This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document.
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**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 at [das.nebraska.gov/benefits](http://das.nebraska.gov/benefits) for exact benefits, exclusions and limitations.
Welcome

Dear Nebraska Teammates,

Welcome to the 2018-2019 Options Guide. We are pleased to provide you with this summary highlighting your employee benefits and programs available to State of Nebraska teammates. Please use this as a resource to review the many benefit options available to you and to assist you in selecting those benefits that best meet the needs of you and your family.

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 enhance your personal responsibilities and work/life balance.

There are few important changes to address for the upcoming plan year. Please be sure to review these changes and seek clarification prior to the Open Enrollment period, Tuesday May 8, 2018 beginning at 7a.m. CST through Tuesday May 22, 2018 at 5p.m. CST.

These changes include:

• Health Fitness – As of April 30, 2018 Health Fitness will no longer be the third party administrator of the wellNEssoptions programming. If you have completed all of the requirements to qualify for the Wellness Incentive for July 1, 2018, you will see the WellNebraska Plan (with incentives) as an option during Open Enrollment. If you failed to meet the requirements, you were notified by letter, in January, of your non-qualification status. You will have to select another plan option.

• Real Appeal – Effective April 1, 2018, your UnitedHealthcare medical plan option will offer a new benefit, Real Appeal. Real Appeal is an online weight loss and healthy lifestyle program based on the science of what really works to help people lose weight and keep it off. It is available at no cost to all eligible State of Nebraska teammates and their family members age 18 and older who are enrolled in State of Nebraska medical coverage through UnitedHealthcare. For additional information on this program see page 17 of this guide.

• All State of Nebraska teammates are expected to log into the Employee Work Center and complete the Open Enrollment process. While you are logged in and making your Open Enrollment plan selections, please verify and update any contact information (address, email, phone number, etc.) for you, your dependents and your beneficiaries. It is important that we have current contact information.

• Critical details are included in this Options Guide, however please remember that this document is designed to be a summary of the offered benefits. For specific information about each plan, be sure to visit our website at das.nebraska.gov/benefits.

If you have questions, please talk to your Human Resource representative or visit with an Employee Wellness and Benefits Specialist by calling 402-471-4443 or 877-721-2228 during business hours or at as.employeebenefits@nebraska.gov.

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

Sincerely,

Christy Osentowski
Wellness and Benefits Manager
Department of Administrative Services - State Personnel

Open Enrollment 2018

If you are currently enrolled in benefits for 2017-2018 all of your current elections will be pre-populated for you EXCEPT medical and dependent care FSA or HSA deductions. You must manually adjust those dollar amounts. Please log in to verify your benefits, update your contact info and print your confirmation page for Open Enrollment.

If you failed to qualify for the Wellness Incentive, you must select an alternate plan. Your WellNebraska Plan with incentive will end as of 6/30/18 and you will be left with no coverage for 2018-2019.
**New Hire Information**

Welcome to employment with the State of Nebraska! We are pleased to provide you with this comprehensive guide to your 2018-19 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

<table>
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<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td>Review your options.</td>
<td>Discuss with family members.</td>
</tr>
<tr>
<td>Prepare list of your dependents with SSN &amp; Date of Birth</td>
<td>You will need this information to enroll dependents in coverage, list as beneficiary and your emergency contact.</td>
</tr>
<tr>
<td>Medical Insurance</td>
<td>Elect or waive coverage. Choose plan, tier, and covered dependents (if any).</td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>Elect or waive coverage. Choose plan, tier, and covered dependents (if any).</td>
</tr>
<tr>
<td>Vision Insurance</td>
<td>Elect or waive coverage. Choose plan, tier, and covered dependents (if any).</td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>Only available if enrolled in a Consumer Focused Health Plan. Select or waive your contributions. You can change your contribution amounts anytime throughout the year.</td>
</tr>
<tr>
<td>FSA Healthcare</td>
<td>Enroll or waive your annual contributions. Plan wisely – unclaimed contributions are forfeited.</td>
</tr>
<tr>
<td>FSA Dependent Care</td>
<td>If you pay for dependent care while you are working, select your annual contributions. Plan wisely – unclaimed contributions are forfeited.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Add your beneficiary. If part-time, you can waive coverage.</td>
</tr>
<tr>
<td>AD&amp;D Life Insurance</td>
<td>Elect or waive coverage. Add your beneficiary. <em>You must be enrolled in Basic Life to enroll in AD&amp;D Life Insurance.</em></td>
</tr>
<tr>
<td>Supplemental Life Insurance</td>
<td>Elect or waive coverage for yourself and eligible dependents and choose level of coverage. Add your beneficiary if choosing employee supplemental life. <em>You must be enrolled in Basic Life to enroll in Supplemental Life Insurance.</em></td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Elect or waive coverage. Choose level of coverage.</td>
</tr>
<tr>
<td>Wellness Programs</td>
<td>Automatically added to WellNebraska with incentives with no requirements for new hires that are eligible between 7/1/18 - 6/30/19</td>
</tr>
</tbody>
</table>

### How to Enroll in Coverage

- Sign into the Employee Work Center.
- Click on your Inbox icon.
- Make your benefit elections.
- Print your confirmation statement.

For more detailed instructions, visit [www.link.nebraska.gov](http://www.link.nebraska.gov) and choose "Employee Work Center – Benefits and Deductions" from the User Guides section.

### Questions?

- Talk to your Agency Human Resources representative.
- Visit [das.nebraska.gov/benefits](http://das.nebraska.gov/benefits).
- Contact Employee Wellness & Benefits
  - Call 402-471-4443
  - Call 877-721-2228, if outside Lincoln
  - Email as.employeeprograms@nebraska.gov
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 at das.nebraska.gov/benefits 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.

