Options

benefits as individual as you

2023-2024

GUIDE TO TEAMMATE WELLNESS & BENEFITS PROGRAMS

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.

Table of Contents & Contact Information

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/personnel/wellness/index.html for exact benefits, exclusions and limitations.

Welcome

Dear Nebraska Teammates,

Welcome to the 2023-2024 Options Guide! The State of Nebraska continues to offer 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, as well as help to maintain work/life balance.

We are pleased to continue to provide this guide highlighting many of the teammate benefits and programs options available to State of Nebraska teammates. For additional and more detailed information concerning plan options, please visit our website: das.nebraska.gov/personnel/wellness/index.html.

We will continue to offer the WellNebraska (with Incentive) plan to those that are eligible with the completion of the Rally Survey by the deadline. If you or your spouse failed to meet the requirement, you will see your medical coverage showing as WAIVED in your OE event, and you will need to select another plan option to ensure you have medical coverage for the plan year. The Direct Primary Care plans through Strada Health will remain for 2023-2024 plan year.

The 2023-2024 plan year changes include:

• Eliminating cost sharing for birth of a child on the Wellness with Incentive Plan: For the last few years our teammates on the Wellness with Incentive plan have been eligible for the Enhanced Maternity Benefits with a $500 co-pay. This year we have reduced that co-pay to $0. In-network medically necessary inpatient and outpatient standard maternity related services will be paid at 100% of eligible expenses. In-network inpatient well baby nursery eligible charges will also be paid at 100%. Please note this benefit only applies to the Wellness with Incentive Medical Plan and on eligible expenses/charges.

• Expanding of our preventative drug coverage list: Starting 7/1/23 our prescription drug list (PDL) will be expanding with the State of Nebraska covering more of the cost share on specific prescriptions. All Plans will have Expanded Preventive drug list (drugs from this list will be subject to preventive lower copays). Our PDL is available on our website.

• Increasing the visits/limits to PT/OT/ST therapies: All plans will be increasing Physical, Occupational and Speech Therapy limits from 20 visits to 30 visits per plan year.

• Reduction of Medical Co-pays: The WellNebraska (with and without Incentive) Plans as well as the Regular Plan will have the medical visit copays reduced by $10. New Co-pays will be listed on your new insurance card.

• In order to comply with IRS requirements: In Network Individual Deductible on Consumer Focused (HSA) Plan is increasing to $3,000

• All State of Nebraska teammates are required to log into the Employee Work Center and complete the Open Enrollment process. As you make your Open Enrollment plan selections, please take the time to verify and update any contact information (address, email, phone number, etc.) for you, your dependents, and your beneficiaries. It is very important that we have current contact information for all Nebraska Teammates.

To select the best benefit options for you and your family, it is recommended that you review plan options and changes or seek clarification prior to the Open Enrollment period. 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 email the team at as.employeebenefits@nebraska.gov.

This year's Open Enrollment begins Tuesday, May 2, 2023 at 7 a.m. CST and will close Tuesday, May 16, 2023 at 5 p.m. CST.

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 Administrator

Open Enrollment 2023

All State of Nebraska teammates are required to log into the Employee Work Center and complete the Open Enrollment process. As you make your Open Enrollment plan selections, please take the time to verify and update any contact information (address, email, phone number, etc.) for you, your dependents, and your beneficiaries. It is very important that we have current contact information for all Nebraska Teammates.

New Hire Information

Welcome to employment with the State of Nebraska! We are pleased to provide you with this comprehensive guide to your 2023-24 State Employee Wellness & Benefits Program, referred to as our Options Guide. You have many choices to make in your first 30 days of eligibility and we want to help simplify the process.

New Hire Check List

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

Review your options.	Discuss with family members.
Prepare list of your dependents with SSN & Date of Birth	You will need this information to enroll dependents in coverage, list as beneficiary and your emergency contact.
Medical Insurance	Elect or waive coverage. Choose plan, tier, and covered dependents (if any).
Dental Insurance	Elect or waive coverage. Choose plan, tier, and covered dependents (if any).
Vision Insurance	Elect or waive coverage. Choose plan, tier, and covered dependents (if any).
Health Savings Account (HSA)	Only available if enrolled in a Consumer-Focused Health Plan. Select or waive your contributions. You can change your contribution amounts any time throughout the year.
FSA Healthcare	Enroll or waive your annual contributions. Plan wisely – unclaimed contributions are forfeited.
FSA Dependent Care	If you pay for dependent daycare while you are working, select your annual contributions. Plan wisely – unclaimed contributions are forfeited.
Basic Life Insurance	Add your beneficiary. If part-time, you can waive coverage.
AD&D Life Insurance	Elect or waive coverage. Add your beneficiary. ***You must be enrolled in Basic Life to enroll in AD&D Life Insurance.***
Supplemental Life Insurance	Elect or waive coverage for yourself and/or eligible dependents and choose level of coverage. Add your beneficiary if choosing employee supplemental life. ***You must be enrolled in Basic Life to enroll in Supplemental Life Insurance.***
Short and Long Term Disability	Elect or waive coverage. Choose either or both coverages.
Wellness Program	New hires who are benefit eligible between 4/1/23 - 6/30/24 are automatically eligible for WellNebraska (with Incentives) with no requirements.

How to Enroll in Coverage

- Go to **https://link.nebraska.gov/**
- 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.ne.gov. Under Resources select "LINK User Guides"** and then select "Employee Work Center – Benefits and Deductions" from the Benefits & Deduction header.*

Questions?

- Talk to your Agency Human Resources representative.
- Visit **das.nebraska.gov/personnel/wellness/index.html**.
- Contact Employee Wellness & Benefits
  - Call 402-471-4443 (all voicemails same business day)
  - Call 877-721-2228, if outside Lincoln
  - Email as.employeebenefits@nebraska.gov

About Your Benefits

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

Understanding your benefit options and making the right decisions are important steps for you and your family. Please review the content carefully and refer to our website at **das.nebraska.gov/personnel/wellness/index.html** 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 **https://link.nebraska.gov/**. You may also scan the QR code to be linked to the Employee Work Center.

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.

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/personnel/wellness/index.html

Holidays

For the 2023-24 benefit year, our office will be closed on all State holidays including:

Independence Day	Tuesday, July 4, 2023
Labor Day	Monday, September 4, 2023
Columbus Day	Monday, October 9, 2023
Veterans Day	Friday, November 10, 2023
Thanksgiving Day	Thursday, November 23, 2023
Day after Thanksgiving	Friday, November 24, 2023
Christmas Day	Monday, December 25, 2023
New Year's Day	Monday, January 1, 2024
Martin Luther King Jr. Day	Monday, January 15, 2024
President's Day	Monday, February 19, 2024
Arbor Day	Friday, April 26, 2024
Memorial Day	Monday, May 27, 2024
Juneteenth	Wednesday, June 19, 2024

Benefit Plan Eligibility & Enrollment

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

	Who is Eligible	How/When to Enroll	Are Dependents Eligible
Health Insurance UnitedHealthcare	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Direct Primary Care (DPC) Strada Healthcare	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Health Savings Account Optum Bank	Teammates enrolled in State's Consumer Focused Health Plan	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Vision Insurance EyeMed	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Dental Insurance Ameritas	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Basic Life Insurance/ AD&D Insurance The Hartford	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	No
Supplement Life Insurance The Hartford	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
Short and Long Term Disability UnitedHealthcare	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	No
Employee Assistance Program Deer Oaks EAP	Full-time Part-time	Auto Enrollment For Participating Agencies only	Yes
FSA – Healthcare ASIFlex	Full-time Part-time	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes
FSA – Dependent Care ASIFlex	Full-time Part-time 6-month temporary	Enroll through Employee Work Center (EWC) within first 30 days from date of hire/eligibility	Yes

Employment Status (ONLY for purposes of benefit eligibility)

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

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

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

Temporary teammates: Eligible for the state's group health, dental, short-term and 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 2, 2023, 7:00 a.m. CST.

