

# 2012 BENEFITS GUIDE

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**NOTE:** This packet is only a summary of the Employee Benefit's program. A more complete description of the program's provisions and benefits can be found in the Summary Plan Description, Plan documents and underlying contracts. In the event of a discrepancy between the Summary Plan Description and the Plan documents, the plan documents and underlying contracts will rule. The Company reserves the right to make final decisions concerning the interpretation and application of the Employee Benefit's program and the benefit plans.

## *Mutual of Omaha Benefits*

### **Benefit Options**

As part of Mutual of Omaha's total compensation package, we offer employees a variety of benefit options. Review the information in this Benefits Guide to help you make the most of your benefit options and to prepare you to make your benefit choices. You may use [HR@Home](#) through the Internet to find benefit information when you are at home, if needed. The Web site is referenced on the last page of this Benefits Guide.

#### **Level of Coverage Options**

Your level of coverage is based on the following categories:

- Employee Only (You are the only person covered)
- Employee + One (You and one eligible dependent is covered)
- Employee + Family (You and two or more eligible dependents are covered)

**NOTE:** If you are enrolling a spouse to any of your coverages, you must provide Corporate Benefits and Services Department a copy of your certified marriage license, in order to have your spouse covered on your benefit effective date. A copy of your certified marriage license can be faxed to (402) 351-6192.

### **Eligibility for Benefits**

#### **Eligible Dependents**

For all applicable benefit plans, eligible dependents include:

- Your spouse
- Your same sex domestic partner
- Your child

Please see the Definition Section of this Benefits Guide for the definition of Child, Foster Child, Same Sex Domestic Partner and Spouse.

If you have a parent who works at Mutual, you cannot be enrolled as a dependent under their health, dental and/or vision coverage. You must be enrolled as an employee. If both you and your spouse work for Mutual of Omaha, you may each enroll separately in a health, dental and/or vision plan. Or, one of you may elect coverage in which the other is enrolled as a dependent. The employee who elects coverage is the primary covered person.

## *Mutual of Omaha Benefits*

### **Eligibility for Benefits, continued**

#### **Benefits Eligibility Based on Scheduled Hours Worked**

The following benefit plans are available according to your employment status, if you enroll during your designated enrollment period:

<b>Benefit Plan (Scheduled Hours Per Week)</b>	<b>Coverage Effective Date</b>	<b>(30 hrs or more)</b>	<b>(20 – 30 hrs)</b>	<b>(&lt; 20 hrs)</b>	<b>Temporary (40 hrs or less)</b>
Basic Employee Life	Date of Hire	X			
Basic Long-Term Disability	Date of Hire	X			
Health	Benefits Effective Date	X			
Dental	Benefits Effective Date	X			
Vision	Benefits Effective Date	X			
Supplemental Life	Benefits Effective Date	X			
Spouse Life	Benefits Effective Date	X			
Child Life	Benefits Effective Date	X			
Basic Accidental Death & Dismemberment	Benefits Effective Date	X			
Supplemental Accidental Death & Dismemberment	Benefits Effective Date	X			
Supplemental Long-Term Disability	Benefits Effective Date	X			
Health Care Flexible Spending Account	Benefits Effective Date	X			
Dependent Care Flexible Spending Account	Benefits Effective Date	X	X	X	
Legal Services	Benefits Effective Date	X	X	X	
401(k) Plan	Benefits Effective Date	X	X	X	X

As an eligible employee, you have the opportunity to enroll in the benefits program each year. Once you have made your benefit elections, they remain in effect throughout the year, unless you have a qualified Life Event as defined in the Definitions Section of this Benefits Guide.

# *Mutual of Omaha Benefits*

## **Eligibility for Benefits, continued**

### **Benefit Effective Dates Based on Hire Date**

<b>Employment Hire Date</b>	<b>Benefit Effective Date</b>
January 1 <sup>st</sup> – January 18 <sup>th</sup>	February 1 <sup>st</sup>
January 19 <sup>th</sup> – January 31 <sup>st</sup>	March 1 <sup>st</sup>
February 1 <sup>st</sup> – February 16 <sup>h</sup>	March 1 <sup>st</sup>
February 17 <sup>th</sup> – February 29 <sup>th</sup>	April 1 <sup>st</sup>
March 1 <sup>st</sup> – March 18 <sup>th</sup>	April 1 <sup>st</sup>
March 19 <sup>th</sup> – March 31 <sup>st</sup>	May 1 <sup>st</sup>
April 1 <sup>st</sup> – April 17 <sup>th</sup>	May 1 <sup>st</sup>
April 18 <sup>th</sup> – April 30 <sup>th</sup>	June 1 <sup>st</sup>
May 1 <sup>st</sup> – May 18 <sup>th</sup>	June 1 <sup>st</sup>
May 19 <sup>th</sup> – May 31 <sup>st</sup>	July 1 <sup>st</sup>
June 1 <sup>st</sup> – June 17 <sup>th</sup>	July 1 <sup>st</sup>
June 18 <sup>th</sup> – June 30 <sup>th</sup>	August 1 <sup>st</sup>
July 1 <sup>st</sup> – July 18 <sup>th</sup>	August 1 <sup>st</sup>
July 19 <sup>th</sup> – July 31 <sup>st</sup>	September 1 <sup>st</sup>
August 1 <sup>st</sup> – August 18 <sup>th</sup>	September 1 <sup>st</sup>
August 19 <sup>th</sup> – August 31 <sup>st</sup>	October 1 <sup>st</sup>
September 1 <sup>st</sup> - September 17 <sup>th</sup>	October 1 <sup>st</sup>
September 18 <sup>th</sup> – September 30 <sup>th</sup>	November 1 <sup>st</sup>
October 1 <sup>st</sup> – October 18 <sup>th</sup>	November 1 <sup>st</sup>
October 19 <sup>th</sup> – October 31 <sup>st</sup>	December 1 <sup>st</sup>
November 1 <sup>st</sup> – November 17 <sup>th</sup>	December 1 <sup>st</sup>
November 18 <sup>th</sup> – November 30 <sup>th</sup>	January 1 <sup>st</sup>
December 1 <sup>st</sup> – December 18 <sup>th</sup>	January 1 <sup>st</sup>
December 19 <sup>th</sup> – December 31 <sup>st</sup>	February 1 <sup>st</sup>

If you are not Actively at Work on the date coverage would normally begin, your effective date is delayed until you return to work.

## *Mutual of Omaha Benefits*

### **An Opportunity to Change Your Benefit Elections During the Year**

#### **Life Event**

IRS regulations determine when you can make changes to your benefit elections depending on changes in your status. Following are some examples of what may qualify:

- You become married or divorced
- You acquire an eligible dependent
- Your spouse loses health coverage under an employer's group plan because of a change in your spouse's job status or because the spouse's employer terminates its group plan
- Your dependent loses his or her eligibility under this Plan or another employer's group plan
- Your spouse or dependent obtains coverage under an employer's group plan because of a change in his or her job status or because his or her employer begins offering a group plan
- Your spouse makes a change during his or her employer's annual enrollment, with an effective date other than January 1.

