Insurance Ends

1. Retiree coverage ends 1st of the month in which they turn age 65.
   - Dependents will be offered to continue coverage on COBRA for 36 months or until the beginning of the month when the dependent turns age 65, whichever is sooner.
2. Spouse coverage ends 1st of the month in which they turn age 65.
3. Coverage in the health care FSA may only be continued only through the remainder of the current plan year.
4. Monthly premiums are not paid in a timely manner.
5. This provision is changed in a subsequent labor contract.
6. The administrative regulation, contract provision, and/or applicable statutes are changed and continued coverage is no longer available.
7. The State of Nebraska ceases to provide group health insurance to employees.

ASI COBRA administers the Early Retiree Insurance Program on behalf of the State. If you are eligible, you will receive enrollment documents from ASI COBRA upon retirement. Additional questions about the Retiree Health Insurance Program should be directed to AS-Employee Wellness & Benefits department at 402-471-4443.

Disability Retirement Insurance

An employee under age 55 may retire as a result of disability. An employee who chooses this option must first elect COBRA and once he/she is approved, the Retirement System will notify Employee Wellness & Benefits office. The individual's coverage will be converted to the Early Retiree Health plan up to the first of the month in which the employee reaches age 65.

Wellness

HealthFitness

If you plan to continue on the State's health insurance plan through COBRA or the Early Retiree Insurance Program, you may continue participating in the State's wellness program. Participants in the Wellness Health Plan will be required to complete the same wellness-related activities as active employees. Contact HealthFitness at 866-956-4285 for assistance.

Flexible Spending Accounts

ASI Flex

Health Care: If you have a balance in your Health Care Account at the time of termination, you may request reimbursement up to October 31 of the following Plan Year. You may claim expenses incurred through the end of the month of your termination date. If you have a positive balance in your FSA account, your are eligible for COBRA. Expenses incurred after your termination date are not eligible for reimbursement unless you continue your coverage through COBRA. If you choose not to elect COBRA, and you have no incurred expenses before leaving State of Nebraska, then those remaining funds are forfeited. You will receive information from ASI COBRA Services in a separate mailing regarding continuing your Health Care, if applicable. If you have questions, please call ASI Flex directly at 800-659-3035

Dependent Care Account: If you have a Dependent Care Account at the time of termination, you may be reimbursed for claims incurred through the end of the current plan year up to the balance in your dependent care account at ASI Flex. The deadline for reimbursement requests is October 31 of the following Plan Year. If you have questions regarding your Dependent Care Account, please call ASI Flex directly at 800-659-3035.

Health Savings Account (HSA)

Optum Bank

If you have a Health Savings Account, it will continue to be owned by you after leaving State of Nebraska. You can keep the account with Optum Bank and continue to use the money for qualified healthcare expenses. You may be able to make personal contributions to the account or roll over the account into a new HSA. Contact Optum Bank at 866-234-8913 for assistance.

Employee Assistance Program (EAP)

Deer Oaks

Deer Oaks offers free and confidential Work/Life benefits to you and your family up to 18 months after termination. Visit www.deeroaks.com. Company ID and Password: SON. Not all agencies offer an EAP through Deer Oaks.

Long Term Disability (LTD)

Mutual of Omaha

Your Long Term Disability policy ends on midnight the day you terminate. You may continue your long term disability coverage under a Portability Policy. A Portability Application is available on the AS-Employee Wellness & Benefits website under www.link.nebraska.gov. Please contact Mutual of Omaha at 800-877-5176 within 31 days of your termination if you would like to take advantage of the Portability Policy.

Basic & Voluntary Life

Aetna

Your life insurance benefits end on the last day of the month in which you terminate. Participants may convert a portion to a private plan. Please contact Aetna directly at 800-523-5065 within 31 days of your termination date for information on how to convert your policy. A conversion form is available on the AS-Employee Wellness & Benefits website under www.link.nebraska.gov.

Need Help?

If you require additional assistance after contacting the appropriate vendors, please contact AS-Employee Wellness & Benefits at:

Phone: 402-471-4443 or 877-721-2228

Email: as.employeebenefits@nebraska.gov

State of Nebraska wishes you luck in your future endeavors!