Ends: Tuesday, May 16, 2023, 5:00 p.m. CST.

Eligible Dependent Types:

- 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
  - Stepchild, 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

A teammate 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 teammate; 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 teammate will be responsible for paying the full premium each month through post tax payroll deduction.

The coverage will terminate if:

- The teammate requests the termination because they no longer meet the criteria
- The teammate'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. Teammates will receive a letter or email from Alight Dependent Verification Center (formerly 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 Alight Dependent Verification Center (formerly Aon Hewitt) which will verify each dependent. You will have approximately 30 days to respond so please be prepared.

PLEASE WATCH YOUR MAIL OR EMAIL 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 2023-24 Benefit plan year runs May 2-16, 2023, with coverage changes effective July 1, 2023. Active teammates will make changes in the Employee Work Center (EWC). Cobra/Retirees will make changes by mail.

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 born to a teammate, a spouse, or a dependent of a teammate currently on a state benefit plan will receive the first 31 days of coverage automatically 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 after 30 days of the date the decree is rendered. (For example; teammate 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, after the

IMPORTANT!

You have 30 days including 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.

waiting period has ended. If the request is not made by July 12th, your next opportunity will be after the six-month waiting period or, November 13th.)

If losing coverage due to divorce, you may apply for coverage when the divorce is final. You must submit the divorce decree and proof of coverage ending.

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 within 14 days, your previous benefits are reinstated with no break in coverage.

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. Long-term and short-term disability - if you are rehired within 6 months, we apply your previous employment in an eligible class towards completing the 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 or the State of Nebraska Wellness and Benefits team.

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.
- Teammate's change in employment status resulting in gain or loss of benefit eligibility, including an unpaid leave of absence greater than 14 calendar days.
- Teammate's change in employment status resulting in a change of benefit tiers, or 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 (you have 60 days to notify the state).
- Gain or loss of coverage under a State Medicaid or CHIP program (you have 60 days to notify the state).
- **Market Place Health Care changes are not a qualified event.**

Health Insurance

Benefits are administered by UnitedHealthcare (UHC)

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

You have five great plans to choose from. All health plan options are administered by UnitedHealthcare and include both in-network and out-of-network coverage. All 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)
- Select Direct Primary Care
- Standard Direct Primary Care

Self-Insured Health Plan

The State of Nebraska provides health insurance for its teammates through a self-funded health insurance program. In addition to deciding on the plan structure, the State pays health care claims for teammates 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-pocket costs.
3. Shop around and compare prices and quality of doctors, facilities, and pharmacies (see page 14 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.
6. Schedule your annual preventive exams for medical, dental, and vision.
7. Set aside money for 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 very serious or life threatening conditions. Consider virtual visits, 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 13).

www.myuhc.com

Once your elected State of Nebraska health plan has taken effect, 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.

What is Preventive Care?

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

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

Preventive or Diagnostic?

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

Preventive Care is when the patient:

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

Diagnostic Care is when:

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

Go to www.uhc.com/health-and-wellness/preventive-care for a list of preventive care approved procedures for your age & gender.

Understanding Insurance Terminology

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

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.

Questions?

Visit das.nebraska.gov/personnel/wellness/index.html or call UnitedHealthcare Customer Care at 877-

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.

Premium Care Providers are designated with two hearts (one for high quality care and second for cost efficiency) in the provider directory located at **www.uhc.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.*
- A maternity nurse for high-risk maternity case management.
- 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.

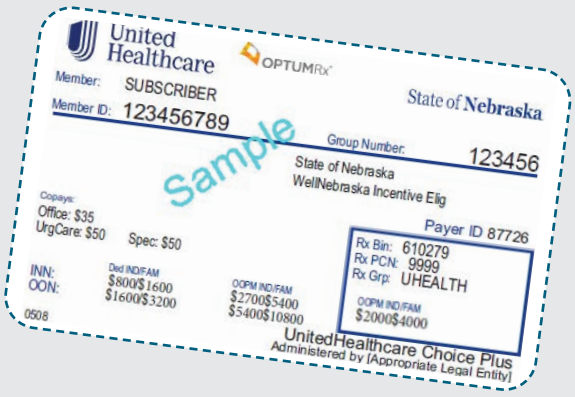
**A nurse may call you regarding specialty care or diabetes disease management and new programs.*

Medical Insurance Cards

Start using your new card on July 1, 2023.

All medical insurance cards will be updated this year with new required information. All members will receive a new ID card in the mail.

Everyone can print their own card on www.myuhc.com any time after benefits effective date.



Virtual Visits

(24/7 Virtual Visits, Virtual Preventive Care and Virtual Centers of Excellence - vCOE)

With your UHC account you now have access to Virtual care in ways like never before. Not only can you do your standard Virtual visits for those non-emergency medical conditions that can spring up, you now can establish a Virtual Primary care provider for your day to day care. Or take it one step further with our Virtual Centers of excellence to see a Virtual Specialist.

Access virtual visits

1. Choose 24/7 Virtual Visits, Virtual Primary Care or available Virtual Specialists by clicking the "Get Started."
2. Virtual Primary Care is provided by Optum Virtual Care. Optum Virtual Care (OVC) is displayed as the integrated provider of 24/7 Virtual Visits however, members can also access Teladoc, Doctor On Demand, Amwell and Walmart Health Virtual Care providers through the FAQ section on myuhc.com.
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. (WellNebraska and Regular Plans cover 24/7 Virtual Visits at 100%; Virtual Primary Care and Virtual Specialist are subject to their standard co-pays.)
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 diagnosis 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 Visit Benefits	WellNebraska Health Plans	Regular Health Plan	Consumer Focused Health Plan
24/7 Virtual Visits	$0 copay Plan pays 100%	$0 copay Plan pays 100%	20% after deductible
Virtual Primary Care and Virtual Specialists (VCOE)	$25 copay for Primary care $40 copay for Specialist	$35 copay for Primary care $45 copay for Specialist	20% after deductible

Virtual Primary Care

- Annual wellness visits
- Regular follow-ups for conditions like asthma, diabetes, etc.
- Lab tests and preventive screenings
- Referrals to quality network specialists
- Medication review and prescriptions, if needed
- Cost aligns with PCP benefit

24/7 Virtual Visits

- Non-emergency care for common health issues like the flu, fevers, sore throats, etc.
- Non-emergency care for sudden health issues like pinkeye, migraines, back pain, even allergies and anxiety
- Prescription refills, if needed
- Cost aligns with 24/7 Virtual Visits benefit

FREE NurseLine

877-263-0911

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

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

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.