In most situations, you may only add or delete dependents from your current coverage as the result of a Life Event change in status with the proper documentation, if required. Changes to your plan options must be consistent with the Life Event. If you increase the payroll deduction amount for Your Health Care Flexible Spending Account with an eligible Life Event, the increased dollar amount must be used for expenses incurred after the Life Event for services to be consistent with the Life Event. See the Definitions Section of this Benefits Guide for examples of Life Event changes.

To make a change in coverage due to a Life Event change in status, you must report the change in status to Corporate Benefits and Services Department within 31 days of the event. If you do not contact the Corporate Benefits and Service Department within 31 days of the Life Event and you are electing to add a dependent, you will need to wait until the next annual enrollment. If you are removing a dependent and did not contact the Corporate Benefits Service Department, you will be required to pay the premium for that dependent for the remainder of the Benefit Year, but the dependent will be removed from your coverages.

Contact the Corporate Benefits and Services Department by calling the HR Hotline at 402-351-3300 or toll free 1-800-365-1405 and select "1" for Benefits. You may also e-mail the Benefits Hotline for any questions you have regarding qualified Life Event changes.

## *Health Options and Coverage Details*

### **Waive Health Coverage**

Waive health coverage means that you are electing not to have health coverage through Mutual of Omaha as your employer. If you waive coverage, you should have health coverage through another plan. For instance, you may prefer to be covered under a spouse's health plan. Compare your options, look at physicians in the network, premiums or differences in coverage in order to find the best option for you and your family.

When deciding whether to be covered by two plans, look at whether the benefit of double coverage is worth the cost. With Coordination of Benefits plan provisions, one plan will pay its full benefits first, then the other plan may only pay the amount it would have paid had it been the primary plan.

You will have the option to change your waive election every year at annual enrollment or if you experience a Life Event, as long as the benefit change requested is consistent with the Life Event.

### **Health**

#### **PPO through Coventry Health Care**

The health plan allows you complete freedom to go to any Preferred Provider Option (PPO) (in-network) and/or Non PPO (out-of-network) health care provider. This includes direct access to specialists without prior approval from the plan. When using in-network providers, you reduce the cost of health care expenses because the plan pays a larger percentage of the expenses and deductibles are lower. On the other hand, if you choose out-of-network providers, you will have higher out of pocket costs because the plan pays a lower percentage of expenses, the deductibles are higher and coinsurance percentages are higher. How to locate a preferred in-network provider is referenced on the last page of this Benefits Guide.

#### **Grandfathered Health Plan**

Mutual of Omaha Group believes that the Mutual of Omaha Group Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Hotline at 402-351-3300 and select "1" for Benefits. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## *Health Options and Coverage Details*

### **In-Network Deductible Options**

Your health plan has two deductible options and you should choose the level of deductible best suited to you. A deductible is the amount of covered expenses that you must pay before the plan will start paying benefits.

Below are your calendar year deductible options:

<u>Individual</u>	<u>Family</u>
\$750	\$1,500
\$1,250	\$2,500

We will recognize your health deductibles met with other coverage only during the first plan year (Jan. 1 – Dec. 31) of service. Explanation of Benefits (EOB's) should be sent to Coventry Healthcare; Aberdeen Service Center; Attn: Katie Pierce; P.O. Box 2778; Bismarck, ND 58504.

### **Networks and Calendar Year Deductibles Comparison**

Plan Type	In-Network Providers	Out-of-Network Providers
<b>Plan Payments*</b>		
Hospitalization	85%	75%
Physician Services	85%	75%
Surgery	85%	75%
Prescription Drugs	RX Drug Program	50%
<b>Calendar Year Deductible</b>	<b>Per Person/Per Family</b>	<b>Per Person/Per Family</b>
Low Deductible	\$750/\$1,500	\$1,000/\$2,000
High Deductible	\$1,250/\$2,500	\$1,750/\$3,500
<b>Out of Pocket Maximum</b>	<b>Per Person/Per Family Excluding RX and Medical Deductible</b>	<b>Per Person/Per Family Excluding RX and Medical Deductible</b>
Low Deductible	\$2,500/\$5,000	\$5,000/\$10,000
High Deductible	\$2,500/\$5,000	\$5,000/\$10,000

There is no Lifetime Maximum Amount for the Health Plan

\* The figures provided refer to the percentage paid after the calendar year deductible has been met.

### **Health Premiums Per Pay Period (Before Tax)**

Health Coverage	<i>You Pay</i> (Per Pay Period)
<b>\$750 Individual/\$1,500 Family Deductible PPO Health Option</b>	
Employee Only	\$54.50
Employee + One	\$105.50
Employee + Family	\$160.00
<b>\$1,250 Individual/\$2,500 Family Deductible PPO Health Option</b>	
Employee Only	\$26.50
Employee + One	\$57.50
Employee + Family	\$93.50

## *Health Options and Coverage Details*

### Schedule of Health Benefits

<b>Schedule of (PPO) Benefits for Active Covered Persons:</b>		
<b>Benefits</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
Choice of Physician	You choose any licensed Physician or Hospital that is participating in the network.	You choose any licensed Physician or Hospital that is <b>not</b> participating in the network.
“Benefit Year” means a Calendar Year, which is the period of 12 consecutive months commencing on January 1 <sup>st</sup> and continuing through December 31 <sup>st</sup> of that year		
Deductible (Per Benefit Year) Individual/Family	Individual \$750/Family \$1,500	Individual \$1,000/Family \$2,000
	Individual \$1,250/Family \$2,500	Individual \$1,750/Family \$3,500
Out-of-Pocket Maximums: (Deductibles and Copayments for Prescription and medical are not included)	Individual \$2,500/Family \$5,000	Individual: \$5,000/Family \$10,000
	Individual \$2,500/Family \$5,000	Individual: \$5,000/Family \$10,000
There is no Lifetime Maximum Limit for the Health Plan		

Note: In-Network and Out-of-Network Deductible and Out-of-Pocket Maximums are combined. Visit limits and Maximum Benefits are combined for both In-Network and Out-of-Network.

#### Preventive Care

<b>Covered Charges</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
Preventive Health Care- Newborn through Age 6	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Childhood Immunizations recommended by the American Academy of Pediatrics – Newborn through Age 6 diphtheria, tetanus, pertussis, measles, mumps and rubella; haemophilus influenza type B (HIB); hepatitis A; hepatitis B; pneumococcal; inactivated poliovirus; varicella; meningococcal; and rotavirus, but excludes influenza vaccinations.	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Physical Exam Benefits-Age 7 and older	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.

## *Health Options and Coverage Details*

### Schedule of Health Benefits, continued

#### Preventive Care

Covered Charges	In-Network Providers	Out-of-Network Providers
Routine vaccines include: <u>Tetanus, Diphtheria &amp; Pertussis (Tdap)</u> ; <u>meningococcal</u> ; <u>pneumococcal</u> ; <u>hepatitis A</u> ; <u>hepatitis B</u> ; <u>inactivated poliovirus</u> ; <u>measles, mumps, rubella</u> ; <u>Varicella (Chickenpox)</u> ; <u>Gardasil Vaccine (cervical cancer and HPV)</u> <u>Zostavax Vaccine (shingles)</u>	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Routine Mammography – (limited to one per Benefit Year)	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Routine Colonoscopy-- one test every 5 years	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Colorectal Cancer Screening limited to: Fecal occult blood test (once annually for age 40 and over); Sigmoidoscopy, screening (one every 5 years for age 50 and over); and Double Contrast Barium Enema (DCBE) (one every 5 years for age 50 and over)	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Prostate Cancer Screening Prostate Specific Antigen (PSA) (one annually for men age 40 and over)	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.