Options

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: das.nebraska.gov/benefits

Holidays

For the 2018-19 benefit year, our office will be closed on all State holidays including:

- Independence Day: Wednesday, July 4, 2018
- Labor Day: Monday, September 3, 2018
- Columbus Day: Monday, October 8, 2018
- Veterans Day: Monday, November 12, 2018
- Thanksgiving Day: Thursday, November 22, 2018
- Day after Thanksgiving: Friday, November 23, 2018
- Christmas Day: Tuesday, December 25, 2018
- New Year's Day: Tuesday, January 1, 2019
- Martin Luther King Jr. Day: Monday, January 21, 2019
- President's Day: Monday, February 18, 2019
- Arbor Day: Friday, April 26, 2019
- Memorial Day: Monday, May 27, 2019
### Benefit Plan Eligibility & Enrollment

Coverage becomes effective the 1st of the month following 30 days of employment

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<th>Plan Type</th>
<th>Employment Status</th>
<th>Eligibility</th>
<th>How/When to Enroll</th>
<th>Are Dependents Eligible</th>
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<tr>
<td>Health Insurance UnitedHealthcare</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6-month temporary</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Health Savings Account Optum Bank</td>
<td>Employees enrolled in State’s Consumer Focused Health Plan</td>
<td></td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision Insurance EyeMed</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Insurance Ameritas</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-month temporary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Life Insurance/AD&amp;D Insurance Aetna</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplement Life Insurance Aetna</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Term Disability Mutual of Omaha</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-month temporary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Program Deer Oaks EAP</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Auto Enrollment For Participating Agencies only</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSA – Healthcare ASI Flex</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSA – Dependent Care ASI Flex</td>
<td>Full-time</td>
<td>Eligible</td>
<td>Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-month temporary</td>
<td></td>
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</tbody>
</table>

**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 health insurance premium as full-time employees.

- **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 the 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.

---

**Open Enrollment**

**Begins:** Tuesday, May 8, 2018, 7:00 a.m. CST.

**Ends:** Tuesday, May 22, 2018, 5:00 p.m. CST.
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)

LB551 – Dependents up to Age 30

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 (age 26), 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 turning age 26, 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.

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 a state 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 which will verify each dependent. You will have approximately 30 days to respond so please be prepared.

PLEASE WATCH YOUR MAIL FOR THE APPROPRIATE DOCUMENTS. 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).
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 (see next page for list of qualifying life events).

Open Enrollment
Open Enrollment for the state’s 2018-19 plan year benefits runs May 8-22, 2018, with coverage changes effective July 1, 2018. You will make changes in the Employee Work Center (EWC).

Qualifying Life Events
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.**

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 within the first 30 days 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, your divorce is considered final six months after the decree is rendered and, your ex-spouse may remain an eligible dependent for medical, dental and vision coverage through the six month waiting period. However, you may elect to discontinue coverage for your ex-spouse within 30 days of the date the decree

**IMPORTANT!**
You have 30 days from the date of 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.
Qualifying Life Events:

- 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 the state).
- Health Care Market Place changes are not a qualified event.

is rendered. (For example; employee goes to court and, decree is rendered on May 15th, with the 30 day waiting period extended to June 13th. You will have until July 12th to initiate the change request. No refunds or retro terminations are allowed; coverage will terminate at the end of the month in which the request is made. If the request is not made by July 12th, your next opportunity will be after the six month waiting period or, November 13th.)

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 proof of prior 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.

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 and tiers you had on your last day of employment. The waiting period is waived and 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 and coverage will begin the first day of the month following the 30 day waiting period.

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. However, if you’re on a qualifying HSA health plan (Consumer Focused Health Plan) your HSA contributions may be reinstated.

For more information on any of these events or making changes to your elections, contact your agency HR representative.
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 include both in-network and out-of-network coverage. New participants will receive an insurance card mailed to your home from UHC.

- Regular Plan
- Consumer Focused Health Plan (with Health Savings Account Eligibility)
- WellNebraska (with or without incentive)

Wellness Incentive Eligibility
New hires are eligible to elect the WellNebraska Health Plan with no requirements to complete between 7/1/18 - 6/30/19.

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

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.

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

1. Save the myNurseLine phone number: 877-263-0911
   It’s FREE for anyone insured under a State of Nebraska health plan.
2. When you compare plans, look at both premiums and out-of-pockets costs.
3. Shop around and compare prices and quality of doctors, facilities, and pharmacies (see page 13 for ways to become an educated consumer).
4. Choose the lowest cost alternative drugs.
5. Write down your questions to ask when you go to the doctor. It’s easy to feel overwhelmed and forget.
7. Set aside money for unplanned healthcare expenses. The Health Savings Account is a great solution for this if you are enrolled in the Consumer Focused Plan.
8. 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 your doctor.
9. Set up your www.myuhc.com account and start shopping for more ways to save money on your health!
10. Register for Virtual Visits (see page 14).

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.
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.

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

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**Network Providers**

**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 [www.myuhc.com](http://www.myuhc.com).

**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.

**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.*
- Healthy 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.

* A nurse may call you regarding specialty care or diabetes disease management and new programs.

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**Questions?**
Visit das.nebraska.gov/benefits or call UnitedHealthcare Customer Care at 877-263-0911.

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**Watch for Your Health Insurance Cards in the Mail!**
Start using your new card on July 1, 2018.

You can also print your own card on [www.myuhc.com](http://www.myuhc.com) any time after your benefits effective date.

Please note: if a teammate selects a new plan they will receive a new card. (i.e. going from WellNebraska with Incentive to the Regular plan)
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.

- Compare the cost of procedures among several providers
- 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
- Order refills for your mail order prescriptions
- Learn what’s covered as preventive care for your age

Money-Saving Tools

Find and Compare Cost
Login to www.myuhc.com or the Health4Me mobile app 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.
- See how that cost is impacted by your deductible, co-insurance, and out-of-pocket maximum
- Select a provider.

Telemental Health

Copay will apply
There are two ways to access Telemental Health:

1. Through www.myuhc.com
   a. Log into your www.myuhc.com account
   b. Click on “Physicians & Facilities”
   c. Then, “find mental health or substance abuse provider”
   d. Then, “Telemental Health”

2. Through the Virtual Visits Provider Sites on www.myuhc.com and the Health4Me mobile app
   a. Select either Doctor on Demand or AmWell
   b. Create an account or login
   c. Schedule an appointment by date or provider

(Please note: due to the length and complexity of this type of visit, the outpatient Copay will apply.)