Online Resources

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

Virtual Behavioral Health Care

Telemental Health Provider

Outpatient benefit will apply

To access Telemental Health:

a. Log into your **www.myuhc.com** account

b. Click on "Find Care & Cost"

c. Then choose "Virtual Care" and select "Virtual Behavioral Health Care"

d. "Find Provider"

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

Amwell and Doctor on Demand are Optum Behavioral Health providers. Optum Virtual Care, Teladoc, and Walmart Health Virtual Care are not contracted to provide behavioral health.

Money-Saving Tools

Find and Compare Cost

Login to **www.myuhc.com** or the UnitedHealthcare mobile app and estimate your health care costs before you see the doctor.

- Search for a condition or treatment.
- Get estimated costs for a treatment or procedure
- See how that cost is impacted by your deductible, co-insurance, and out-of-pocket maximum
- Select a provider.

UnitedHealthcare® 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

Consumer Focused Health Plan

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

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

Why choose the Consumer Focused Health Plan and HSA?

Lower premiums

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

Annual deductible

When you receive medical care or need a prescription, you pay out of pocket for those expenses until you reach your deductible. For 2023-24, the in network deductible is $3,000 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. Medications on this list are not subject to 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 2023-24, 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.

Wellness: The WellNebraska Health Plan

Wellness programming provided by UnitedHealthcare and Rally

The WellNebraska Health Plan is a plan option open to State teammates. 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 rates.

Eligibility & Participation

Any teammate is eligible to enroll in the WellNebraska Health Plan. Teammates 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 April 1, 2023 - June 30, 2024 have no qualification requirements.

If you and your spouse (if applicable) qualified for the wellness incentives for the 2023-24 health plan year by:

- Completing the online Rally Health Survey through www.myuhc.com by March 31, 2023.

Then you must select the WellNebraska Health Plan to receive your wellness incentives. When a qualifying teammate 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.

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 teammates enrolled in the WellNebraska Health Plan. You will not, be eligible for lower copays, deductibles, and premiums.

If you believe you should qualify for the wellness incentives but are not seeing the premiums referenced to the right, 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

Employee Only	$72.42 bi-weekly or $144.84 monthly
Employee & Spouse	$191.93 bi-weekly or $383.86 monthly
Employee & Children	$148.47 bi-weekly or $296.94 monthly
Family	$257.11 bi-weekly or $514.22 monthly

Advantages

- Plan with lowest deductible and annual out-of-pocket maximums
- First $500 of all non-preventative lab and pathology work is covered (preventative lab and pathology already covered under the WellNebraska plan)
- Routine and follow-up mammograms covered at 100%
- Routine and follow-up colonoscopies covered at 100%
- Cholesterol, hypertension, asthma, COPD, and diabetic medications at no cost or lower copays compared to other plans
- Enhanced maternity benefits
- In-network medically necessary inpatient and outpatient standard maternity related services will be paid at 100% of eligible expenses. In-network inpatient well baby nursery eligible charges will also be paid at 100%

Confidentiality is a Top Priority

Privacy of personal information is our top priority. UnitedHealthcare/Rally maintains the confidentiality of all personal health information in accordance with federal regulations. This means your personal health information, which is obtained by UnitedHealthcare/Rally, 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 will continue to offer 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 health 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 Health Score — 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

Your UnitedHealthcare medical plan will continue to offer 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 FitnessOnDemand™, Body-weight scale, Food scale and balanced portion plate, 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 1-844-924-REAL (7325) or visit https://coachinghelp.werally.com/realappeal.

UnitedHealthcare®

RALLY®

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:

Open Enrollment	Health Survey	Register, Email or call Real Appeal using your work e-mail or phone *(not for coaching or weekly sessions)*

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 2023 maximum limits are:

- $3,850 for individual coverage
- $7,750 for family coverage
- If you're age 55 or older, you can contribute an additional $1,000 to your HSA during the plan year

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.

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.

To Learn More. . .

Visit www.optumbank.com or call
800-791-9361 Monday - Friday
7:00 a.m. - 7:00 p.m. Central Time

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

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

Flexible Spending Accounts (FSA)

Benefits are offered through ASIFlex

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

Important Facts about 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.
- 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 enrollees for the 7/1/2023 plan year a confirmation of your election.
- You cannot contribute to a general purpose Healthcare FSA 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/personnel/wellness/index.html**.

Save Money with an FSA

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

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

Additional FSA Tools

Visit www.ASIFlex.com today!

- **FSA Store** - Go to asiflex.com and click on the FSA Store icon to receive special pricing. All products are eligible – no prescription required! For information on what is covered please visit asiflex.com.
- **Recuring Direct Pay** - You can sign up to have payments made directly to your daycare provider. Just login to your account to "schedule a recuring direct payment".
- **ASIFlex Cardless Pay Service** - ASIFlex and FSA Store have teamed up to make your shopping experience easier and more secure. With our Cardless Pay service, you no longer need to use any credit or debit card numbers. Payment to FSA Store can be made directly from your ASIFlex account.
- **ASIFlex Mobile App** - Check your balance or submit claims at any time, from anywhere! The app is free from Google Play or the App Store.
- **ASIFlex Card** - You can submit health care FSA claims or use the ASIFlex Card – the choice is yours. Learn more at **asiflex.com/debitcards.**

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.
- Your minimum annual contribution is $72
- You can use your dependent care FSA for eligible expenses incurred from July 1, 2023, to June 30, 2024.
- You have until **October 31, 2024**, to file a claim for reimbursement. ***Any balance left in your account after October 31, 2024, 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.

****During Open Enrollment, please double check you are selecting the correct FSA.***

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. Just sign into your online account to update your personal settings.

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 $3,050 for the plan year.
- Your minimum annual contribution is $120.00.
- New enrollees will receive a set of two debit cards. If you do not want the card(s), contact ASIFlex to cancel.
- Claims must be incurred between July 1, 2023, and June 30, 2024.
- You have until **October 31, 2024**, to file a claim for reimbursement. **Any balance left in your account after October 31, 2024, will be forfeited.**

NOTE: **SAVE YOUR ITEMIZED RECEIPTS from your FSA, Health insurance plan Explanation of Benefits (EOB) statements and debit card transactions.**

Eligible Health Care Expenses:

Go to **www.ASIFlex.com** and click on the Resources Tab and select "FSA Store" and/or "Eligible Expenses" to learn more.

- Deductibles, copays and coinsurance for medical care, prescriptions, dental, vision or hearing care.
- Dental expenses including exams, fillings, crowns, bridges, implants, dentures and cleansers/adhesives, orthodontics, etc.
- Vision expenses including exams, prescription eyeglasses/sunglasses, reading glasses, contact lenses and cleaners, laser eye surgery, etc.
- Over-the-counter health care products (no prescription required) including allergy medicines, cough and flu remedies, pain relievers, menstrual care products, bandages, baby monitors, breast pumps, blood pressure monitors, sunscreen/lip balm 15+ SPF and broad spectrum, thermometers, etc.
- Mileage you incur while traveling to obtain health care. Reimbursement is available up to the IRS standard mileage rate. See asiflex.com News for the up-to-date limits.