#### In-Hospital Confinement and Services

Covered Charges	In-Network Providers	Out-of-Network Providers
Room and Board, X-ray, Lab and other covered Hospital charges	\$100 Copayment per Hospital admission. Services covered at 85% after Deductible. Coinsurance 15%.	\$100 Copayment per Hospital admission. Services covered at 75% after Deductible. Coinsurance is 25%.

## *Health Options and Coverage Details*

### Schedule of Health Benefits, continued

#### **In-Hospital Confinement and Services**

<b>Covered Charges</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
Mental and Nervous Disorders	\$100 Copayment per Hospital admission. Health Plan pays 85% after the Deductible, Coinsurance is 15%.	\$100 Copayment per Hospital admission. Health Plan pays 75% after the Deductible, Coinsurance is 25%.
Substance Abuse Treatment	\$100 Copayment per Hospital admission. Health Plan pays 85% after the Deductible, Coinsurance is 15%.	\$100 Copayment per Hospital admission. Health Plan pays 75% after the Deductible, Coinsurance is 25%.
Emergency Room (Copayment waived if Hospitalized)	\$50 Copayment each visit. Services covered at 85% after Deductible, Coinsurance is 15%.	\$50 Copayment each visit. Services covered at 75% after Deductible, Coinsurance is 25%.
Organ Transplant Benefits	Coventry Transplant Network: Health Plan pays 85% after Deductible; including up to \$25,000 for Donor Expenses. Coinsurance is 15%. Other Network Providers: Health Plan pays 85% after Deductible; including up to \$10,000 for Donor Expenses. Coinsurance is 15%.	Health Plan pays 75% after Deductible, including up to \$5,000 for Donor Expenses. Coinsurance is 25%.  Coinsurance for out of network Organ Transplants will not be applied to the Out-of-Pocket Maximum.
Inpatient Rehabilitation Therapy Services (Maximum combined In-Network and Out-of-Network Providers is limited to 60 days per Benefit Year)	Health Plan pays 85% after the Deductible, Coinsurance is 15%.	Health Plan pays 75% after the Deductible, Coinsurance is 25%.

#### **Outpatient Facility Services**

<b>Covered Charges</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
Hospitals, Outpatient Surgery Facility	Health Plan pays 85% after the Deductible, Coinsurance is 15%.	Health Plan pays 75% after the Deductible, Coinsurance is 25%.
Urgent Care Facility	Health Plan pays 85% after the Deductible, Coinsurance is 15%.	Health Plan pays 75% after the Deductible, Coinsurance is 25%.

#### **Physician Services**

<b>Covered Charges</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
Hospital, Office and Home Visits	Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Maternity Care	Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Physician Surgical Services	Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Outpatient Mental and Nervous Disorders	Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Outpatient Substance Abuse Treatment	Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.

## *Health Options and Coverage Details*

### Schedule of Health Benefits, continued

#### Physician Services

Covered Charges	In-Network Providers	Out-of-Network Providers
Outpatient Therapy Services	Health Plan pays 85% after Deductible not to exceed 60 visits per Benefit Year for Occupational and Physical therapy combined; and 30 visits per Benefit Year for Speech therapy. Coinsurance is 15%.	Health Plan pays 75% after Deductible not to exceed 60 visits per Benefit Year for Occupational and Physical therapy combined; and 30 visits per Benefit Year for Speech therapy. Coinsurance is 25%.
Acupuncture Treatment	Health Plan pays 85% of a maximum allowable of \$50 per visit, after Deductible, not to exceed 18 visits per Benefit Year. Coinsurance is 15%.	Health Plan pays 75% of a maximum allowable of \$50 per visit, after Deductible, not to exceed 18 visits per Benefit Year. Coinsurance is 25%.
Non Surgical Spinal Treatment (example – Chiropractic Care)	Health Plan pays 85% of a maximum allowable of \$35 per visit, after Deductible, not to exceed one visit each day and 30 visits per Benefit Year. Coinsurance is 15%.	Health Plan pays 75% of a maximum allowable of \$35 per visit, after Deductible, not to exceed one visit each day and 30 visits per Benefit Year. Coinsurance is 25%.
E.R. physician, radiologist, anesthesiologist, pathologist (ERAP) When service is rendered in a Network Facility	Health Plan pays 85% after Deductible, Coinsurance is 15%.	If the ERAP provider is not participating in the network, but the facility is an In-Network Provider, the Health Plan pays 85% after the PPO Deductible, Coinsurance is 15%. For services rendered in an out-of-network facility, the Health Plan pays 75% after the out of network Deductible, Coinsurance is 25%.

#### Miscellaneous

Covered Charges	In-Network Providers	Out-of-Network Providers
Independent Radiology and Pathology (Lab, X-ray and High End Radiology (MRI, CT, PET, SPECT scans))	Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Colonoscopy : One test every 5 years, if not used for preventive care	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Mammography – If not used for preventive care, limited to one per Benefit Year.	Deductible is waived. Health Plan pays 100%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
Home Health Care	Health Plan pays 85% after Deductible up to one visit for the same type of visit per day and 100 visits per Benefit Year. Coinsurance is 15%.	Health Plan pays 75% after Deductible not to exceed 100 visits per Benefit Year and no more than one visit for the same type of service per day. Coinsurance is 25%.

## *Health Options and Coverage Details*

### Schedule of Health Benefits, continued

#### Miscellaneous

Covered Charges	In-Network Providers	Out-of-Network Providers
Hospice Care Inpatient:  Outpatient: (Maximum combined Inpatient and Outpatient benefit is limited to 185 days/visits)	Health Plan pays 85% after Deductible, Coinsurance is 15%.  Health Plan pays 85% after Deductible, Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.  Health Plan pays 75% after Deductible, Coinsurance is 25%.
Skilled Nursing Facility  (Maximum combined In-Network and Out-of-Network benefit is limited to 100 days per Benefit Year)	\$100 Copayment per Hospital admission. Health Plan pays 85% after the Deductible. Coinsurance is 15%.	\$100 Copayment per Hospital admission. Health Plan pays 75% after Deductible, Coinsurance is 25%.
Ambulance	Health Plan pays 80% of charges, Coinsurance is 20%. Deductible waived.	Health Plan pays 80% of charges, Coinsurance is 20%. Deductible waived.
Infertility	Health Plan pays up to a maximum of \$2,500 while covered under the Health Plan.	Health Plan pays up to a maximum of \$2,500 while covered under the Health Plan.
Smoking Cessation	\$50 Copayment for Chantix and other smoking cessation drugs.	Reimbursement for Covered Drugs and medicines will be limited to 50% for nonparticipating providers.

#### All Other Covered Charges

Covered Charges	In-Network Providers	Out-of-Network Providers
Durable Medical Equipment and Prosthetics	Health Plan pays 85% after the Deductible, and Coinsurance is 15%.	Health Plan pays 75% after Deductible, Coinsurance is 25%.
VSP Free Vision Discounts	If You are enrolled in Mutual of Omaha's health plan and not enrolled in the Voluntary VSP vision coverage, You are entitled to discounts on eye exams and eyewear from VSP participating vendors.	If You are enrolled in Mutual of Omaha's health plans and not enrolled in the Voluntary VSP vision coverage, You are entitled to discounts on eye exams and eyewear from VSP participating vendors.