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
- Compare the cost of procedures among several providers
**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 www.myuhc.com or the Health4Me App and click on Virtual Visits.

2. Choose a provider group and click through to their website. Once you make that choice, you leave www.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” visits to a brick-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 your visit, you will be asked to describe your symptoms and health concerns.

6. Diagnosis and Prescription - The treating physician will provide a diagnoses and likely ask about your primary care physician so any notes can be shared. The virtual visit physician will then create an integrated medical record with full documentation. You can access this record once the visit is complete so you can email it or print and bring it to your primary care physician. If required, the virtual visit doctor can write a prescription that is sent electronically to your chosen pharmacy, where you can pick it up.

**Virtual Visits Rate**

<table>
<thead>
<tr>
<th>WellNebraska Plan</th>
<th>Regular Health Plan</th>
<th>Consumer Focused Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 copay</td>
<td>$10 copay</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

You will be 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 in 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

**FREE myNurseLine**

877-263-0911

24 hours a day, 7 days a week

MonTTY: 711

**myNurseLine**

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

- Speak with a registered nurse
- Understand your symptoms and treatment options
- Ask medication questions
- Decide if you should use virtual visits, see a doctor, go to the ER, or try self-care
- Find a doctor, hospital, or specialist
- Make an appointment with your provider
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 2018-19, the in network 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 2018-19, the most you’ll pay in a year is $4,100 for in network 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.
The WellNebraska Health Plan is a plan option open to State employees. Like our other plan options (the Regular Plan and the Consumer Focused Plan), the WellNebraska Health Plan offers comprehensive medical and pharmacy coverage at competitive prices.

**Eligibility & Participation**

Any employee is eligible to enroll in the WellNebraska Health Plan. However, employees and spouses (if applicable) who choose this option will benefit from reduced premiums and lower out-of-pocket costs for certain benefits. New hires eligible for benefits as of July 1, 2018 - June 30, 2019 have no qualification requirements.

If you and your spouse (if applicable) qualified for the wellness incentives for the 2018-19 health plan year by:

- Completing a Biometric Screening and online Health Assessment by May 31, 2017;
- Signing up for an eligible wellness program by May 31, 2017; and
- Completing the wellness program by March 31, 2018.

Then you must select the WellNebraska Health Plan to receive your wellness incentives. When a qualifying employee selects this plan, he or she will see the following premium amounts populate on the right-hand side of the health insurance area of the Open Enrollment form, confirming his or her eligibility.

<table>
<thead>
<tr>
<th>Employee Only</th>
<th>$63.42 bi-weekly or $126.84 monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee &amp; Spouse</td>
<td>$168.08 bi-weekly or $336.16 monthly</td>
</tr>
<tr>
<td>Employee &amp; Children</td>
<td>$130.02 bi-weekly or $260.04 monthly</td>
</tr>
<tr>
<td>Family</td>
<td>$225.16 bi-weekly or $450.32 monthly</td>
</tr>
</tbody>
</table>

If you select the new WellNebraska Health Plan and see higher premium rates populated on the right-hand side of your Open Enrollment form, this indicates that you did not attempt and/or meet all requirements in order to be eligible for the wellness incentives. Rest assured, however, that you will still receive access to the same coverage as other employees enrolled in the WellNebraska Health Plan. You will not, however, be eligible for lower copays, deductibles, and premiums.

Those enrolled in the Wellness Health Plan in 2017-18 but did not complete all steps to qualify for the 2018-19 wellness incentives, as well as those in other health plan options who took some action to qualify but did not complete one or more steps, were notified by mail, email, and/or phone prior to Open Enrollment. However, if you believe you should qualify for the wellness incentives but are not seeing the premiums referenced to the left, you MUST complete your Open Enrollment session, print a confirmation report, and contact the State Employee Wellness and Benefits office at 402-471-4443 or 877-721-2228 to speak with a Wellness and Benefits representative.

**Wellness Incentives**

Employees and spouses who completed the required qualifying steps between April 2017 and March 2018 will be eligible to enroll in the wellness incentive during Open Enrollment in May 2018.

**Wellness Incentive Advantages**

- Plan with lowest deductible and annual out-of-pocket maximums
- All lab and pathology work is covered up to $500
- No age restrictions for preventive screenings
- 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

**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.
Wellness Programs from UnitedHealthcare

Rally℠
Achieving our health goals is a journey, and sometimes it’s not easy. That’s why we are thrilled to introduce Rally℠, a UnitedHealthcare® digital health and wellness experience.

Rally can help you make simple changes to your daily routine, set smart goals and stay on target. After completing a quick and fun survey, you’ll get personalized recommendations to get you moving more, eating better, feeling happier — and you’ll have fun doing it.

As a member of UnitedHealthcare, you have access to Rally at no additional cost.

How Rally can help you:
Discover your Rally Age — a way for you to measure your health
• Get personalized health tips
• Earn chances to win rewards for taking healthy actions
• Get full access to your personal health records

Enjoy all the benefits of Rally today. Get started at myuhc.com.

Real Appeal
Effective April 1, 2018, your UnitedHealthcare medical plan option will offer a new benefit: Real Appeal. Real Appeal is an online weight loss and healthy lifestyle program based on the science of what really works to help people lose weight and keep it off. It is available at no cost to all eligible State of Nebraska teammates and their family members age 18 and older who are enrolled in State of Nebraska medical coverage through UnitedHealthcare.

Real Appeal helps you lose weight and reduce your risk of developing certain diseases like diabetes and cardiovascular disease as it’s based on decades of proven clinical research. Most members lose an average of 10 pounds after completing only four sessions of the program. Enrollment in the program includes:
• 52 weeks of access to a Transformation Coach. Your coach guides you through the program and develops a simple, customized plan that fits your needs, preferences and goals.
• 24/7 access to digital tools and dashboards that help you track your food, activity, and weight.

A success kit full of healthy weight management tools including fitness guides, recipe book (including quick family meal ideas and fast-food eating tips), weight scale, and more.
• Support from weekly online group classes to learn healthy ideas from your coach and other members who share what’s helped them achieve success.