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

Medical, Dental, & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2023, through June 30, 2024, are shown below. The state contributes 79% of the total cost of your health care benefits for full-time teammates. 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 teammate 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

		WellNebraska Health Plan			
		With Wellness Incentive		Without Wellness Incentive	
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only (Single Coverage)	**Your Cost:**	**$144.84**	**$237.28**	**$174.96**	**$286.60**
	State Cost:	$544.92	$452.48	$658.18	$546.54
	Total:	$689.76	$689.76	$833.14	$833.14
Employee + Spouse (Two-Party Coverage)	**Your Cost:**	**$383.86**	**$628.80**	**$463.62**	**$759.46**
	State Cost:	$1,444.04	$1,199.10	$1,744.14	$1,448.30
	Total:	$1,827.90	$1,827.90	$2,207.76	$2,207.76
Employee + Dependent Children (Four-Party Coverage)	**Your Cost:**	**$296.94**	**$486.42**	**$358.66**	**$587.52**
	State Cost:	$1,117.10	$927.62	$1,349.26	$1,120.40
	Total:	$1,414.04	$1,414.04	$1,707.92	$1,707.92
Employee + Spouse + Dependent Children (Family Coverage)	**Your Cost:**	**$514.22**	**$842.34**	**$621.08**	**$1,017.40**
	State Cost:	$1,934.44	$1,606.32	$2,336.50	$1,940.18
	Total:	$2,448.66	$2,448.66	$2,957.58	$2,957.58

		Regular Health Plan		Consumer Focused Health Plan	
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only (Single Coverage)	**Your Cost:**	**$174.96**	**$286.60**	**$98.94**	**$162.08**
	State Cost:	$658.18	$546.54	$372.22	$309.08
	Total:	$833.14	$833.14	$471.16	$471.16
Employee + Spouse (Two-Party Coverage)	**Your Cost:**	**$463.62**	**$759.46**	**$262.20**	**$429.50**
	State Cost:	$1,744.14	$1,448.30	$986.38	$819.08
	Total:	$2,207.76	$2,207.76	$1,248.58	$1,248.58
Employee + Dependent Children (Four-Party Coverage)	**Your Cost:**	**$358.66**	**$587.52**	**$202.84**	**$332.28**
	State Cost:	$1,349.26	$1,120.40	$763.08	$633.64
	Total:	$1,707.92	$1,707.92	$965.92	$965.92
Employee + Spouse + Dependent Children (Family Coverage)	**Your Cost:**	**$621.08**	**$1,017.40**	**$351.24**	**$575.38**
	State Cost:	$2,336.50	$1,940.18	$1,321.40	$1,097.26
	Total:	$2,957.58	$2,957.58	$1,672.64	$1,672.64

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

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

Monthly Vision Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$5.26	$8.18
Employee + Spouse (Two-Party Coverage)	$8.44	$13.08
Employee + Dependent Children (Four-Party Coverage)	$8.62	$13.32
Employee + Spouse + Dependent Children (Family Coverage)	$13.86	$21.50

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$25.92	$30.34
Employee + Spouse (Two-Party Coverage)	$51.92	$60.74
Employee + Dependent Children (Four-Party Coverage)	$74.88	$87.56
Employee + Spouse + Dependent Children (Family Coverage)	$81.58	$95.06

NOTES

Your Health Insurance Benefits

	WellNebraska Health Plan			
	With Wellness Incentive		Without Wellness Incentive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	$800 individual $1,600 family	$1,600 individual $3,200 family	$1,400 individual $2,600 family	$2,800 individual $5,200 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	$2,700 individual $5,400 family	$5,400 individual $10,800 family	$4,000 individual $8,000 family	$8,000 individual $16,000 family
Annual Pharmacy Out-of-Pocket Maximum	$2,000 individual $4,000 family		$2,250 individual $4,500 family	
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit	$25 copay	30% after deductible	$35 copay	40% after deductible
Specialty Office visit	$40 copay		$45 copay	
Virtual Visits	Plan pays 100%	Not covered	Plan pays 100%	Not covered
Allergy testing / serum	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
Allergy shots	Plan pays 100%			
Lab and Pathology Services	Paid at 100% up to $500; then 20% after deductible			
Radiology and Chemotherapy/Radiation Therapy	20% after deductible			
Routine Vision Exam plus Refraction	Not covered		Not covered	
PREVENTIVE EXAMS				
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. **See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.**	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.
EMERGENCY CARE				
Ambulance	Plan pays 100%		20%; deductible waived	
Urgent care center	$40 copay	30% after deductible	$45 copay	40% after deductible
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient and outpatient hospital services **Approved skilled nursing facility** **Home health care, Hospice care**	20% after deductible	30% after deductible	20% after deductible	40% after deductible
BEHAVIORAL HEALTH SERVICES				
Inpatient	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient	$25 copay		$35 copay	
OTHER SERVICES				
Chiropractic Office visit (Limit 30 sessions per year)	$40 copay	30% after deductible	20% after deductible	40% after deductible
Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)	$25 copay			
Hearing aids & exam (Limit $3,500 every 3 years)	20% after deductible			
Durable Medical Equipment (including continuous glucose monitors)				
MATERNITY SERVICES				
Outpatient maternity services (medically necessary)	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
Inpatient maternity related hospital charges (medically necessary)	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
Inpatient well baby nursery (eligible charges)	Plan pays 100%	30% - deductible doesn't apply	20% - deductible doesn't apply	40% deductible doesn't apply

	Regular Health Plan		Consumer Focused Health Plan (HSA Eligible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	$1,400 individual $2,600 family	$2,800 individual $5,200 family	$3,000 individual $5,200 family	$5,200 individual $10,400 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	$4,000 individual $8,000 family	$8,000 individual $16,000 family	$4,100 individual $8,200 family	$8,200 individual $16,400 family
Annual Pharmacy Out-of-Pocket Maximum	$2,250 individual $4,500 family		Included in the medical out-of-pocket maximum	
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit	$35 copay	40% after deductible	20% after deductible	40% after deductible
Specialty Office visit	$45 copay			
Virtual Visits	Plan pays 100%	Not covered		Not covered
Allergy testing / serum	20% after deductible	40% after deductible		40% after deductible
Allergy shots				
Lab and Pathology Services				
Radiology and Chemotherapy/Radiation Therapy				
Routine Vision Exam plus Refraction	Not covered		Not covered	
PREVENTIVE EXAMS				
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. **See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.**	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.
EMERGENCY CARE				
Ambulance	20%; deductible waived		20% after deductible	
Urgent care center	$45 copay	40% after deductible	20% after deductible	40% after deductible
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient and outpatient hospital services **Approved skilled nursing facility** **Home health care, Hospice care**	20% after deductible	40% after deductible	20% after deductible	40% after deductible
BEHAVIORAL HEALTH SERVICES				
Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient	$35 copay			
OTHER SERVICES				
Chiropractic Office visit (Limit 30 sessions per year)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)				
Hearing aids & exam (Limit $3,500 every 3 years)				
Durable Medical Equipment (including continuous glucose monitors)				

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/personnel/wellness/index.html** for exact benefits, exclusions and limitations.

Direct Primary Care (DPC)

Direct Primary Care Pilot Program Provided through Strada Healthcare

Currently available in the following locations: Bellevue, Council Bluffs (IA), Sioux City, (IA), Grand Island, Gretna, Kearney, Lincoln, Mitchell, Norfolk, North Platte, Omaha, and Papillion. Please visit the Benefit's webpage for the most current locations and updated information.

What is Direct Primary Care (DPC)?