#### Prescription Benefits

Prescription Drug Card Deductible: \$50 per person per Benefit Year before Copayment applies				Reimbursement for Covered Drugs and medicines will be limited to 50% for nonparticipating providers.
	<b>Generic</b>	<b>Brand Formulary</b>	<b>Brand Non-Formulary</b>	
Retail Pharmacy (30-day supply)	\$12	\$30	\$50	
Mail Order (90-day supply)	\$36	\$90	\$150	

# *Health Options and Coverage Details*

## Schedule of Health Benefits, continued

### Prescription Benefits

Covered Charges		In-Network Providers		Out-of-Network Providers
Diabetic Supplies-Retail	\$5	\$5	\$50	
Diabetic Supplies-Mail Order	\$15	\$15	\$150	
Prescription Drug Card				
Deductible: \$50 per person per Benefit Year before Copayment applies				
Diabetic Supplies include needles, syringes, test tablets, sticks, strips and lancets.				
Specialty Pharmacy Drugs (for rare or complex diseases)	\$100 Copayment for a 30 day supply after prescription Deductible has been met.			
Contraceptives, which require a physician's written prescription are included.				

**Recertification** - You must recertify any hospital confinement, outpatient surgery and certain other services in order to receive maximum benefits payable under the plan. Refer to the Employee Benefits Handbook for a complete explanation of all of your group benefits including your medical coverages. You may also call the Customer Service number on the back of your ID card for more preauthorization information.

## Prescription Benefits

Prescription Drug Benefits are available to you and your eligible dependents if you are covered under one of the health deductible plans.

### Prescription Drug Deductibles

- A \$50 per person per calendar year deductible must be paid before copayments apply.

When purchasing prescription drugs, the calendar year deductible for each covered person on the plan must be paid first. Then on the remaining balance, the appropriate copay will follow on a claim over the deductible amount. The total of the prescription drug deductible and the copayment will not exceed the cost of the prescription. The prescription drug deductible is separate from the calendar year deductible on your health and dental plans. Reimbursement for out-of-network benefits for prescription drugs will be limited to 50%.

### Prescription Drug Copayments

<u>Retail Program (30-day supply)</u>		<u>Mail Order Program (90-day supply)</u>	
Generic	\$12	Generic	\$36
Brand Formulary	\$30	Brand Formulary	\$90
Brand Non-formulary	\$50	Brand Non-formulary	\$150

Utilize formulary prescription drugs to keep your prescription drug costs down for you and your eligible dependents. A formulary is a preferred list of drugs. If your prescription is on the formulary you will pay a lower copayment. If your prescription is not on the formulary you still have coverage but you will pay a

## *Health Options and Coverage Details*

### **Prescription Benefits, continued**

higher copayment. To view the formulary list or search for an in-network pharmacy, reference the Web site on the last page of this Benefits Guide. You may want to print out the formulary list and bring a copy with you when you visit your doctor.

There is a \$5 copayment payable for diabetic supplies listed on the Brand Formulary and a \$50 copayment for diabetic supplies listed on the Brand Non-formulary.

Specialty Pharmacy Drugs are most often an injectable medication for chronic diseases. When you receive a prescription for a specialty drug, you will pay a \$100 copayment for a 30-day supply after the calendar year prescription deductible has been met. For more detailed information on Specialty Pharmacy Drugs, please see your Employee Benefits Handbook.

## *Dental Options and Coverage Details*

### **Waive Dental Coverage**

Waive dental coverage means that you are electing not to have dental coverage through the Mutual of Omaha Dental Plan. Perhaps you prefer to be covered under a spouse's dental plan. Compare your options, look at dentists in the network, premiums or differences, in coverage in order to find the best option for you and your family.

When deciding whether to be covered by two plans, look at whether the benefit of double coverage is worth the cost. With Coordination of Benefits plan provisions, one plan will pay its full benefits first, then the other plan may only pay the amount it would have paid had it been the primary plan.

You will have the option to change your waive election every year at annual enrollment or if you experience a Life Event, as long as the benefit change requested is consistent with the Life Event.

### **Dental**

Mutual of Omaha Dental balances savings, service and customer satisfaction by providing easy access to the DenteMax network. The DenteMax network is available nationwide. When using DenteMax network providers, you reduce the cost of dental care expenses because the plan pays a larger percentage of the expenses and deductibles are lower. If you choose out-of-network providers, you will have higher out of pocket costs because the plan pays a lower percentage of expenses, the deductibles are higher and coinsurance percentages are higher. To view the DenteMax network provider directory, reference the Web site on the last page of this Benefits Guide.

All benefits are subject to your calendar year deductible. Our dental covers preventive, basic services, major services and orthodontics. Two dental cleanings are covered per calendar year for each covered person, unless You or Your eligible dependents are pregnant, have diabetes or heart disease, then four dental cleanings are covered per calendar year for each covered person.

## *Dental Options and Coverage Details*

### **Deductibles**

There is a calendar year deductible. A deductible is the amount of covered expenses that you must pay before the plan will start paying benefits. Below are the calendar year dental deductibles:

<u>In-network</u>	<u>Out-of-network</u>
\$25 per person, \$50 per family	\$75 per person, \$150 per family

### **Percentage Paid for Covered Services After The Calendar Year Deductible Has Been Met**

<u>Covered Services</u>	<u>Examples</u>	<u>In-Network Providers</u>	<u>Out-of-Network Providers</u>
Class I	Cleanings & X-rays	100%	100% of maximum allowance for out of network covered services
Class II	Prefabricated Crowns, Root Canals & Fillings	80%	60% of maximum allowance for out of network covered services
Class III	Cast Restoration Crowns, Dentures & Bridgework	60%	50% of maximum allowance for out of network covered services
Orthodontics	Braces	60%	50% of maximum allowance for out of network covered services
Annual Maximum		\$1,500 per person	\$1,500
Orthodontics Lifetime Maximum		\$1,500 per person	\$1,200

For detailed information on covered services, see the Employee Benefits Handbook Web site referenced on the last page of this Benefits Guide.

### **Predetermination of Benefits**

If your dental expense is going to be over \$300, we recommend you submit a dental Predetermination of Benefits form (Dental Claim Form) to show you and your dentist, in advance, what benefits will be payable. If available, less expensive alternative treatment plans will be presented. To access the Dental Claim Form used for predetermination of benefits, reference the link on the last page of this Benefits Guide.

### **Premiums Per Pay Period (Before Tax)**

Dental Coverage	<i>You Pay</i> (Per Pay Period)
Dental	
Employee Only	\$4.00
Employee + One	\$8.50
Employee + Family	\$15.00

## *Vision Option and Coverage Detail*

### **VSP Vision Benefits**

- You can purchase VSP vision coverage, even if you did not elect one of our health plans.
- By using a VSP participating vendor, you will have the following benefits:
  - Exam covered after a \$25 copay every calendar year
  - Prescription glasses (after a \$35 copay):
    - ◆ Lenses covered every calendar year
    - ◆ Frames covered up to \$150 every other calendar year
  - Contact Lens Care – up to \$60 copay for your contact lens exam (fitting and evaluation). When you choose contacts instead of glasses, your \$150 allowance applies to the cost of your contacts. The every calendar year exam is in addition to your vision exam to ensure proper fit of contacts. If you choose contact lenses, you will be eligible for a frame the next calendar year from the date the contact lenses were obtained.
  - Laser Vision Correction discounts
  - To search for a VSP participating vendor and to find out more about your VSP vision benefits, reference the last page of this Benefits Guide.