Real Appeal is a fun and engaging program that helps you learn simple steps for a healthier life so you can spark your transformation. Learn more and enroll today at: nebraska.realappeal.com.

For customer service questions please call 844-344-REAL (7325) or email help@realappeal.com.

What is allowed during work hours?
Submitting activities is allowed on a State computer, but is 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 allowed for participation during work hours:

<table>
<thead>
<tr>
<th>Open Enrollment</th>
<th>Health assessment</th>
<th>Email or call Real Appeal using your work e-mail or phone (not for coaching or weekly sessions)</th>
</tr>
</thead>
</table>

If in doubt, refer to your personnel policy, or ask your supervisor.
Health Savings Account (HSA)

HSA Provided by Optum Bank

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 future healthcare needs – even into 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 healthcare 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 on whether or not you carry dependent coverage. You’ll need to make sure your contributions don’t put you over the annual maximum.

**The 2018 maximum limits are:**

- $3,450 for individual coverage
- $6,850 for family coverage
- If you’re age 55 or older, you can contribute an additional $1,000 to your HSA during the plan year

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 online 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.

Can You Open an HSA?

Because you don’t pay taxes on HSA contributions, 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 a general-purpose 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
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 healthcare provider.
- Reimburse yourself for qualified healthcare expenses from your HSA.
- Pay bills for qualified expenses online at no charge, or pay with checks linked to your HSA, if you choose to purchase them.
- Save for future healthcare expenses.

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
- Toothbrushes or toothpaste
- Swimming lessons
- Teeth whitening

How is it different from an 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 listed below. For a complete listing, see IRS Publication 502 at www.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, or tax-deductible health insurance
- Hearing aids
- Laboratory fees
- Laser eye surgery
- Physical therapy
- Psychiatric care
- Speech therapy
- Stop-smoking programs
- Walker
- Wheelchair

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

- 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 the end of the plan year will be forfeited.
- Money cannot be transferred from a Health Care FSA to the Dependent Care (Daycare) FSA and vice versa.
- ASIFlex 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 FSAs and eligible expenses, go to ASIFlex website at www.ASIFlex.com or visit das.nebraska.gov/benefits.

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.

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

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 ASIFlex account and click on the FlexMinder icon.
- **ASIFlex Mobile App** - Check your FSA balance and file claims from your mobile device. Available online or from Google Play Store or the App Store.
- **ASIFlex Card** - Visit the ASI website at www.ASIFlex.com/debitcards for more information on use of the card and to view a list of merchants where you can use your ASIFlex Card.
Dependent Care FSA

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, 2018, to June 30, 2019.
- You have until October 31, 2019, to file a claim for reimbursement. Any balance left in your account after October 31, 2019, 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, babysitting, 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.

*Please make sure you are selecting the correct FSA.

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 $2,650 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 ASIFlex to cancel.
- Claims must be incurred between July 1, 2018, and June 30, 2019.
- You have until October 31, 2019, to file a claim for reimbursement. Any balance left in your account after October 31, 2019, will be forfeited.

NOTE: 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 (e.g. face lifts, teeth whitening, veneers, etc.)
- 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

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.

FLEXIBLE SPENDING ACCOUNTS (FSA)
Medical, Dental, & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2018, through June 30, 2019, 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, meaning you do not pay taxes on them as they are deducted from your pay before taxes are withheld.

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.

### Monthly Medical Plan Premiums

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>With Wellness Incentive</th>
<th>Without Wellness Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FULL-TIME</td>
<td>PART-TIME</td>
</tr>
<tr>
<td>Employee Only (Single Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$126.84</td>
<td>$207.80</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$477.22</td>
<td>$396.26</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$604.06</td>
<td>$604.06</td>
</tr>
<tr>
<td>Employee + Spouse (Two-Party Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$336.16</td>
<td>$550.66</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$1,264.60</td>
<td>$1,050.10</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$1,600.76</td>
<td>$1,600.76</td>
</tr>
<tr>
<td>Employee + Dependent Children (Four-Party Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$260.04</td>
<td>$425.98</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$978.26</td>
<td>$812.32</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$1,238.30</td>
<td>$1,238.30</td>
</tr>
<tr>
<td>Employee + Spouse + Dependent Children (Family Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$450.32</td>
<td>$737.66</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$1,694.06</td>
<td>$1,406.72</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$2,144.38</td>
<td>$2,144.38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Regular Health Plan</th>
<th>Consumer Focused Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FULL-TIME</td>
<td>PART-TIME</td>
</tr>
<tr>
<td>Employee Only (Single Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$153.22</td>
<td>$250.98</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$576.38</td>
<td>$478.62</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$729.60</td>
<td>$729.60</td>
</tr>
<tr>
<td>Employee + Spouse (Two-Party Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$406.02</td>
<td>$665.10</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$1,527.40</td>
<td>$1,268.32</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$1,933.42</td>
<td>$1,933.42</td>
</tr>
<tr>
<td>Employee + Dependent Children (Four-Party Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$314.08</td>
<td>$514.50</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$1,181.58</td>
<td>$981.16</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$1,495.66</td>
<td>$1,495.66</td>
</tr>
<tr>
<td>Employee + Spouse + Dependent Children (Family Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Cost:</strong></td>
<td>$543.90</td>
<td>$890.98</td>
</tr>
<tr>
<td><strong>State Cost:</strong></td>
<td>$2,046.16</td>
<td>$1,699.08</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$2,590.06</td>
<td>$2,590.06</td>
</tr>
</tbody>
</table>

**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 Vision Plan Premiums

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only (Single Coverage)</td>
<td>$5.34</td>
<td>$8.30</td>
</tr>
<tr>
<td>Employee + Spouse (Two-Party Coverage)</td>
<td>$8.58</td>
<td>$13.28</td>
</tr>
<tr>
<td>Employee + Dependent Children (Four-Party Coverage)</td>
<td>$8.76</td>
<td>$13.52</td>
</tr>
<tr>
<td>Employee + Spouse + Dependent Children (Family Coverage)</td>
<td>$14.10</td>
<td>$21.84</td>
</tr>
</tbody>
</table>