COBRA & Retiree Medical, Dental & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2016 through June 30, 2017 are shown below.

Monthly Medical Premiums

		Wellness Health Plan	Regular Health Plan	Consumer Focused Health Plan
Retiree/COBRA Employee Only (Single Coverage)	**Retiree:**	$552.88	$663.08	$377.66
	COBRA:	$563.94	$676.34	$385.21
Retiree/COBRA Employee + Spouse (Two-Party Coverage)	**Retiree:**	$1,465.14	$1,757.16	$1,000.80
	COBRA:	$1,494.44	$1,792.30	$1,020.82
Retiree/COBRA Employee + Dependent Children (Four Party Coverage)	**Retiree:**	$1,133.40	$1,359.32	$774.22
	COBRA:	$1,156.07	$1,386.51	$789.70
Retiree/COBRA Employee + Spouse + Dependent Children (Family Coverage)	**Retiree:**	$1,962.72	$2,353.94	$1,340.70
	COBRA:	$2,001.97	$2,401.02	$1,367.51

Monthly Dental Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	$23.58	$27.54
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	$47.21	$55.12
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	$68.01	$79.48
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	$73.89	$86.29

Monthly Vision Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	$5.41	$8.36
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	$8.67	$13.42
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	$8.85	$13.67
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	$14.24	$22.07

Legal Notifications

Summary Plan Documents

Plan documents are accessible through the Employee Wellness & Benefits Resources page located at www.link.nebraska.gov.

Women's Health and Cancer Rights Act of 1998 (WHRCA)

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits 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
- Treatment of physical complications of the mastectomy, including lymphedema

Your State sponsored health coverage plans comply with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the plan administrator at 402-471-4443.

Mental Health Parity Act

The Mental Health Parity and Addiction Equity Act of 2008 prohibit separate treatment limits for mental illness and substance abuse. It requires equivalent cost sharing and out-of- pocket expenses for these benefits. Coverage must have the financial requirements as any other illness including: deductibles and coinsurance.

Services must still be provided by a qualified physician or licensed psychologist, licensed special psychologist, licensed clinical social worker, licensed mental health practitioner or auxiliary providers supervised by a qualified physician.

Benefits for ALL inpatient admissions must be pre-certified.

Please refer to your Summary Plan Description booklet and Schedule of Benefits for exact benefit language.

Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Employee Wellness & Benefits at 402-471-4443 or 877-721-2228.

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 either of 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).

Cont'd on page 42

Cont'd from page 41 - Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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 January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
Web:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone Outside of Anchorage: 888-318-8890
Phone Anchorage: 907-269-6529

COLORADO – Medicaid
Medicaid Web: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center:
800-221-3943

FLORIDA – Medicaid
Web: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Web: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Web: http://www.hip.in.gov
Phone: 877-438-4479
All other Medicaid
Web: http://www.indianamedicaid.com
Phone: 800-403-0864

IOWA – Medicaid
Web: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Web: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Web: http://chfs.ky.gov/dms/default.htm
Phone: 800-635-2570

LOUISIANA – Medicaid
Web: http://dhh.louisiana.gov/index.cfm/
subhome/1/n/331
Phone: 888-695-2447

MAINE – Medicaid
Web: http://www.maine.gov/dhhs/ofi/public-assistance/
index.html
Phone: 800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Web: http://www.mass.gov/MassHealth
Phone: 800-462-1120

MINNESOTA – Medicaid
Web: http://mn.gov/dhs/ma/
Phone: 800-657-3739

MISSOURI – Medicaid
Web: http://www.dss.mo.gov/mhd/participants/pages/
hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Web: http://dphhs.mt.gov/
MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_
Services/AccessNebraska/Pages/accessnebraska_
index.aspx
Phone: 1-855-632-7633

NEW HAMPSHIRE – Medicaid
Web: http://www.dhhs.nh.gov/oii/documents/hippapp.
pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid & CHIP
Medicaid Web: http://www.state.nj.us/humanservices/
dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Web: http://www.nyhealth.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Web: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Web: http://www.nd.gov/dhs/services/medicalserv/
medicaid/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Web: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Web: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Web: http://www.dhs.pa.gov/hipp
Phone: 800-692-7462