<b>VSP Vision Coverage</b>	<b>You Pay (Per Pay Period)</b>
VSP Vision	
Employee Only	\$3.94
Employee + One	\$5.65
Employee + Family	\$10.10

## *Health Care Flexible Spending Account*

### **Advantages of a Health Care Flexible Spending Account (FSA)**

The Health Care FSA allows you to set aside before-tax dollars to pay eligible health, prescription drug, dental, and vision expenses that other benefit plans don't cover. Mutual of Omaha does not cover over the counter expenses, even if prescribed by a physician, which includes prescribed marijuana. The Health Care FSA reduces your taxable income because your contributions are deposited in the FSA on a pre-tax basis. On a pre-tax basis means that your contribution is deducted from your paycheck before taxes are withheld. Your FSA can help you pay for expenses that are predictable. For example, if your income was \$30,000 and your out-of-pocket expenses totaled \$540 and you had \$45 a month deducted from your paycheck before taxes, you could save \$122 in taxes over the course of the year, because your taxable income would be reduced.

### **Contribution Amounts**

Minimum - \$60 per year

Maximum - \$5,000 per year

# *Health Care Flexible Spending Account*

## **Eligible Expenses**

- Health/dental out of pocket expenses
- Copayments
- Deductibles
- Expenses not covered by the plans or over plan maximums
- Vision/hearing expenses
- Lasik surgery to correct vision (make certain you are a candidate before enrolling in the FSA)

## **Setting Up Your Health Care Flexible Spending Account**

Estimate how much money you will need to cover your eligible expenses for the period from your benefit effective date to the end of the year to determine your annual contribution amount. Each year during annual enrollment period, as required by law, you will have the opportunity to re-enroll in the Health Care Flexible Spending Account. When you incur an eligible expense, you pay the expense, then you get reimbursed.

## **Important Internal Revenue Service (IRS) Requirements**

- Money contributed to Flexible Spending Accounts must be used for eligible expenses incurred during the year that it is taken from your pay or it will be forfeited.
- Eligible expenses must be incurred after the date your plan participation begins.
- Money cannot be transferred between the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.
- The amount paid out will be equal to the annual pledge anytime during the calendar year.
- If you or your dependents are enrolled in a health savings account, participation in the Health Care FSA could jeopardize the ability for you or your dependents to make contributions to the health savings account. Please contact your tax advisor for additional information.

## **Reimbursement Methods**

To be reimbursed for you and your dependents' incurred expenses for health care, you have two methods to submit your expenses:

- Online
- Paper

### **Online Expense Reimbursement**

Eligible health, dental, prescription drug and vision expenses are submitted through Employee Self Service to the claim system, if you have elected one of our health, dental and/or vision plans. You will receive an e-mail notifying you when these expenses are available for online submission for reimbursement. The e-mail will provide you with a link to view your account online.

### **Paper Expense Reimbursement**

Eligible expenses that are not processed through our Employee Group Insurance Plan must be submitted on a paper claim form. These expenses include:

## *Health Care Flexible Spending Account*

### **Reimbursement Methods, continued**

- Vision, if not covered under VSP
- Lasik surgery
- Routine hearing exams and hearing aids
- Covered out-of-pocket health, dental, vision and prescription drug expenses incurred while you or your eligible dependents were covered under another health, dental or vision plan.

Paper claim forms are submitted to the Payroll Department for reimbursement. To print a copy of the paper Health Care FSA Claim Form, reference the link on the last page of this Benefits Guide.

### **Submitting the Claim**

Claim forms can be submitted weekly, bi-weekly, monthly or how often you wish. You can be reimbursed each week for eligible expenses from your Flexible Spending Account that you have submitted during the week. Reimbursement requests received by Monday at noon will be processed the same week. If Monday is a holiday, the reimbursement request must be received by 4:30 p.m., on the previous Friday. Reimbursement payments will be directly deposited into your existing payroll deposit account on Fridays after the claim has been processed.

After December 31, 2012, you will have until March 31, 2013, to submit reimbursement claims for health care expenses incurred during 2012.

## *Dependent Care Flexible Spending Account*

### **Advantages of a Dependent Care Flexible Spending Account (FSA)**

The Dependent Care FSA allows you to set aside before-tax dollars to pay eligible dependent care expenses. The Dependent Care FSA reduces your taxable income because your contributions are deposited in the FSA on a pre-tax basis. Pre-tax basis means that your contribution is deducted from your paycheck before taxes are withheld. Consult your tax advisor to determine if participating in the dependent care account would be to your advantage based on your combined household income and financial situation.

### **Contribution Amounts**

If both you and your spouse work or you are a single parent, you can contribute to the dependent care account. The maximum listed is a combined amount for you and your spouse. This is an IRS limit so you need to make sure you don't exceed it, if you have been contributing to a Dependent Care Flexible Spending Account through another employer.

Minimum - \$60 per year

Maximum - \$5,000 per year

# *Dependent Care Flexible Spending Account*

## **Eligible Expenses**

- Dependent Day Care expenses for an eligible dependent incurred while you are at work

Eligible expenses cannot exceed your spouse's earnings, unless your spouse is a full-time student or is disabled. If your spouse is a full-time student or disabled, their earnings are considered to be \$200 a month or \$400 a month if two or more dependents are receiving care.

## **Eligible Dependents**

An eligible dependent is someone you claim as a dependent on your tax return. The dependent must be under age 13 or a mentally or physically disabled spouse or dependent who lives in your home and is unable to care for himself or herself.

## **Setting Up Your Dependent Care Flexible Spending Account**

Estimate how much money you will need to cover your expenses for the rest of this year to determine your annual contribution amount. Remember vacation and school breaks (including the summer months). Each year during annual enrollment period, as required by law, you will have the opportunity to re-enroll in the Dependent Care Flexible Spending Account. When you incur an eligible expense, you pay the expense, and then you get reimbursed.

## **Important Internal Revenue Service (IRS) Requirements**

- Money contributed to Flexible Spending Accounts must be used for eligible expenses incurred during the year that it is taken from your pay or it will be forfeited.
- Eligible expenses must be incurred after the date your plan participation begins.
- Money cannot be transferred between the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.
- Expenses paid out are limited by the amount you contribute anytime during the year.

## **Reimbursement Method**

Once you incur and pay the expense, submit the expense to the Payroll Department. Use a reimbursement claim form and submit to PL – Payroll-Flexible Spending Accounts. If you are attaching a receipt with your claim form, remember a canceled check cannot be accepted as a receipt. To print a Dependent Care FSA Claim Form, reference the link on the last page of this Benefits Guide.