### Monthly Dental Plan Premiums

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only (Single Coverage)</td>
<td>$23.84</td>
<td>$27.84</td>
</tr>
<tr>
<td>Employee + Spouse (Two-Party Coverage)</td>
<td>$47.72</td>
<td>$55.72</td>
</tr>
<tr>
<td>Employee + Dependent Children (Four-Party Coverage)</td>
<td>$68.72</td>
<td>$80.32</td>
</tr>
<tr>
<td>Employee + Spouse + Dependent Children (Family Coverage)</td>
<td>$74.64</td>
<td>$87.20</td>
</tr>
</tbody>
</table>

**NOTES**
# Your Health Insurance Benefits

**WellNebraska Health Plan**

<table>
<thead>
<tr>
<th>With Wellness Incentive</th>
<th>Without Wellness Incentive*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Deductible</strong> (must be satisfied before coinsurance is paid)</td>
<td><strong>Plan Year Deductible</strong> (must be satisfied before coinsurance is paid)</td>
</tr>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>$800 individual</td>
<td>$1,600 individual</td>
</tr>
<tr>
<td>$1,600 family</td>
<td>$3,200 family</td>
</tr>
<tr>
<td>Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, &amp; medical co-pays)</td>
<td>Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, &amp; medical co-pays)</td>
</tr>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>$2,700 individual</td>
<td>$5,400 individual</td>
</tr>
<tr>
<td>$5,400 family</td>
<td>$10,800 family</td>
</tr>
<tr>
<td>Annual Pharmacy Out-of-Pocket Maximum</td>
<td>Annual Pharmacy Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>$2,000 individual</td>
<td>$4,000 family</td>
</tr>
</tbody>
</table>

**Physician Office Visits**

<table>
<thead>
<tr>
<th>Primary Care Physician Office visit</th>
<th>Specialty Office visit</th>
<th>Virtual Visits</th>
<th>Allergy testing / serum</th>
<th>Allergy shots</th>
<th>Lab and Pathology Services</th>
<th>Radiology and Chemotherapy/Radiation Therapy</th>
<th>Routine Vision Exam plus Refraction</th>
<th>Preventive Exams</th>
<th>Emergency Care</th>
<th>Hospital Services</th>
<th>Behavioral Health Services</th>
<th>Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For further description of WellNebraska Health Plan without incentives, see page 16.**

*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 at das.nebraska.gov/benefits for exact benefits, exclusions and limitations.*
# HEALTH INSURANCE CHART & PREMIUMS

## Regular Health Plan

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Deductible</strong> (must be satisfied before coinsurance is paid)</td>
<td>$1,400 individual</td>
<td>$2,800 individual</td>
</tr>
<tr>
<td></td>
<td>$2,600 family</td>
<td>$5,200 family</td>
</tr>
<tr>
<td><strong>Annual Medical Out-of-Pocket Maximum</strong> (deductible, coinsurance, &amp; medical co-pays)</td>
<td>$4,000 individual</td>
<td>$8,000 individual</td>
</tr>
<tr>
<td></td>
<td>$8,000 family</td>
<td>$16,000 family</td>
</tr>
<tr>
<td><strong>Annual Pharmacy Out-of-Pocket Maximum</strong></td>
<td>$2,250 individual</td>
<td>$4,500 family</td>
</tr>
<tr>
<td></td>
<td>$4,500 family</td>
<td></td>
</tr>
</tbody>
</table>

## Consumer Focused Health Plan (HSA Eligible)

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Deductible</strong> (must be satisfied before coinsurance is paid)</td>
<td>$2,600 individual</td>
<td>$5,200 individual</td>
</tr>
<tr>
<td></td>
<td>$5,200 family</td>
<td>$10,400 family</td>
</tr>
<tr>
<td><strong>Annual Medical Out-of-Pocket Maximum</strong> (deductible, coinsurance, &amp; medical co-pays)</td>
<td>$4,100 individual</td>
<td>$8,200 individual</td>
</tr>
<tr>
<td></td>
<td>$8,200 family</td>
<td>$16,400 family</td>
</tr>
<tr>
<td><strong>Annual Pharmacy Out-of-Pocket Maximum</strong></td>
<td>Included in the medical out-of-pocket maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Physician Office Visits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician Office visit</td>
<td>$45 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Specialty Office visit</td>
<td>$55 copay</td>
<td></td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>$10 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Allergy testing / serum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy shots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab and Pathology Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology and Chemotherapy/Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Vision Exam plus Refraction</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

## 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.

## Emergency Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>20%; deductible waived</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>$55 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

## Hospital Services

- Inpatient and outpatient hospital services
- Approved skilled nursing facility
- Home health care, Hospice care

## Behavioral Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$45 copay</td>
<td></td>
</tr>
</tbody>
</table>

## Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Office visit (Limit 30 sessions per year)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Therapy - Occupational, Physical, Speech (Limit 20 sessions each per year)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hearing aids &amp; exam (Limit $3,500 every 3 years)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 das.nebraska.gov/benefits or the Pharmacy page on www.myuhc.com.

Smoking Cessation Products

Select over-the-counter and prescription tobacco cessation products will be covered at $0 cost-share for eligible members on all three health plans. To qualify, members must:

- Be age 18 or older
- 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.

Get registered at myuhc.com

Upon enrolling in a State of Nebraska health plan, you will receive a welcome kit from UnitedHealthcare. Go online 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.

Prescription Drug List

The pharmacy program offers flexibility and choice in finding the right medication for you. The Advantage PDL promotes medications with the greatest overall healthcare value, regardless of brand or generic status, while offering affordable choices. This aligns the cost share level with the overall healthcare value of the medication and makes the highest-value medications more affordable. Drugs can be placed in any tier based on their overall healthcare value. Drugs may be moved between tiers (up or down) on January 1 and July 1. To learn more about the tiers, covered drugs, and a list of network pharmacies, go to the Prescription Plan page on the Employee Wellness & Benefits web page at das.nebraska.gov/benefits.