NEVADA – Medicaid
Medicaid Web: http://dwss.nv.gov/
Medicaid Phone: 800-992-0900

SOUTH CAROLINA – Medicaid
Web: http://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Web: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Web: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Web: http://health.utah.gov/medicaid
CHIP Web: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

RHODE ISLAND – Medicaid
Web: http://www.eohhs.ri.gov/
Phone: 401-462-5300

VIRGINIA – Medicaid and CHIP
Medicaid Web: http://www.coverva.org/programs_
premium_assistance.cfm
Medicaid Phone: 800-432-5924
CHIP Web: http://www.coverva.org/programs_
premium_assistance.cfm
CHIP Phone: 855-242-8282

WASHINGTON – Medicaid
Web: http://www.hca.wa.gov/medicaid/premiumpymt/
pages/index.aspx
Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Web: http://www.dhhr.wv.gov/bms/Medicaid%20
Expansion/Pages/default.aspx
Phone: 877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
Web: https://www.dhs.wisconsin.gov/publications/p1/
p10095.pdf
Phone: 800-362-3002

WYOMING – Medicaid
Web: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
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 State of Nebraska 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 with State of Nebraska and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join 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. State of Nebraska has determined that the prescription drug coverage offered by the State of Nebraska 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 to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) 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 State of Nebraska coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current State of Nebraska coverage, be aware that you and your dependents will not be able to get this coverage back.

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 current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current 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 nineteen months without creditable coverage, your premium may consistently be at 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.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through State of Nebraska changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under 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).

Date: April 14, 2016
Name of Entity/Sender: State of Nebraska

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990
FOR USE ON OR AFTER APRIL 1, 2011

Contact--Position/Office: DAS Employee Wellness & Benefits
Address: 1526 K Street, Suite 110, Lincoln, NE 68508
Phone Number: 402-471-4443

Your Rights After a Mastectomy

Women's Health and Cancer Rights Act of 1998

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

These services must be provided in a manner determined in consultation between the attending Physician and the patient.

Call your plan administrator 402-471-4443 for more information.

NOTICE OF PRIVACY PRACTICES OF CERTAIN GROUP HEALTH PLANS

SPONSORED BY STATE OF NEBRASKA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Each Group Health Plan in which you participate is required by federal law to maintain the privacy of your personal health information. Each Plan is also required to give you a Notice which describes its privacy practices, its legal duties and your rights concerning such information. This is the required joint Notice for all group health plans sponsored by State of Nebraska, collectively referred to in this Notice as (the "Plan Sponsor"):

USES AND DISCLOSURES OF YOUR INFORMATION

The Plan is permitted or required to use or disclose your health information without your authorization (permission) to carry out certain services and activities. Health information includes medical information involving your diagnosis or treatment, insurance information, and health care claims and payment information. Many of those services or activities are performed through contracts with outside persons or organizations, such as auditing, actuarial services, administrative services, legal services, etc. It may be necessary for the Plan to provide certain of your health information to these outside persons or organizations who assist the Plan with these functions or activities. The Plan requires these persons and entities to appropriately safeguard the privacy of your information.

The following are the types of uses and disclosures the Plan may make of your health information without your authorization. Where State or federal law restricts one of the described uses or disclosures, the Plan will follow the requirements of such State or federal law. The following are general descriptions only. They do not cover every example of a disclosure within a category.

Treatment. The Plan will make disclosures of your health information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request certain of your health information that the Plan maintains in order to make decisions about your care. We will disclose your medical information to your physician and other practitioners, providers and health care facilities for their use in treating you.

Payment. The Plan will use and disclose your health information as necessary for payment purposes. For example, the Plan may use and disclose your health information to pay claims from doctors, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to determine whether services are medically necessary or to pre-authorize or certify services as covered under your plan of benefits. We may also disclose medical information about you to other health care providers and health plans for their payment purposes. For example, if you have other health coverage, the Plan may disclose your health information to other health care programs or insurance carriers in order to coordinate payment of benefits. The Group Health Plans jointly following this Notice will share your health information for purposes of payment.