## **Submitting the Claim**

Claim forms can be submitted weekly, bi-weekly, monthly or how often you wish. You can be reimbursed each week for eligible expenses from your Flexible Spending Account that you have submitted during the week. Reimbursement requests received by Monday at noon will be processed the same week. If Monday is a holiday, the reimbursement request must be received by 4:30 p.m., on the previous Friday. Reimbursement payments will be directly deposited into your existing payroll deposit account on Fridays after the claim has been processed. After December 31, 2012, you will have until March 31, 2013, to submit reimbursement claims for dependent care expenses incurred during 2012.

## *Employee Life Insurance*

**The Employee, Spouse and Child Life options are term life products. The premiums are on an after-tax basis. Life restriction rules do apply to the Employee, Spouse and Child Life options. Life restriction rules apply after your new hire enrollment. You will only be able to move up one level at annual enrollment unless you experience a qualified Life Event, without proof of good health at your own expense.**

### **Basic Employee Life Benefits**

- The coverage is equal to one times your Annual Benefit Salary. Annual Benefit Salary is defined in the Definitions Section of this Benefits Guide
- Provided by the company at no cost to you
- Premiums for coverage exceeding \$50,000 (basic benefit only) are considered taxable income

### **Employee Supplemental Life Options**

- You may purchase an additional 1, 2, 3, 4 times your Annual Benefit Salary (Basic and Supplemental Life coverage cannot exceed a total of \$750,000)
- Includes waiver of premium for employees who become disabled

### **Employee Supplemental Life Costs**

The premiums for Employee Supplemental Life Insurance are paid by you on an after tax basis. The after tax amount is based on your age as of your new hire date and your smoking status. Thereafter, your after tax amount is based on your age as of August 31 in the current year and your smoking status. The amount of your coverage will not change during the year, even if your monthly pay changes. Below you can calculate your premiums per \$1,000 of coverage per pay period based on your age and smoking status:

<b>Employee Age As of Benefits Start Date</b>	<b>Nonsmoker Monthly Rate per \$1,000 of Coverage</b>	<b>Smoker Monthly Rate per \$1,000 of Coverage</b>
Under 30	\$ .07	\$ .16
30-34	\$ .08	\$ .16
35-39	\$ .10	\$ .16
40-44	\$ .15	\$ .21
45-49	\$ .23	\$ .33
50-54	\$ .30	\$ .46
55-59	\$ .45	\$ .69
60-64	\$ .56	\$1.05
65 and older	\$ .98	\$3.38

**EXAMPLES:** If you are under 30 and a nonsmoker you would multiply **.07 x \$25,000 (employees' annual salary) /\$1,000 = \$1.75 per month** or if you are 42 and a smoker you would multiply **.21 x \$35,000 (employees' annual salary) /\$1,000 = \$7.35 per month**. Divide by two to determine your after tax per pay period cost.

## *Spouse Life Insurance*

### **Spouse Life Options**

You may purchase the following amounts of life insurance:

- \$10,000
- \$25,000
- \$50,000
- \$75,000

The amount of life insurance for your spouse or same sex domestic partner cannot be greater than the amount of group life insurance carried on you, which includes your basic benefit plus any supplemental.

### **Spouse Life Costs**

<b>Spouse's Age</b>	<b>Per Pay Period Premium Based on Coverage Level Elected:</b>			
	<b>\$10,000</b>	<b>\$25,000</b>	<b>\$50,000</b>	<b>\$75,000</b>
Younger than 40	\$0.80	\$2.00	\$4.00	\$6.00
40-44	\$1.00	\$2.50	\$5.00	\$7.50
45-49	\$2.00	\$5.00	\$10.00	\$15.00
50-54	\$3.00	\$7.50	\$15.00	\$22.50
55-59	\$4.50	\$11.25	\$22.50	\$33.75
60-64	\$6.00	\$15.00	\$30.00	\$45.00
65 and older	\$13.50	\$33.75	\$67.50	\$101.25

## *Child Life Insurance*

### **Child Life Options**

You may purchase the following amounts of life insurance:

- \$10,000
- \$15,000
- \$20,000

Dependent children at least 14 days old can be covered as long as they are an eligible dependent.

### **Child Life Costs**

One premium covers all eligible children. Below are your per pay period after tax premiums based on coverage level elected:

<b>\$10,000</b>	\$0.35
<b>\$15,000</b>	\$0.70
<b>\$20,000</b>	\$1.40

## *Accidental Death & Dismemberment Insurance (AD&D)*

Accidental Death and Dismemberment benefits will be paid only if you die as a result of an accident or suffer certain losses in an accident. Benefits are also paid for paralysis as a result of an accident.

### **Basic AD&D Benefits**

- You will receive \$25,000 of employee AD&D coverage
- Provided by the company at no cost to you

### **Supplemental AD&D Options**

- You may purchase additional Supplemental AD&D benefits for the employee and eligible dependents from \$50,000 to \$250,000 in \$50,000 increments.
- If you enroll in family coverage, the benefit for your spouse or your same sex domestic partner is 40% of your benefit and the eligible child benefit is 10% of your benefit.

<b>Employee</b>	<b>Spouse (40%)</b>	<b>Children (10%)</b>
\$50,000	\$20,000	\$5,000
\$100,000	\$40,000	\$10,000
\$150,000	\$60,000	\$15,000
\$200,000	\$80,000	\$20,000
\$250,000	\$100,000	\$25,000

### **Supplemental AD&D Costs**

Below are your per pay period after tax premiums for the following options you may purchase:

	<b>Employee Only</b>	<b>Employee + One or Employee + Family</b>
<b>\$50,000</b>	\$ .75	\$1.00
<b>\$100,000</b>	\$1.50	\$2.00
<b>\$150,000</b>	\$2.25	\$3.00
<b>\$200,000</b>	\$3.00	\$4.00
<b>\$250,000</b>	\$3.75	\$5.00

## *Long-Term Disability (LTD)*

### **Basic Long-Term Disability Benefits**

Long-Term Disability benefits replace a portion of your pay if you become disabled and are unable to work.

- At no cost to you, the company provides basic monthly pay replacement of 60% of your Annual Benefit Salary, not to exceed a maximum monthly benefit of \$10,000. Annual Benefit Salary is defined in the Definitions Section of this Benefit Guide
- There is a six-month period before benefits are payable

### **Long-Term Disability Supplemental Options**

- You may purchase an additional 10% of supplemental LTD coverage for a total monthly pay replacement of 70% of your Annual Benefit Salary, not to exceed a maximum monthly benefit of \$13,333.

### **Long-Term Disability Supplemental Costs**

If you elect the additional 10% of coverage, your portion of the cost will be paid with before tax dollars from your pay. The cost is your monthly Annual Benefits Salary x .0030. Divide the monthly premium by two to get the per pay period premium.

## *Definitions*

**Accident:** An undesigned, sudden, and unexpected event in which you or your dependent is injured, and that injury is not due to a disease or sickness.

**After tax dollars:** Amounts taken from your paycheck after federal, state and Social Security taxes are deducted. Premiums for supplemental life insurance and AD&D insurance for the employee and life insurance and AD&D insurance for your spouse and your children are paid for with after-tax dollars.

**Annual Benefit Salary -**

(a) For salaried Employees hired prior to August 31 of the Annual Benefit Salary Determination Period, Annual Benefit Salary means base salary as of the last payroll in August of the Annual Benefit Salary Determination Period, plus any overtime pay, designated incentive compensation and any designated production bonus, paid during the 12 month period immediately prior to August 31 of the Annual Benefit Salary Determination Period.