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. Continuous blood glucose monitors, 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.
## Your Pharmacy Benefits

<table>
<thead>
<tr>
<th></th>
<th>WellNebraska Plan</th>
<th>Regular Health Plan</th>
<th>Consumer Focused Health Plan (HSA Eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RETAIL - 30 DAY SUPPLY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>$5 copay</td>
<td>$5 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$30 copay</td>
<td>$40 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$50 copay</td>
<td>$60 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$60 copay</td>
<td>$80 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$100 copay</td>
<td>$120 copay</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Pharmacy Out-of-Pocket Maximum</td>
<td>$2,000 - individual</td>
<td>$2,250 - individual</td>
<td>Included in the medical out-of-pocket maximum</td>
</tr>
<tr>
<td></td>
<td>$4,000 - family</td>
<td>$4,500 - family</td>
<td></td>
</tr>
</tbody>
</table>

**WellNebraska Health Plan ONLY (with Wellness Incentive)**

**DIABETIC, HYPERTENSION, AND HIGH CHOLESTEROL PRESCRIPTIONS**

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

**Consumer Focused Health Plan ONLY**

**UHC PREVENTIVE DRUG LIST (FORMULARY)**

For list, go to Wellness & Benefits Resources page at das.nebraska.gov/benefits

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

**Pay the Difference**

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

**WellNebraska 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 24-25. 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.
What is a specialty medication?

An injectable, oral, or inhaled medication is most often considered a 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
- Is not typically available at retail pharmacies

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.
Vision Benefits

State of Nebraska employees who elect vision benefits will enjoy the advantage of America’s largest vision care network, comprised of independent providers and top optical retailers. This means you get access to more convenient evening and weekend hours to fit anyone’s schedule.

Employees can 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 however an ID card is not needed to obtain benefits.

Accessing your vision care benefit is easy:

- Find a provider near you by logging into EyeMed.com and selecting the Insight Network to schedule an appointment with a simple phone call or stop by one of the many retail 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 in the Google Play Store or the App Store for easy access on the go.

**NOTE:** Vision benefits are available once every Plan Year.

### 2018-19 Plan Year

Just as a reminder, **Insight Network** is the network you choose when searching for an in-network provider.

### Monthly Vision Plan Premiums

<table>
<thead>
<tr>
<th></th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Single Coverage)</td>
<td>$5.34</td>
<td>$8.30</td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Two-Party Coverage)</td>
<td>$8.58</td>
<td>$13.28</td>
</tr>
<tr>
<td><strong>Employee + Dependent Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Four-Party Coverage)</td>
<td>$8.76</td>
<td>$13.52</td>
</tr>
<tr>
<td><strong>Employee + Spouse + Dependent Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Family Coverage)</td>
<td>$14.10</td>
<td>$21.84</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam</strong></td>
<td>$10 copay Every 12 months</td>
<td>$10 copay Every 12 months</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>80% over $105 Every 24 months</td>
<td>80% over $120 Every 12 months</td>
</tr>
</tbody>
</table>

**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**

- Single, Bifocal, Trifocal
- Standard Progressive Lens
- Premium Progressive Lens

**Contact Lenses**

- Conventional
- Disposable

**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 **º**Policy 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.

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

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.
### Ameritas Dental Plan Benefits

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>$50 per individual</td>
<td>$50 per individual</td>
</tr>
<tr>
<td>Deductible Basic &amp; Major Procedures Only</td>
<td>$150 per family</td>
<td>$150 per family</td>
</tr>
<tr>
<td>Type 1 - Preventive</td>
<td>Plan covers 100%</td>
<td>Plan covers 50%</td>
</tr>
<tr>
<td>Type 2 - Basic</td>
<td>Plan covers 80%</td>
<td>Plan covers 50%</td>
</tr>
<tr>
<td>Type 3 - Major</td>
<td>Plan covers 50%</td>
<td>Plan covers 25%</td>
</tr>
<tr>
<td>Benefit Year Maximum</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Dental Rewards®</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

**ORTHODONTICS & TMJ**

<table>
<thead>
<tr>
<th>Coinsurance (No Deductible)</th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan covers 50% (To age 19)</td>
<td>Plan covers 25% (To age 19)</td>
<td>Plan covers 50% (Adults &amp; Children)</td>
</tr>
<tr>
<td>Lifetime Maximum (per person)</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Dental Rewards®</td>
<td>Excluded</td>
<td>Excluded</td>
</tr>
</tbody>
</table>

### Find a Participating Provider


**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

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only (Single Coverage)</td>
<td>$23.84</td>
<td>$27.84</td>
</tr>
<tr>
<td>Employee + Spouse (Two-Party Coverage)</td>
<td>$47.72</td>
<td>$55.72</td>
</tr>
<tr>
<td>Employee + Dependent Children (Four-Party Coverage)</td>
<td>$68.72</td>
<td>$80.32</td>
</tr>
<tr>
<td>Employee + Spouse + Dependent Children (Family Coverage)</td>
<td>$74.64</td>
<td>$87.20</td>
</tr>
</tbody>
</table>
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.

*The elimination period is the amount of time you have to wait in between the day you become disabled and the day the insurance company will start to pay you long-term disability benefits if, the claim is approved and, meets the criteria of disability.

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 completed 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) $  

2018–19 Voluntary Long-Term Disability Rates

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

<table>
<thead>
<tr>
<th>Age</th>
<th>2 Months</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 &amp; Under</td>
<td>$0.14</td>
<td>$0.08</td>
<td>$0.06</td>
<td>$0.06</td>
</tr>
<tr>
<td>20 - 24</td>
<td>$0.16</td>
<td>$0.08</td>
<td>$0.06</td>
<td>$0.06</td>
</tr>
<tr>
<td>25 - 29</td>
<td>$0.26</td>
<td>$0.12</td>
<td>$0.10</td>
<td>$0.10</td>
</tr>
<tr>
<td>30 - 34</td>
<td>$0.34</td>
<td>$0.16</td>
<td>$0.14</td>
<td>$0.12</td>
</tr>
<tr>
<td>35 - 39</td>
<td>$0.38</td>
<td>$0.20</td>
<td>$0.16</td>
<td>$0.14</td>
</tr>
<tr>
<td>40 - 44</td>
<td>$0.46</td>
<td>$0.26</td>
<td>$0.20</td>
<td>$0.18</td>
</tr>
<tr>
<td>45 - 49</td>
<td>$0.60</td>
<td>$0.36</td>
<td>$0.28</td>
<td>$0.24</td>
</tr>
<tr>
<td>50 - 54</td>
<td>$0.88</td>
<td>$0.54</td>
<td>$0.42</td>
<td>$0.36</td>
</tr>
<tr>
<td>55 - 59</td>
<td>$1.04</td>
<td>$0.64</td>
<td>$0.50</td>
<td>$0.44</td>
</tr>
<tr>
<td>60 - 64</td>
<td>$1.10</td>
<td>$0.66</td>
<td>$0.52</td>
<td>$0.46</td>
</tr>
<tr>
<td>65 - 69*</td>
<td>$1.14</td>
<td>$0.70</td>
<td>$0.54</td>
<td>$0.48</td>
</tr>
<tr>
<td>70 &amp; Over*</td>
<td>$1.20</td>
<td>$0.74</td>
<td>$0.58</td>
<td>$0.50</td>
</tr>
</tbody>
</table>