DPC is membership-based healthcare offered through Strada Healthcare in conjunction with the Standard Plan or Select Plan (High Deductible plans) through United Healthcare. With this plan, members get unlimited access to their Strada healthcare providers by office, phone, or text as needed with no co-pay. Strada gives their members accessible primary care that focuses on prevention and health management. Strada providers reserve their time for DPC members to create personalized health plans. They have time to build relationships with the mutual goal of good health. Personalized care along with better access means happier and healthier patients.

Members who enroll for Standard DPC Plan and Select DPC Plans do not meet the IRS requirements for HSA accounts, therefore, they are not eligible to make contributions to an HSA account. DPC is not health insurance.

Why Direct Primary Care?

Access and Communication

Members have unlimited access to their Strada healthcare team through a secure smartphone app called Spruce. Members can text symptoms, schedule appointments, send a picture, or video-chat with a provider who is only a few taps away. This helps you get the care you need when you need it because of this access Urgent Care and ER visits may not be neccessary.

Covered Services

The following medical services are included in a DPC membership:

- Annual physicals and annual lab work
- Preventative appointments and follow-ups
- EKGs
- Repair of simple cuts and abrasions
- Treatment of sprains
- Women's health (excluding labs and mammograms)
- Well checks for infants and children (excluding immunizations)
- Chronic disease management
- Weight management and health risk assessment
- Work, school, and sport physicals
- Basic mental health
- Stress management

Cash Pricing

DPC members also have access to discounted cash prices for medical services such as labs, imaging, physical therapy, and chiropractic care. The list of providers and services can be viewed on the Strada website at **www.stradahealthcare.com/Nebraska** under About Us, Cash-Priced Partners.

Monthly Membership Fees

	Employee Cost	State Cost	Total Cost
Employee Only (Single Coverage)	$18.68	$70.32	$89.00
Employee + Spouse (Two-Party Coverage)	$37.38	$140.62	$178.00
Employee + Dependent Children (Four-Party Coverage)	$31.50	$118.50	$150.00
Employee + Spouse + Dependent Children (Family Coverage)	$62.78	$236.22	$299.00

LEGAL NOTICE: Employees who are eligible for or enrolled in a government healthcare program, including but not limited to Medicare, Medicaid, TRICARE/CHAMPUS, the Veterans' Administration, and Indian Health Service are not eligible for Direct Primary Care Services.

How does DPC impact me?

See below for a few possible scenarios:

I have 3 small children. How does DPC help me and my family?

Let's say your 6-year-old wakes up with a swollen, itchy, red eye. You know that another child in daycare stayed home last week with pink eye. With DPC, you can use the Spruce app on your phone to take a picture of your child's eye and send it to your Strada provider. You can text back and forth to determine the right treatment, which may include a prescription. All without having to miss work and go to the doctor's office.

I am a 45-year-old woman. Do I have to see a different provider for my annual preventive gynecological exam?

You have options with DPC. (1) You can continue to see your gynecologist for annual preventive screening exams because preventive care is covered at 100% by your Standard or Select health plan. (2) Or, you can see your Strada provider who can perform your annual exam. The annual exam is included in your DPC membership, but you will be responsible for the labs associated with the exam. The labs are typically under $50.

What happens if I am traveling and I get sick? My Strada provider is in Nebraska.

If your illness isn't an emergency, contact your Strada provider through your Spruce app. Your Strada provider may be able to diagnose your condition and recommend treatment over the phone.

I take several medications. How is that handled through DPC?

Your Strada provider will help you find medications at the lowest cost. Medications may be less expensive if you pay cash for them. You can also continue to access medications through your health plan.

FAQs

Q. What if I discover the DPC is not a good fit for me and my family?

A. You may opt out of DPC upon request to your Employee Wellness & Benefit Team. However you will continue coverage with your current High Deductible Plan.

Q. Are there co-pays when I see my Strada provider?

A. There is never a co-pay when members see their Strada provider.

Q. Can I really come to the clinic as often as I want?

A. Yes. Come in to the clinic, call, or text as needed.

Q. What services are not covered?

A. Lab work done after the first visit is not covered, however, it is priced at a very reasonable rate. Medications and diagnostic imaging are also not covered; however, they are available at negotiated prices listed on our website. Specialist, and Hospital care is not included in a DPC Membership. You can access your health plan for this coverage.

Q. What if I need to see a specialist?

A. Strada providers specialize in family practice and can care for a wide variety of health issues for the whole family. For more complex issues, our Strada provider may refer to a specialist. You can access your health plan for this coverage.

Questions about Direct Primary Care (DPC)?

Please call Strada Member Services Department at 402-401-4404, or email info@stradahealthcare.com.

Direct Primary Care Monthly Medical Premiums

Monthly Membership Fees with Health Plan Premiums

		Select High Deductible Health Plan		Standard High Deductible Health Plan	
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only (Single Coverage)	**Your Cost:**	**$70.62**	**$115.66**	**$61.00**	**$99.94**
	State Cost:	$265.64	$220.60	$229.54	$190.60
	Total:	$336.26	$336.26	$290.54	$290.54
	Your TOTAL Cost: (Membership Fees and Plan Premiums)	**$89.30**	**$146.28**	**$79.68**	**$130.56**
Employee + Spouse (Two-Party Coverage)	**Your Cost:**	**$200.26**	**$328.04**	**$174.82**	**$286.36**
	State Cost:	$753.40	$625.62	$657.68	$546.14
	Total:	$953.66	$953.66	$832.50	$832.50
	Your TOTAL Cost: (Membership Fees and Plan Premiums)	**$237.64**	**$389.26**	**$212.20**	**$347.58**
Employee + Dependent Children (Four-Party Coverage)	**Your Cost:**	**$152.12**	**$249.20**	**$132.44**	**$216.96**
	State Cost:	$572.32	$475.24	$498.26	$413.74
	Total:	$724.44	$724.44	$630.70	$630.70
	Your TOTAL Cost: (Membership Fees and Plan Premiums)	**$183.62**	**$300.80**	**$163.94**	**$268.56**
Employee + Spouse + Dependent Children (Family Coverage)	**Your Cost:**	**$254.52**	**$416.92**	**$220.42**	**$361.10**
	State Cost:	$957.52	$795.12	$829.30	$688.62
	Total:	$1,212.04	$1,212.04	$1,049.72	$1,049.72
	Your TOTAL Cost: (Membership Fees and Plan Premiums)	**$317.30**	**$519.78**	**$283.20**	**$463.96**

Direct Primary Care Pharmacy Benefits

UHC PREVENTIVE DRUG LIST (FORMULARY)
For list, go to Wellness & Benefits Resources page at **das.nebraska.gov/personnel/wellness/index.html.**

	Select High Deductible Health Plan with Direct Primary Care	Standard High Deductible Health Plan with Direct Primary Care
RETAIL - 30 DAY SUPPLY		
Tier 1	20% after deductible	30% after deductible
Tier 2	20% after deductible	30% after deductible
Tier 3	20% after deductible	30% after deductible
MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY		
Tier 1	20% after deductible	30% after deductible
Tier 2	20% after deductible	30% after deductible
Tier 3	20% after deductible	30% after deductible