Health Care Operations. The Plan will use and disclose your health information as necessary for the Plan's Health Care Operations. For example, the Plan may use and disclose your medical information to conduct quality improvement activities, engage in care coordination or to purchase reinsurance coverage. The Plan may also disclose your health information to another Covered Entity for purposes of that entity's Health Care Operations. For example, another health plan or health care provider may request your health information for purposes of conducting quality assurance and improvement activities, or accreditation, certification, licensing or credentialing activities. The Group Health Plans jointly following this Notice will share your health information for purposes of joint Health Care Operations of the Plan.

Plan Sponsor. The Plan may disclose your health information to the Plan Sponsor to permit the Plan Sponsor to perform plan administration functions on behalf of the Plan. The Plan may disclose "Summary Health Information" to the Plan Sponsor for obtaining bids or for the purpose of amending or terminating the Plan. "Summary Health Information" includes claim history, claim expenses and types of claims by individuals without including any personally identifying information. The Plan may also disclose to the Plan Sponsor information on whether you are participating in the Plan. If the Plan discloses any other health information to the Plan Sponsor without your authorization, the Plan documents will restrict how the information is used and prevent it from being used to make employment decisions about you. The Plan documents restrict the uses and disclosures that the Plan Sponsor may make of your health information, and require the Plan Sponsor to certify that the information provided will be maintained in a confidential manner and not used for employment-related decisions or for other employee benefit determinations without your authorization or in any other manner not permitted by law or the Plan documents.

Information Received Prior to Enrollment. The Plan may receive from you and your health care providers health information prior to your enrollment in the Plan. The Plan will not use or further disclose this health information for any purpose, except as required by law, unless you enroll in the Plan. After enrollment, uses and disclosures are governed by the terms of the Notice then in effect.

Friends and Family. The Plan may disclose health information to family members or friends who are involved in your care or payment for your care to facilitate that person's involvement in caring for you or paying for your care. If you are present, the Plan will give you the opportunity to object before it makes such disclosures. If you are unavailable, incapacitated or are in an emergency situation, the Plan may disclose limited information to these persons if the Plan determines disclosure is in your best interest.

Disaster Relief. The Plan may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.

Deceased Individuals. The Plan may disclose the health information of a deceased individual to a coroner, medical examiner or funeral director to carry out their duties as allowed by law.

Organ Donation. If you are an organ donor, or recipient, the Plan may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Research. The Plan may use or disclose your medical information for research purposes in accordance with certain safeguards.

Law Enforcement. The Plan may disclose your health information to law enforcement authorities for law enforcement purposes, such as reporting wounds of violence and physical injuries or other similar disclosures allowed by the law; in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; if you are the victim of a crime, but only if your agreement is obtained or, under certain limited circumstances, if the Plan is unable to obtain your agreement; about a death which is believed to be the result of criminal conduct; and in emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. The Plan must comply with federal and state laws in making such disclosures.

Public Health Activities. The Plan may disclose medical information about you for public health activities. These activities may include disclosures to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability; to appropriate authorities authorized to receive reports of child abuse and neglect; to the Food and Drug Administration (FDA) or a person subject to the jurisdiction of the FDA for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect and Domestic Violence. The Plan may notify the appropriate government authority if it believes you have been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law, the Plan will only make this disclosure if you agree or, if unable to obtain your agreement, under other limited circumstances when authorized by law.

To Avert a Serious Threat To Health or Safety. Under certain circumstances the Plan may use or disclose Protected Health Information if, in good faith, the use or disclosure is necessary to prevent or lessen the threat and is to a person reasonably able to prevent or lessen the threat (including the subject of the threat) or, under limited circumstances, is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Military and National Security. The Plan may release your health information if you are a member of the armed forces as required by military command authorities. It may also release medical information about foreign military personnel to the appropriate foreign military authority. The Plan may also release your health information to federal authorities, if necessary, for national security or intelligence activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your Protected Health Information 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 health and security of the correctional institution.

Legal Proceedings. If you are involved in a lawsuit or a dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

Workers' Compensation. The Plan may disclose your health information to comply with workers' compensation laws or other similar programs providing benefits for work-related injuries.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Required by Law. The Plan will disclose health information about you when required to do so by federal or state law, including disclosures to the U.S. Department of Health and Human Services upon request for purposes of determining the Plan's compliance with federal law.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. We will make reasonable efforts to limit these incidental uses and disclosures.