*Benefits reduced. Check website for further information.

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.

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, at or greater than 20 hours per week, are eligible for the $20,000 insurance benefit and pay 50% of the monthly rate. The part-time rate is $0.48 per month.

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.

*You must be enrolled in Basic Life to elect Supplemental Life Insurance

| 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 |

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.

*You must be enrolled in Basic Life to elect AD&D Life Insurance

<table>
<thead>
<tr>
<th>AD&amp;D Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
</tr>
<tr>
<td>Coverage</td>
</tr>
</tbody>
</table>

Accidental Death Benefit

The voluntary group life insurance plan offers an “Accidental 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.
Supplemental Employee Life Insurance

You may elect to purchase additional life insurance coverage for yourself. Coverage can be purchased in increments of 0.5, 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

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate/$1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.024</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.024</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.032</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.049</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.073</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.105</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.178</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.381</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.729</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.191</td>
</tr>
<tr>
<td>70-74</td>
<td>$1.620</td>
</tr>
<tr>
<td>75-79</td>
<td>$3.677</td>
</tr>
<tr>
<td>80 and over</td>
<td>$7.444</td>
</tr>
</tbody>
</table>

Calculating Life Insurance Monthly Cost

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

1. Enter your annual basic gross pay (not including overtime): $_________
   x ___ = _________
2. Multiply by the increment you elected (0.5, 1, 1.5, 2, 3, 4, or 5) _________
3. Round the amount in line #2 up to the next highest $1,000 _________
   Multiply line #3 by the rate per $1,000 _________
4. $1,000 of coverage for your age as of 7/1/2018 (see table to left) _________
   Divide the amount on line #4 by 1,000. This will be the cost of your Supplemental Employee Life Insurance per month _________

Monthly Cost Calculation Example

1. Callie is 54 years old and makes $20,949/hour. She works a 40-hour week, or 2080 hours a year. This makes her annual basic gross pay $43,573.92.

2. She elects 4 times her salary, so she multiplies her annual basic gross pay, $43,573.92, by 4 to get $174,295.68.

3. Then, she rounds up to the next highest $1,000, which is $175,000 in supplemental life coverage.

4. The rate per $1,000 of coverage for someone Callie’s age is $0.178. She multiplies $175,000 by $0.178 for a total of $31,150.

5. Finally, she divides by $31,150 by 1,000. Callie’s cost of supplemental life coverage will be $31.15 each month.

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.
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.

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 at 866-792-3616. You may also visit us online at www.deeroakseap.com (login and password are "SON") to browse articles, interactive assessments, audio and video files, and to participate in monthly webinars and live chat sessions.

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

Program Access
Helpline: (866) 792-3616
Website: www.deeroakseap.com
Login and Password: SON
Termination/Retirement/COBRA

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 the State of Nebraska informed of any changes to your address and/or phone number. The 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.

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 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.

Early Retiree Insurance Program

This program was created for state employees who meet the qualifications and retire from employment between ages 55 through 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.

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.
Flexible Spending Accounts

ASIFlex

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 and are eligible for COBRA, expenses incurred after your termination date will not be 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 the 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 ASIFlex directly at 800-659-3035 or email asi@asiflex.com.

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 ASIFlex. The deadline for reimbursement requests is October 31 of the following Plan Year. If you have questions regarding your Dependent Care Account, please call ASIFlex directly at 800-659-3035 or email asi@asiflex.com.

Health Savings Account (HSA)

Optum Bank

If you have a Health Savings Account, it will continue to be owned by you after leaving the 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. Please note: not all agencies offer an EAP through Deer Oaks.

Need Help?

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

Phone: 402-471-4443 or 877-721-2228
Email: as.employeebenefits@nebraska.gov

The State of Nebraska wishes you luck in your future endeavors!

Long Term Disability (LTD)

Mutual of Omaha

Your Long Term Disability policy ends at midnight the day you terminate. You may continue your long term disability coverage under a Portability Policy. A Portability Application is available on the Employee Wellness & Benefits web page at das.nebraska.gov/benefits. 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 Employee Wellness & Benefits website at das.nebraska.gov/benefits.
COBRA and Retiree Medical, Dental, and Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2018, through June 30, 2019, are shown below.