(b) For salaried Employees hired after August 31 of the Annual Benefit Salary Determination Period, Annual Benefit Salary means base salary on the date of hire. For salaried sales Employees hired after August 31 of the Annual Benefit Salary Determination Period, Annual Benefits Salary means base salary on date of hire plus any designated guarantee compensation determined by the Policyholder or the applicable Affiliated Company on the date of hire.

## *Definitions, continued*

(c) For Employees who are paid on an hourly basis and were hired prior to August 31 of the Annual Benefit Salary Determination Period, Annual Benefit Salary means the scheduled hourly compensation, plus any overtime pay, designated incentive compensation and any designated production bonus, paid during the 12 month period immediately preceding August 31 of the Annual Benefit Salary Determination Period.

(d) For Employees who are paid on an hourly basis and were hired after August 31 of the Annual Benefit Salary Determination Period, Annual Benefit Salary means the annual equivalent salary (i.e., hourly rate x standard hours per month multiplied by 12) on the date of hire.

Except as described in the preceding paragraphs (a) through (d), Annual Benefit Salary does not include irregular, nonrecurring or extraordinary payments (other than irregular compensation included in base salary pursuant to the applicable compensation plan document), such as, but not limited to, severance pay, termination pay, lump-sum vacation pay, initial employment (sign on) or critical position bonuses, consulting fees, Deferred Compensation payments, employment referral bonuses, directors' fees, expense reimbursements, contest awards, Quality award payments, Employee performance awards, capital accumulation buy outs, relocation allowances, amounts not paid in cash or any payments reported on Form 1099 for tax purposes. Also, any commissions earned by division office personnel due to the personal sale of insurance or investment products and any imputed income because of taxable benefit amounts attributable to employer contributions will be excluded.

Annual Benefit Salary will only reflect changes in pay and scheduled hours that are in effect during the 12 month period immediately preceding August 31 of the Annual Benefit Salary Determination Period.

**Annual Benefit Salary Determination Period:** The calendar year preceding the year in which a Disability begins.

**Basic benefit:** Coverage is provided by the Company at no cost to you. Basic benefits are provided for Employee Life Insurance, Basic AD&D and Long-Term Disability (LTD) Insurance.

**Before tax dollars:** Amounts taken from your pay before federal, Social Security and, in most states, state income taxes are withheld. Therefore, you do not pay income taxes on most of the before tax dollars spent on premiums for the coverages you select and you have a tax savings because your taxable income is reduced.

**Child:** Your naturally-born child; a child that you have legally adopted; your step-child who is living in your home or who is the subject of a Qualified Medical Child Support Order requiring you or your spouse to provide health benefit coverage for the child; your foster child who has been placed in your care pursuant to a judgment, decree or court order; or a child for whom you have been appointed legal guardian.

**Deductible:** The amount of covered services you must pay before benefits are paid. A family deductible is the maximum amount of covered services that two or more family members must pay before benefits are paid.

**Default Coverage:** Employee will have no health and dental coverage, but will have Basic Employee Life Insurance, Basic AD&D and Basic Long-Term Disability (LTD) Insurance.

**Disability:** A participant will have a disability for purposes of the Benefit Plans if the participant is determined to have a disability under the Mutual of Omaha Long-Term Disability Plan.

**Disabled:** The status of an employee or a terminated employee who has a Disability.

## *Definitions, continued*

**Dismemberment:** Loss of limbs, eyes or eyesight.

**Formulary:** A list of preferred drugs that have been reviewed and approved by the Pharmacy and Therapeutics (P&T) committee. A formulary will be revised and updated according to the entrance of new drugs onto the market. Additions or revisions to the formulary occur only after a clinical review of the health literature. At all times, therapeutic safety and efficacy are reviewed prior to financial considerations when the P&T committee makes a formulary decision.

**Imputed income:** The cost of Basic Employee Life Insurance premiums paid by the company for insurance coverage exceeding \$50,000 (basic benefit) is subject to income tax reporting. The amount of imputed income is based on your age and the amount of coverage you have in excess of \$50,000 (basic benefit only). The amount that is taxable is added to your regular compensation and appears under the “Other” column on the right side of your pay advice as “Basic Life Insurance.” The cost is subject to Social Security (OASDI) and Medicare withholding. State and federal income taxes are not withheld during the year; however, the amount of imputed income will be included on your W-2 statement for the tax year and subject to state and federal income tax when completing your income tax return. Imputed income does not apply to supplemental life insurance coverage because the premiums are paid on an after tax basis.

**In-Network Provider:** A provider who is participating in a health and/or dental network.

**Life Event:** Events that allow you to change most of your benefit elections at any time during the year. If you have a Life Event, you must notify the Corporate Benefits and Services Department **within 31 days**. Permissible election changes are defined as follows according to each benefit area:

- **Gain dependents (Marriage, Birth, and Adoption):** You may add dependent coverage in the health, dental and vision plans if you are enrolled prior to the Life Event. Spouse Life Insurance and/or Child Life Insurance may be added or increased by one level without proof of good health. This coverage may be increased by more than one level if proof of good health is furnished. Employee Life Insurance also may be increased by one level without proof of good health, and by more than one level with proof of good health. The amount in Health Care and Dependent Care Flexible Spending Accounts may be added or increased.
- **Dependent ceases to qualify as a dependent (Attaining maximum age, foster child, stepchild):** You must drop coverage for dependents not eligible for the health, dental, vision, family AD&D, Spouse Life Insurance and Child Life Insurance. The former dependent may qualify for COBRA (extension of coverage for health and/or dental), if the loss of eligibility is reported in a timely basis.
- **Lose dependents (Death or Divorce):** You must drop coverage if a dependent dies or you get divorced. This could affect the level of health coverage you currently have.
- **Spouse loses coverage (Change in job status or spouse’s employer terminates its group plan):** You may add coverage for your spouse under any benefits area in which your spouse lost coverage. Coverage under certain life options would be available without proof of good health. This could affect the level of health coverage you currently have.

## *Definitions, continued*

- **Spouse or dependent obtains coverage (Change in job status or his or her employer begin offering a group health plan):** You may drop coverage for your spouse or dependent under any benefit area in which your spouse or dependent has recently obtained coverage through a group plan or because of a change in his or her job status
- **Transfer:** You can elect a higher deductible level by notifying the Corporate Benefits and Services Department within 31 days of your transfer.

**Out-of-Network Provider:** A doctor or other provider who is not participating in a health and/or dental network.

**Out of Pocket Maximum:** Once the amount you have paid (excluding deductibles) for covered services reaches the dollar amount shown, the plan pays 100% of incurred expenses for covered services for the rest of the calendar year.

**Paralysis:** Complete loss of function on one side of the body, the lower extremities or both the upper and lower extremities, which is total, irrecoverable and uncorrectable.

**Plan payments:** The percentage of expense the plan pays.

**Production Sales Employee:** An employee who participates in a sales incentive plan or sales compensation plan and are not eligible for the Mutual of Omaha Corporate Incentive Plan.