	Direct Primary Care Select Plan		Direct Primary Care Standard Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	$3,500 individual $7,000 family	$7,000 individual $14,000 family	$5,000 individual $10,000 family	$10,000 individual $20,000 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	$5,000 individual $10,000 family	$10,000 individual $20,000 family	$7,000 individual $14,000 family	$14,000 individual $28,000 family
Annual Pharmacy Out-of-Pocket Maximum	Included in the medical out-of-pocket maximum		Included in the medical out-of-pocket maximum	
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit*	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Specialty Office visit				
Virtual Visits		Not covered		Not covered
Allergy testing / serum		40% after deductible		50% after deductible
Allergy shots				
Lab and Pathology Services				
Radiology and Chemotherapy/Radiation Therapy				
Routine Vision Exam plus Refraction	Not covered		Not covered	
PREVENTIVE EXAMS				
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. **See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.**	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 50% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.
EMERGENCY CARE				
Ambulance	20% after deductible		30% after deductible	
Urgent care center	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Hospital emergency room	20% after deductible		30% after deductible	
HOSPITAL SERVICES				
Inpatient and outpatient hospital services **Approved skilled nursing facility** **Home health care, Hospice care**	20% after deductible	40% after deductible	30% after deductible	50% after deductible
BEHAVIORAL HEALTH SERVICES				
Inpatient	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Outpatient				
OTHER SERVICES				
Chiropractic Office visit (Limit 30 sessions per year)	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)				
Hearing aids & exam (Limit $3,500 every 3 years)				
Durable Medical Equipment (including continuous glucose monitors)				

* Primary Care Physician Office Visits are covered under the memembership with the selected Strada provider.

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/personnel/wellness/index.html** 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 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.

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/down or added/excluded) 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/personnel/wellness/index.html**.

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 "Pharmacies and Prescriptions" and you will be able to:

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

Diabetic Supplies

Diabetic supplies covered under the prescription drug benefit include syringes, needles, lancets, blood monitor kits, test strips, blood glucose calibration solutions, urine tests, and blood test strips. **Continuous blood glucose monitors and insulin pumps are covered under the medical benefit as Durable Medical Equipment (sensors are covered under both, Medical and Rx).** If you have any questions, call customer service at 877-263-0911.

Your Pharmacy Benefits

	WellNebraska Plan		Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
	With Wellness Incentive	Without Wellness Incentive		
RETAIL - 30 DAY SUPPLY				
Tier 1	$5 copay	$5 copay	$5 copay	20% after deductible
Tier 2	$30 copay	$40 copay	$40 copay	20% after deductible
Tier 3	$50 copay	$60 copay	$60 copay	20% after deductible
MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY				
Tier 1	$10 copay	$10 copay	$10 copay	20% after deductible
Tier 2	$60 copay	$80 copay	$80 copay	20% after deductible
Tier 3	$100 copay	$120 copay	$120 copay	20% after deductible
Pharmacy Out-of-Pocket Maximum	$2,000 - individual $4,000 - family	$2,250 - individual $4,500 - family	$2,250 - individual $4,500 - family	Included in the medical out-of-pocket maximum

WellNebraska Health Plan ONLY (with Wellness Incentive)

UHC PREVENTIVE DRUG LIST (FORMULARY)
For list, go to Wellness & Benefits Resources page at **das.nebraska.gov/personnel/wellness/index.html.**

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	2 Times the 30-day supply
Tier 2	
Tier 3	

All Other Plans

UHC PREVENTIVE DRUG LIST (FORMULARY)
For list, go to Wellness & Benefits Resources page at **das.nebraska.gov/personnel/wellness/index.html.**

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	2 Times the 30-day supply
Tier 2	
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.

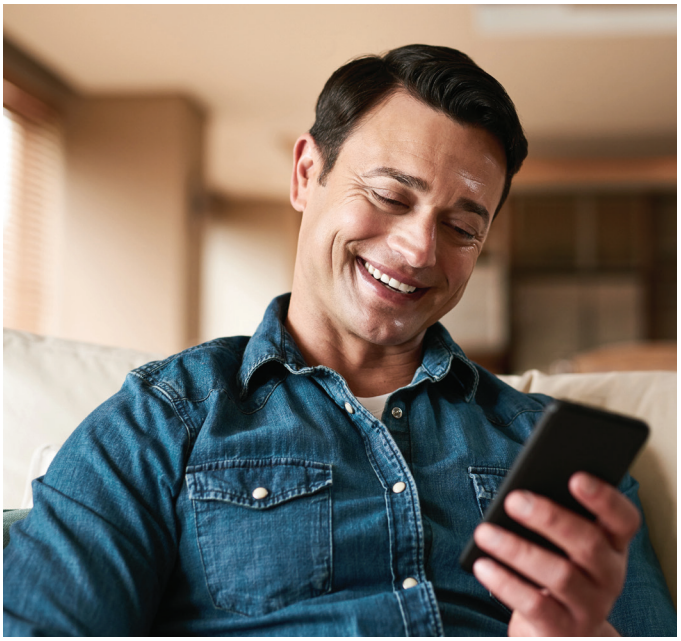
WellNebraska and Regular Health Plans Pharmacy Out-Of-Pocket Maximums

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.

Consumer Focused Health Plan

1. If your medication is on the UHC Preventive Drug List, you pay the copay. Your copay will apply towards your annual out-of-pocket maximum. After your limit is met, the plan pays 100% of your costs. For more details, go to **das.nebraska.gov/personnel/wellness/index.html**.

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



Mail Order – Save money & time!

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

To start using mail order:

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

-OR-

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

Your Prescription Medication Options

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

Specialty Pharmacy Program

Optum Specialty Pharmacy

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

What is a specialty medication?

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

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

Contact the Optum 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.

Are YOU getting the most out of your Pharmacy Benefit?

- **Register at www.myuhc.com**
- **Choose drugs on Tier 1, when available**
- **Use mail order**

Vision Benefits

Benefits are provided by EyeMed Vision Care

State of Nebraska teammates 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.

Teammates 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.
- When out on the EyeMed portal or if you are in the EyeMed app, make sure to check out the special offers tab to see if any of the value added benefits listed could boost your current vision benefits with additional savings.

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

2023-24 Plan Year

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

Monthly Vision Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$5.26	$8.18
Employee + Spouse (Two-Party Coverage)	$8.44	$13.08
Employee + Dependent Children (Four-Party Coverage)	$8.62	$13.32
Employee + Spouse + Dependent Children (Family Coverage)	$13.86	$21.50

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

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

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

Dental Benefits

Benefits are provided by Ameritas

The State of Nebraska offers dental insurance to all full-time and part-time teammates. All of the premiums are paid by the teammate 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 network dentist). This continues until you reach a total reward of $1,000. The Dental Rewards amount is available to use in future years in addition to your annual maximum. It can only be reduced if you have claims totaling more than $1,000 or if you fail to submit at least one claim during any given year.

Penalty for Late Entrants

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

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

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

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.

Ameritas Dental Plan Benefits

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

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	$25.92	$30.34
Employee + Spouse (Two-Party Coverage)	$51.92	$60.74
Employee + Dependent Children (Four-Party Coverage)	$74.88	$87.56
Employee + Spouse + Dependent Children (Family Coverage)	$81.58	$95.06

Find a Participating Provider

Visit our website at: https://explore.ameritas.com/nebraska/ and select Classic (PPO) Plus Network Option or call 800-487-5553.

Short-Term Disability Benefits

Benefits are offered through UnitedHealthcare

How the plan works.