### Monthly Medical Plan Premiums

<table>
<thead>
<tr>
<th></th>
<th>Wellness Health Plan</th>
<th></th>
<th>Regular Health Plan</th>
<th>Consumer Focused Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Wellness Incentive</td>
<td>Without Wellness Incentive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retiree/COBRA Employee Only (Single Coverage)</td>
<td>Retiree: $604.06</td>
<td>$729.60</td>
<td>$729.60</td>
<td>$412.62</td>
</tr>
<tr>
<td></td>
<td>COBRA: $616.14</td>
<td>$744.19</td>
<td>$744.19</td>
<td>$420.87</td>
</tr>
<tr>
<td>Retiree/COBRA Employee + Spouse (Two-Party Coverage)</td>
<td>Retiree: $1,600.76</td>
<td>$1,933.42</td>
<td>$1,933.42</td>
<td>$1,093.44</td>
</tr>
<tr>
<td></td>
<td>COBRA: $1,632.78</td>
<td>$1,972.09</td>
<td>$1,972.09</td>
<td>$1,115.31</td>
</tr>
<tr>
<td>Retiree/COBRA Employee + Dependent Children (Four Party Coverage)</td>
<td>Retiree: $1,238.30</td>
<td>$1,495.66</td>
<td>$1,495.66</td>
<td>$845.88</td>
</tr>
<tr>
<td></td>
<td>COBRA: $1,263.07</td>
<td>$1,525.57</td>
<td>$1,525.57</td>
<td>$862.80</td>
</tr>
<tr>
<td>Retiree/COBRA Employee + Spouse + Dependent Children (Family)</td>
<td>Retiree: $2,144.38</td>
<td>$2,590.06</td>
<td>$2,590.06</td>
<td>$1,464.80</td>
</tr>
<tr>
<td></td>
<td>COBRA: $2,187.27</td>
<td>$2,641.86</td>
<td>$2,641.86</td>
<td>$1,494.10</td>
</tr>
</tbody>
</table>

### Monthly Dental Plan Premiums

<table>
<thead>
<tr>
<th></th>
<th>Basic Option</th>
<th>Premium Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>COBRA/Retiree Employee Only (Single Coverage)</td>
<td>$24.32</td>
<td>$28.40</td>
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<td>COBRA/Retiree Employee + Spouse (Two-Party Coverage)</td>
<td>$48.67</td>
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<td>COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)</td>
<td>$70.09</td>
<td>$81.93</td>
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<tr>
<td>COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)</td>
<td>$76.13</td>
<td>$88.94</td>
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### Monthly Vision Plan Premiums

<table>
<thead>
<tr>
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<th>Basic Option</th>
<th>Premium Option</th>
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<tbody>
<tr>
<td>COBRA/Retiree Employee Only (Single Coverage)</td>
<td>$5.45</td>
<td>$8.47</td>
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<tr>
<td>COBRA/Retiree Employee + Spouse (Two-Party Coverage)</td>
<td>$8.75</td>
<td>$13.55</td>
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<tr>
<td>COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)</td>
<td>$8.94</td>
<td>$13.79</td>
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<tr>
<td>COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)</td>
<td>$14.38</td>
<td>$22.28</td>
</tr>
</tbody>
</table>
Legal Notifications

Summary Plan Documents
Plan documents are accessible through the Employee Wellness & Benefits Resources page at das.nebraska.gov/benefits.

Women's Health and Cancer Rights Act of 1998 (WHPCA)
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 WHPCA 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.askbsa.dol.gov or call 1-866-444-EBSA (3272).
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Phone: 1-855-692-5447</td>
</tr>
<tr>
<td>Alaska</td>
<td>Web: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone Outside of Anchorage: 888-318-8890 Phone Anchorage: 907-269-6529</td>
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<tr>
<td>Colorado</td>
<td>Medicaid Web: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a> Medicaid Customer Contact Center: 800-221-3943</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>Web: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
<td>Phone: 1-877-357-3268</td>
</tr>
<tr>
<td>Georgia</td>
<td>Web: <a href="http://dch.georgia.gov/medicaid/">http://dch.georgia.gov/medicaid/</a></td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Indiana</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Web: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a> Phone: 877-438-4479 All other Medicaid Web: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone: 800-403-0864</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>Web: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a></td>
<td>Phone: 1-888-346-9562</td>
</tr>
<tr>
<td>Kansas</td>
<td>Web: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
<td>Phone: 1-785-296-3512</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Web: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>Phone: 800-635-2570</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Web: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>Phone: 888-695-2447</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP Web: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 800-462-1120</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Medicaid Web: <a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a></td>
<td>Phone: 800-657-3739</td>
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<tr>
<td>Missouri</td>
<td>Medicaid Web: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</td>
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<tr>
<td>Montana</td>
<td>Medicaid Web: <a href="http://dhpps.mt.gov/">http://dhpps.mt.gov/</a> Montana Healthcare Programs/HIPP Phone: 500-694-3084</td>
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<tr>
<td>Nebraska</td>
<td>Medicaid Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a> Phone: 1-855-632-7633</td>
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<tr>
<td>New Jersey</td>
<td>Medicaid &amp; CHIP Medicaid Web: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 800-701-0710</td>
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<td>New York</td>
<td>Medicaid Web: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 919-855-4100</td>
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</tr>
<tr>
<td>North Carolina</td>
<td>Medicaid Web: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a> Phone: 919-855-4100</td>
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<td>North Dakota</td>
<td>Medicaid Web: <a href="http://www.nd.gov/dhs/services/medicalservices/medicaid/">http://www.nd.gov/dhs/services/medicalservices/medicaid/</a> Phone: 844-854-4825</td>
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<tr>
<td>Oklahoma</td>
<td>Medicaid &amp; CHIP Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 888-365-2372</td>
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<tr>
<td>Oregon</td>
<td>Medicaid Web: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a> Phone: 800-699-9075</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Medicaid Web: <a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a> Phone: 800-692-7462</td>
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</tr>
<tr>
<td>Nevada</td>
<td>Medicaid Web: <a href="http://dwws.nv.gov/">http://dwws.nv.gov/</a> Medicaid Phone: 800-992-0900</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>Medicaid Web: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> Phone: 888-549-0820</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>Medicaid Web: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 800-829-0059</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>Medicaid Web: <a href="http://gethealthtexas.com/">http://gethealthtexas.com/</a> Phone: 800-440-0493</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>Medicaid Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427</td>
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</tr>
<tr>
<td>Rhode Island</td>
<td>Medicaid Web: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 401-462-5300</td>
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</tr>
<tr>
<td>West Virginia</td>
<td>Medicaid Web: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a> Phone: 877-598-5820, HMS Third Party Liability</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Medicaid and CHIP Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a> Phone: 800-362-3002</td>
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<tr>
<td>Wyoming</td>
<td>Medicaid Web: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a> Phone: 307-777-7531</td>
<td></td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since January 31, 2017, 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 10/31/2017)
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 [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](http://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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: April 14, 2017
Name of Entity/Sender: State of Nebraska

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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
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, 2017.