**Receipt:** Proof of payment. In many cases, Explanation of Benefits (EOBs) statements are required to submit a claim under your Health Care Flexible Spending Account, if the automated claim process is not used. It is important that you retain copies of EOBs for expenses you plan to submit. Canceled checks cannot be accepted as receipts for dependent day care expenses. It is your responsibility to obtain a receipt from the day care provider showing dates of service and amounts paid, or have the provider sign the reimbursement claim form.

**Same Sex Domestic Partner:** A license or certificate and/or other evidence acceptable to the Plan Administrator issued by a state, city and/or county demonstrating Your same sex marriage, civil union or other domestic partner relationship recognized under the applicable laws of such state, city and/or county.

**Smoking status:** Smoking status for Supplement Life Insurance is determined by whether or not you have regularly used tobacco or tobacco related products in the past 12 months. Regular usage is defined as frequent, recurring and habitual usage. Regular usage does not mean irregular, occasional or passive use. If you are a new employee, “past 12 months” is defined as the 12-month period prior to your employment. If your smoking status changes during the year, contact the HR Hotline at (402) 351-3300 and select “1” for Benefits.

**Spouse:** A person of Your opposite sex who is Your husband or wife, as applicable, as a result of a legal union between You and that individual.

## *Benefits Enrollment Tips*

- Take advantage of using in-network providers to lower your out of pocket costs.
- To reduce your health premiums, accept some risk by enrolling in the \$1,250 individual/\$2,500 family deductible PPO health option.
- Use generic or formulary prescriptions versus brand nonformulary prescriptions in order to eliminate higher copayments.
- Participate in the Flexible Spending Accounts (FSA) and save money by reducing your taxable income.
- Provide financial security for your family by enrolling in the Employee, Spouse and Child Life Insurance plans (if applicable), Accidental Death & Dismemberment and the additional 10% of supplemental Long-Term Disability plans.
- Keep your beneficiaries updated on-line with the correct beneficiary information to ensure that the person responsible for your expenses will receive the benefits payable.

## *Benefits FAQs*

1. **Q.** Are there any pre-existing condition exclusions on the health or dental plans?  
**A.** There are no pre-existing condition exclusions on the health or dental plans.
2. **Q.** I'm single and I don't anticipate having any out of pocket health expenses for the rest of this calendar year, so which health plan might be best for me?  
**A.** The \$1,250 individual/\$2,500 family deductible PPO health option would be the cheapest option for someone who has no out of pocket expenses.
3. **Q.** I have three children, so how much premium would I pay each pay period for \$10,000 worth of Child Life Insurance coverage?  
**A.** One premium covers all eligible dependents for the Child Life Insurance coverage, so the cost per pay period would be \$.35.
4. **Q.** When are my benefits effective?  
**A.** The Basic Employee Life and Basic Long-Term Disability (LTD) coverages are effective your first day of active employment. All other benefit coverages are effective on the first of the month, following 14 days of employment. To see when your benefits will be effective, please refer to the Benefits Start Dates table in the Benefits Guide.
5. **Q.** Can I list my children, who are ages 16 and 14, as my beneficiaries for the life insurance and Accidental Death and Dismemberment (AD&D) coverage?  
**A.** You may list your children as your beneficiaries, but please note that since they are under the age of 19, they are considered minors and therefore any benefits that would be payable to them, would instead be paid to their legal guardian(s).

## *Benefits FAQs, continued*

6. **Q.** What is dental pre-determination of benefits and when is it necessary?  
**A.** If the expense for your dental procedure(s) is going to be over \$300, we recommend you submit a dental Predetermination of Benefits form to show you and your dentist, in advance, what benefits will be payable. The Dental Claim form is available on Associate Access under Human Resources and then under Benefits & Retirement Planning.
7. **Q.** If I elect Accidental Death and Dismemberment (AD&D) coverage in addition to life insurance and I die in an accident, what benefits would be payable to my beneficiaries?  
**A.** Your beneficiaries would receive a life insurance benefit, as well as an AD&D benefit.
8. **Q.** I understand that if I'm approved for disability, there is a six-month waiting period before Long-Term Disability (LTD) benefits would begin. Are there any disability benefits available during the six-month waiting period?  
**A.** As a new employee, short-term disability benefits would be available to you, through an individual disability policy that you could purchase through Associate Insurance. Please contact Dewey Meyer (x8069) for information on this coverage. After 12 months of continuous service the Extended Illness Plan would provide benefit after a five-day elimination period, if eligible.
9. **Q.** How does the family deductible work?  
**A.** The family deductible amount is a combined deductible, which can be met through the covered expenses incurred by all covered family members. Once the family deductible is met, any additional covered expenses incurred by covered family members would be payable by the plan at the coinsurance percentage shown in the Schedule of Health Benefits table, found in the Benefits Guide.
10. **Q.** What if I waive (decline) health coverage, because I'm already covered by my spouse's insurance, but then he subsequently loses his job and therefore his health coverage ends?  
**A.** This would be a qualifying Life Event and as long as you contact the Corporate Benefits and Services Department within 31 days of this event, you would be able to make permissible changes to your benefit elections.
11. **Q.** How do I elect my beneficiaries for my life insurance and the 401(k) Plan?  
**A.** You will enter your beneficiary information through PeopleSoft Employee Quick Links. Entering your beneficiary information on-line through PeopleSoft Employee Quick Links will make it easier for you to review, change and update your designations at your convenience.

## *Web Sites, Links and Contact Information References*

While at work, you can find a lot of information about the benefit plans available to you on [Associate Access](#). Simply select “Human Resources” from the featured site links and then select “Benefits & Retirement Planning” to access your applicable topic of information.

You can also access information when you are away from work by utilizing [HR@Home](#).  
[www.mutualofomaha.com/HR@home](http://www.mutualofomaha.com/HR@home)

Select “Benefits” from the Reference Site Links found on the left hand menu to access applicable topics.

Coventry Medical In-Network Provider Link:

[www.chcnebraska.com](http://www.chcnebraska.com)

800-467-4917

Select “Locate a Provider (choose PPO)” located at the top of the screen to quickly access provider search links, Pharmacy locators and Rx Formulary listings.

If outside of Nebraska/ Iowa, use “Coventry National Network” as the product type.

DenteMax Dental In-Network Provider Link:

[www.mutualofomaha.com/dental](http://www.mutualofomaha.com/dental)

877-999-2330

VSP Provider Link:

[www.vsp.com](http://www.vsp.com)

800-877-7195

401(k) Account Information:

[www.getretirementright.com](http://www.getretirementright.com)

888-917-7191

Resources for additional information can be found on Associate Access or [HR@Home](#) by following instructions above. Among other pieces of information, you can find:

- Employee Quick Links
- Schedule of Health Benefits
- Flexible Spending Account Info & Reimbursement Forms
- Dental Pre-determination Forms
- Paid Time off benefits
- HR Policies

Refer to the Employee Benefits Handbook, found on Associate Access or [HR@Home](#) for a complete explanation of all of your group benefits.

Benefits Hotline:

Local (402) 351-3300, option 1

Toll Free (800) 365-1405, option 1

[Benefits.Hotline@mutualofomaha.com](mailto:Benefits.Hotline@mutualofomaha.com)

Payroll Hotline:

for questions on FSA processing:

Local (402) 351-3300, option 2

Toll Free (800) 365-1405, option 2