Other Uses and Disclosures. Other uses and disclosures of your medical information not covered above will be made only with your written authorization. If you authorize us to use and disclose your information, you may revoke that authorization at any time. Such revocation will not affect any action we have taken prior to the revocation in reliance on your authorization.

INDIVIDUAL RIGHTS

Access to Your Health Information. You have the right to copy and/or inspect the health information that the Plan maintains on your behalf, with limited exceptions. All requests for access must be made in writing and signed by you or your representative. If you request copies, the Plan may charge you a reasonable, cost-based fee for each page, plus an additional amount for postage if you request a mailed copy. If you prefer, the Plan may agree to prepare a summary or an explanation of your health information and may charge a fee to prepare such summary.

Amendment to Your Health Information. You have the right to request in writing that the health information the Plan maintains about you be amended or corrected. The Plan is not obligated to make all requested amendments but will give each request careful consideration. For example, if the Plan did not create the information, your request will be denied. If the Plan denies your request, you will be provided with a written explanation and an explanation of your rights. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment.

Accounting for Disclosures of Your Health Information. You have the right to receive an accounting of certain disclosures made by the Plan of your personal health information after April 14, 2004. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you may be charged a fee for each subsequent accounting you request within the same 12-month period.

Request for Voluntary Restrictions on Use and Disclosure. You have the right to request that the Plan voluntarily place additional restrictions on its use or disclosure of your health information for treatment, payment, Health Care Operations or to persons you identify. The Plan is not required to agree to these additional restrictions, but if it does, it will abide by the agreement (except in an emergency). To be effective, any agreement by the Plan must be in writing signed by a person authorized to make such an agreement on the Plan's behalf. The Plan retains the right to terminate any agreed to restriction upon notification to you of such termination. The termination will only be effective for health information received after providing notice to you.

Confidential Communications. You have the right to request that the Plan communicate with you about your health information by alternative means or at an alternative location. You must make your request in writing to the address listed at the end of this Notice. The Plan is required to accommodate reasonable requests if you inform the Plan that disclosure of all or part of your information could place you in danger, specify the alternative means or location and continue to permit the Plan to collect premiums and pay claims under your health plan, including issuance of explanation of benefits to the subscriber of Plan in which you participate.

Complaints. If you have concerns about any of the Plan's privacy practices or believe that your privacy rights may have violated. You may also submit a written complaint to the U.S. Department of Health and Human Services. The Plan supports your right to protect the privacy of your health information. Neither the Plan nor the Plan Sponsor will retaliate in any way if you chose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Exercising Your Rights. The Plan contracts with outside administrators (the "Administrator") to actually administer and operate the Plan. Under the terms of the arrangement, it is the Administrator, not the Plan, which creates, maintains and uses most or all of the medical information about you. To exercise the individual rights described in this Notice, or to file a complaint, contact:

Medical & Prescription Drug Benefits
UnitedHealthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815
866-633-2446

Dental Benefits
UNIFI Privacy Office
Attn: HIPAA Privacy
P.O. Box 81889
Lincoln, NE 68510
800-487-5553

Vision Benefits
Eyemed
Privacy Office
Luxottica Retail
4000 Luxottica Place
Mason, OH 45040
513-765-4321

FSA Benefits
ASI Flex
Attn: HIPAA Privacy
201 W Broadway, Suite 4-C
Columbia, MO 65203
800-659-3035

ABOUT THIS NOTICE

The Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all of your personal health information that it maintains, including that which it created or received while the prior Notice was in effect. If the Plan makes a material change to its privacy practices, it will revise its Notice and provide you with a copy of the revised Notice.

If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact the Privacy Officer at the address listed below to obtain a written copy of this Notice.

CONTACT INFORMATION

PRIVACY OFFICER: For questions about this Notice, contact the Plan's Privacy Officer at:

Wellness & Benefits Administrator
Attn: HIPAA Privacy Officer
1526 K Street, Suite 110
Lincoln, NE 68508
402-471-2832

EFFECTIVE DATE OF NOTICE: April 1, 2016.