The Short-term Disability plan will pay you 60% of your paycheck each week if you have a qualifying disability on the 1st day of injury or the 8th day of a sickness and you are unable to perform your job duties for up to a maximum of 26 weeks.

This means you will have a weekly income to help you and your family pay for expenses like your mortgage or rent, medical bills, food and more.

2023–24 Voluntary Short-Term Disability Rates	
Age as of July 1	
Less than 25	$0.774
25 - 29	$0.762
30 - 34	$0.774
35 - 39	$0.643
40 - 44	$0.690
45 - 49	$0.681
50 - 54	$0.777
55 - 59	$0.951
60 - 64	$1.199
65 +	$1.378

You can even work part-time.

Being productive feels good. That's why the plan also allows you to work part-time and still receive benefit payments. We understand that you may have to work your way back up to earning 100 percent of your income, which is the goal.

Disability specialists can help you return to work.

The plan includes personal support from disability specialists who will work with you and your employer to help you return to work more quickly so you can get back to work safely and back to earning your full wage. Due to the complex nature of disability claims, it is not possible to provide answers to questions related to hypothetical claims.

Please note: Your benefit payment will be reduced by other income you receive or are eligible to receive, due to your disability. This includes, but is not limited to sick leave or donated leave. *(Please see the Certificate of Coverage for additional details)*

Premium Calculation

1.	Enter your Basic Gross Annual Salary up to $150,000 pay (not including overtime)	$
2.	Annual salary divided by 52 weeks (#1/52)	$
3.	Benefit %	60%
4.	Weekly Benefit (#2 x .60)	
5.	Weekly Benefit divided by 10 (#4/10)	$
6.	Enter the rate for your age as of July 1st	
7.	Your monthly cost (#5 x #6)	$

Why UnitedHealthcare Short-term Disability?

- Income protection with weekly payments
- Personal claim support to help you through the process
- Disability specialists to help you get back to work safely

Pre-existing Conditions Exclusion

UnitedHealthcare will not cover any disability that begins during the first 12 months after the covered person's effective date of insurance that is caused or contributed to by a pre-existing condition.

Pre-existing condition means: any Sickness or Injury including Mental Illness, Substance Abuse or Subjective Symptoms for which the Covered Person, within 3 months prior to his Effective Date of insurance:

- was diagnosed by or received Treatment from a legally qualified Physician; or
- had symptoms for which an ordinarily prudent person would have sought Treatment.

If you enroll when you first become eligible, you don't need to provide evidence of insurability, which requires you to complete a form to prove your physical condition.

UnitedHealthcare Disability products are provided by UnitedHealthcare Insurance Company. The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, see your Certificate of Coverage or contact your employer. UnitedHealthcare Insurance Company is located in Hartford, CT.

Long-Term Disability Benefits

Benefits are offered through UnitedHealthcare

Almost half of American adults indicate they can't pay an unexpected $400 bill without having to take out a loan or sell something to do so.

Disability Statistics; Chance of Becoming Disabled." Council for Disability Awareness: Prevention, Financial Planning, Resources and Information, 28 Mar. 2018, disabilitycanhappen.org/disability-statistic/

Help secure a monthly income if an illness or injury keeps you out of work for a long period of time.

Don't let an off-the-job accident or an illness leave you in a financial bind if you are unable to work for months.

An injury or long illness can create more than just financial and emotional stress. That's why a UnitedHealthcare Long-term Disability plan is designed to do two important things:

1. Give you long-term financial support.
2. Help reduce stress and health issues that can prolong being out of work.

How the plan works.

The Long-term Disability plan will pay you 60% of your paycheck each month if you have a qualifying long-term disability where you are unable to perform your job duties for 180 days or longer.

A steady monthly income not only helps you and your family cover expenses, it may help reduce stress that comes with being out of work for a long period.

You can even work part-time.

Being productive feels good. That's why the plan also allows you to work part-time and still receive benefit payments. We understand that you may have to work your way back up to earning 100 percent of your income, which is the goal.

Your well-being is what matters most.

The plan includes resources and benefits designed to support you along the way and at no extra cost:

- 24/7 Employee Assistance Program (EAP)
- Return-to-work preparation
- Workplace modification benefit

2023–24 Voluntary Long-Term Disability Rates	
As of July 1	**6 Months**
Less than 25	$0.050
25 - 29	$0.080
30 - 34	$0.120
35 - 39	$0.140
40 - 44	$0.170
45 - 49	$0.240
50 - 54	$0.360
55 - 59	$0.430
60 - 64	$0.450
65 - 69*	$0.470
70 & Over*	$0.500

**Benefits reduced. Check website for further information.*

Please note: Your benefit payment will be reduced by other income you receive or are eligible to receive, due to your disability. This includes, but is not limited to sick leave or donated leave. *(Please see the Certificate of Coverage for additional details)*

Why UnitedHealthcare Long-term Disability?

- Income protection with monthly payments
- Personal claim support to help you through the process
- 24/7 Employee Assistance Program for confidential and emotional support
- Disability specialists to help you adjust and get back to work safely

Premium Calculation

1.	Enter your Basic Gross Annual Salary up to $150,000 pay (not including overtime)	$ _____
2.	Annual salary divided by 12 = covered monthly earnings	$ _____
3.	Monthly divided by 100 (#2/100)	$ _____
4.	Enter the rate for your age as of July 1st	_____
5.	Your monthly cost (#3 x #4)	$ _____
6.	Monthly Benefits = 60% of Covered Monthly earnings (#2 x .60)	$ _____

Pre-existing Conditions Exclusion

UnitedHealthcare will not cover any disability that begins during the first 12 months after the covered person's effective date of insurance that is caused or contributed to by a pre-existing condition.

Pre-existing condition means: any Sickness or Injury including Mental Illness, Substance Abuse or Subjective Symptoms for which the Covered Person, within 3 months prior to his Effective Date of insurance:

- was diagnosed by or received Treatment from a legally qualified Physician; or
- had symptoms for which an ordinarily prudent person would have sought Treatment.

If you enroll when you first become eligible, you don't need to provide evidence of insurability, which requires you to complete a form to prove your physical condition.

Life and AD&D Insurance Benefits

Benefits are provided by The Hartford

The State of Nebraska offers both life and accidental death and dismemberment (AD&D) insurance coverage to teammates. Newly hired teammates 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 teammates with a basic life insurance benefit of $20,000 at no cost. Part-time teammates, 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) – Teammate Only

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

AD&D Information	
Rate	$0.10/month
Coverage	Up to $7,500
* Dependent coverage is not available.	

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

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

Accelerated Death Benefit

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

- Diagnosed with a terminal illness and not expected to survive more than 24 months; or

The Amount of Accelerated Death Benefit

You can request up to the Accelerated Death Benefit percentage or 80% of the life insurance that is currently in effect however not:

- Less than $3,000 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 The Hartford. 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. Teammates 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, teammates currently enrolled in Supplemental Life may increase one increment of coverage without approval by the carrier. Any increases outside of the Open Enrollment period, or any increases greater than one increment, will require evidence of insurability and approval by the carrier.