NOTES:

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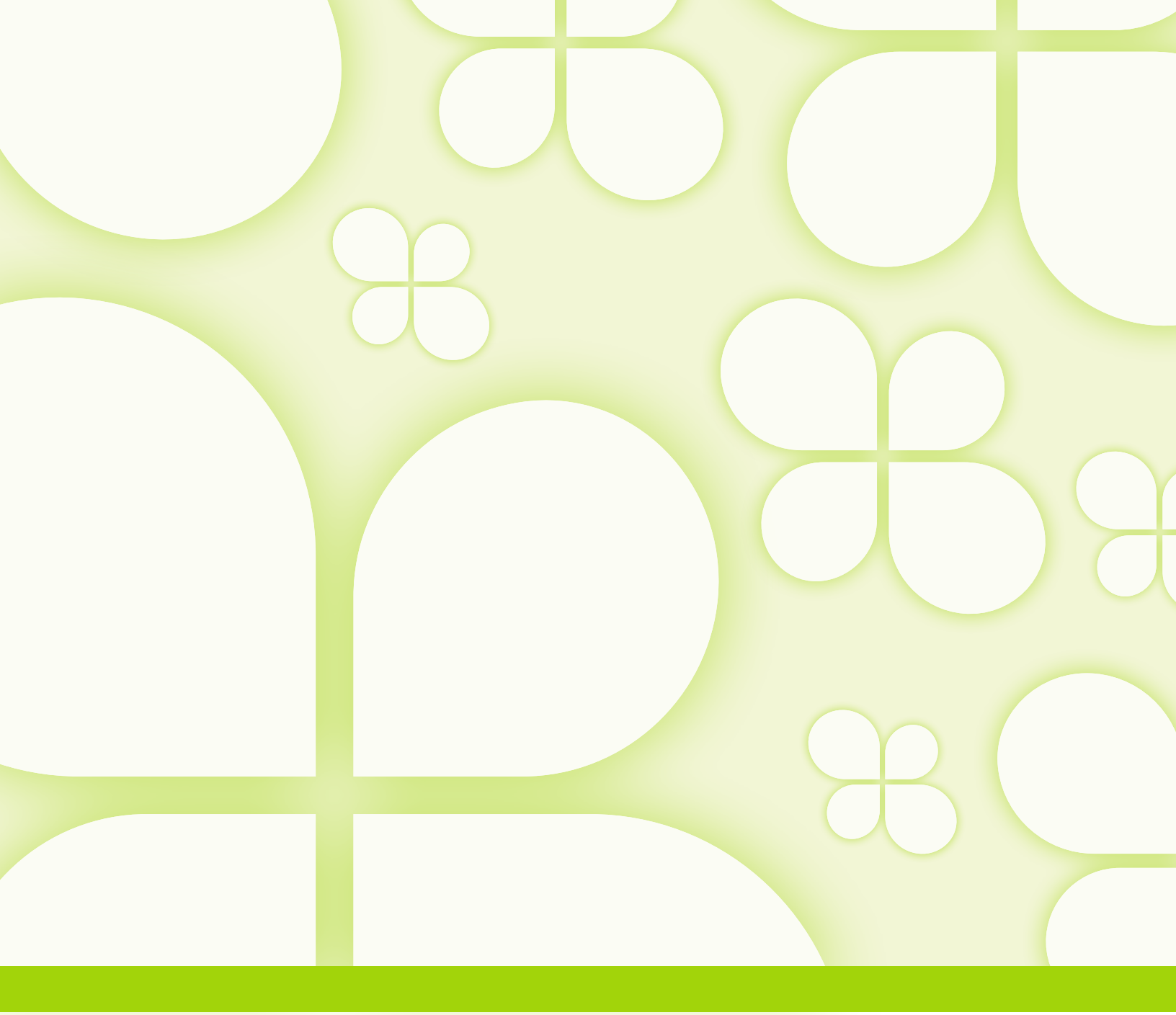

NEBRASKA Administrative Services

Employee Wellness & Benefits
1526 K Street, Suite 110
Lincoln, NE 68508

das.nebraska.gov/benefits.html