Supplemental Life Coverage - Monthly Rates

Age	Rate/$1,000
Under 25	$0.020
25-29	$0.020
30-34	$0.026
35-39	$0.039
40-44	$0.058
45-49	$0.084
50-54	$0.142
55-59	$0.305
60-64	$0.583
65-69	$0.952
70-74	$1.295
75-79	$2.060
80 and over	$2.060

Open Enrollment Only

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

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):	$ _____
2.	Multiply by the increment you elected (0.5, 1, 1.5, 2, 3, 4, or 5)	x ___ =
3.	Round the amount in line #2 up to the next highest $1,000	_____
4.	Multiply line #3 by the rate per $1,000 of coverage for your age as of 7/1 (see table to left)	x _____
5.	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 $0.142. She multiples $175,000 by $0.142 for a total of $24,850.

5. Finally, she divides by $24,850 by 1,000. Callie's cost of supplemental life coverage will be $24.85 each month.

Employee Assistance Program (EAP)

Benefits are offered through Deer Oaks Employee Assistance Program

Program Access

Helpline: (866) 792-3616
Website: www.deeroakseap.com
Login and Password: SON

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for teammates 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.

Check out the iConnectYou Mobile App through which members may engage with their benefit via phone, video, or instant messaging. The app not only allows users to initiate contact with the program, but can also be used to deliver structured telephone or video counseling. Informational resources are also available. iConnectYou is available as a free download via Google Play and App Store.

FEATURES INCLUDE:

- Regularly updated information and links
- Downloadable articles and tip sheets
- Self-search provider databases for summer camps, education resources, pet sitters, attorneys, financial advisors, volunteer opportunities, and more
- Legal and medical encyclopedias
- Financial and daily living calculators
- Savings Center providing 25 to 70 percent discounts on namebrand merchandise
- Spanish-language content

COBRA and Retiree Medical, Dental, and Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2023, through June 30, 2024, are shown below.

Monthly Medical Plan Premiums

		Wellness Health Plan With Wellness Incentive	Wellness Health Plan Without Wellness Incentive	Regular Health Plan	Consumer Focused Health Plan
Retiree/COBRA Employee Only (Single Coverage)	**Retiree:**	$689.76	$833.14	$833.14	$471.16
	COBRA:	$703.55	$849.80	$849.80	$480.59
Retiree/COBRA Employee + Spouse (Two-Party Coverage)	**Retiree:**	$1,827.90	$2,207.76	$2,207.76	$1,248.58
	COBRA:	$1,864.46	$2,251.91	$2,251.91	$1,273.56
Retiree/COBRA Employee + Dependent Children (Four Party Coverage)	**Retiree:**	$1,414.04	$1,707.92	$1,707.92	$965.92
	COBRA:	$1,442.32	$1,742.08	$1,742.08	$985.24
Retiree/COBRA Employee + Spouse + Dependent Children (Family)	**Retiree:**	$2,448.66	$2,957.58	$2,957.58	$1,672.64
	COBRA:	$2,497.64	$3,016.73	$3,016.73	$1,706.09

Direct Primary Care Monthly Premiums and Membership Fees

		High Deductible Health Plan Select	High Deductible Health Plan Standard	Membership Fees
Retiree/COBRA Employee Only (Single Coverage)	**Retiree:**	$336.26	$290.54	$89.00
	COBRA:	$342.98	$296.35	$90.78
Retiree/COBRA Employee + Spouse (Two-Party Coverage)	**Retiree:**	$953.66	$832.50	$178.00
	COBRA:	$972.73	$849.15	$181.56
Retiree/COBRA Employee + Dependent Children (Four Party Coverage)	**Retiree:**	$724.44	$630.70	$150.00
	COBRA:	$738.93	$643.32	$153.00
Retiree/COBRA Employee + Spouse + Dependent Children (Family Coverage)	**Retiree:**	$1,212.04	$1,049.72	$299.00
	COBRA:	$1,236.28	$1,070.72	$304.98

Monthly Dental Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	$26.44	$30.95
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	$52.96	$61.95
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	$76.38	$89.31
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	$83.21	$96.96

Monthly Vision Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	$5.37	$8.34
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	$8.61	$13.34
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	$8.79	$13.59
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	$14.14	$21.93

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 or email at as.employeebenefits@nebraska.gov.

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

See page 41 for COBRA/Retiree Premiums.

Early Retiree Insurance Program

This program was created for state teammates 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 teammate costs. The teammate 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 teammate/retiree is also enrolled.

When Retiree Insurance Ends

1. Retiree coverage ends 1st of the month in which they turn age 65.
   - Dependents will be offered to continue coverage on COBRA for 36 months or until the beginning of the month when the dependent turns age 65, whichever is sooner.
2. Spouse coverage ends 1st of the month in which they turn age 65.
3. Coverage in the health care FSA may only be continued 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 teammates.

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 or email at as.employeebenefits@nebraska.gov.

Disability Retirement Insurance

A teammate under age 55 may retire as a result of disability. A teammate 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 teammate 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 following the end of each 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 following the end of each 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 800-791-9361 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.**

Long Term Disability (LTD)

UnitedHealthcare

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/personnel/wellness/index.html**. Please contact UnitedHealthcare at 877-683-8601 within 31 days of your termination if you would like to take advantage of the Portability Policy.

Short Term Disability is not portable upon leaving employment with the State of Nebraska.

Basic & Voluntary Life

The Hartford

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 The Hartford directly at 877-320-0484 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/personnel/wellness/index.html**.

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!

Legal Notifications

Summary Plan Documents

Plan documents are accessible through the Employee Wellness & Benefits Resources page at **das.nebraska.gov/personnel/wellness/index.html**.

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

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

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

Mental Health Parity Act

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

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

Benefits for ALL inpatient admissions must be pre-certified.

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

Notice of Special Enrollment

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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, 2022.** Contact your State for more information on eligibility –

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Medicaid
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.colorado.gov/pacific/hcpf/healthinsurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 678-561-1162, Press 1
CA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaida-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TYY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp
Phone: 1-800-657-3739

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

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid & CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programsand-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
https://www.dol.gov/agencies/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 1/31/2023)

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?

Members that become eligible for Medicare part D can keep this coverage if they elect part D and this plan will coordinate with Part D coverage.

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 the State of Nebraska and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

CMS Form 10182-CC Updated April 1, 2011

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

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

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

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

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.
PLEASE REVIEW IT CAREFULLY.

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

USES AND DISCLOSURES OF YOUR INFORMATION

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

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

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

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

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

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

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

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

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

Deceased Individuals. The Plan may disclose the health information of a deceased individual to a coroner, medical examiner or funeral

director to carry out their duties as allowed by law.

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

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

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

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

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

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

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

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your Protected Health Information to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you, (2) your health and safety and the health and safety of others, or (3) the health and security of the correctional institution.

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

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

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

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

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

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

INDIVIDUAL RIGHTS

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

Amendment to Your Health Information. You have the right to request in writing that the health information the Plan maintains about you be amended or corrected. The Plan is not obligated to make all requested amendments but will give each request careful consideration. For example, if the Plan did not create the information, your request will be denied. If the Plan denies your request, you

will be provided with a written explanation and an explanation of your rights. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment.

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

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

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

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

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

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

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

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

FSA Benefits
ASIAdmin
ASIFlex
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.

NOTES

NEBRASKA

DEPT. OF ADMINISTRATIVE SERVICES

Employee Wellness and Benefits
1526 K Street, Suite 110
Lincoln, Nebraska 68508

das.nebraska.gov/personnel/wellness/index.html

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