
The power is MUTUAL
2023
BENEFITS
GUIDE
Mutual of Omaha
612675

Table of Contents

NOTE: This packet is only a summary of the Employee Benefits 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.

Benefit Options

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

		Regular Status			Temporary Status
Benefit Plan	**Coverage Effective Date**	**30 hrs or more**	**20 – 29 hrs**	**< 20 hrs**	**40 or less**
Basic Employee Life & Basic Long-Term Disability	Date of Hire	X			
Health, Dental, Vision	Benefits Effective Date	X			*
Supplemental Life, Spouse Life, Child Life, Basic Accidental Death & Dismemberment, 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			
Voluntary Accident Insurance	Benefits Effective Date	X			
Voluntary Critical Illness Insurance	Benefits Effective Date	X			
Voluntary Hospital Indemnity Insurance	Benefits Effective Date	X			
Dependent Care Flexible Spending Account	Benefits Effective Date	X	X	X	
ARAG Legal Services w/ ID Theft Protection	Benefits Effective Date	X	X	X	
Nationwide Pet Insurance	Benefits Effective Date	X	X	X	X
Amplifon Hearing Discount Program	Benefits Effective Date	X	X	X	X
401(k) Plan	Benefits Effective Date	X	X	X	X
Vacation Accrual	Benefit Effective Date	X	X	X	X
Personal Time	Date of Hire	X	X	X	X
Holidays	Date of Hire	X	X	X	X
Tuition Reimbursement	Date of Hire	X	X		

***May be eligible for health only benefits if scheduled hours are 30 hours or more per week**

Your benefit effective date is based on your hire date with the company:

Hire Dates	Benefit Effective Date
1/1 - 1/18	2/1
1/19 - 2/15	3/1
2/16 - 3/18	4/1
3/19 - 4/17	5/1
4/18 - 5/18	6/1
5/19 - 6/17	7/1
6/18 - 7/18	8/1
7/19 - 8/18	9/1
8/19 - 9/17	10/1
9/18 - 10/18	11/1
10/19 - 11/17	12/1
11/18 - 12/18	1/1
12/19 - 12/31	2/1

Eligible Dependents

You may elect coverage for applicable benefits for yourself and any of the following dependents:

- Your spouse
  - A person to whom you are legally married, whether of the opposite sex or the same sex, as recognized and allowed by the laws of the state in which you become married. Copy of certified marriage license is required to establish eligibility.
- Your Child, or Foster Child, up to age 26, unless the Child meets the requirements as an Incapacitated Child
  - Your naturally-born child; a child that you have legally adopted; your step-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.

NOTE: If you are enrolling a spouse for any coverage, you must provide a copy of your certified marriage license, if you are married, prior to your benefits effective date. You must also provide a birth certificate for each child you are covering under any of your benefits prior to your benefits effective date. These can be faxed to (402) 351-6192 or scanned/ emailed to benefits.hotline@mutualofomaha.com.

Level of Coverage Options

You can elect enrollment coverage for:

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

Enrollment

Mutual of Omaha utilizes an electronic enrollment process. You will need to make elections prior to your benefits effective date.

Coverages elected remain in effect throughout the year, unless you experience a qualified life event. Each fall, we offer an open enrollment period to review and or make changes in your benefits for the following year.

Qualified Life Events

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.

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 spouse 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, if ineligible.

Contact the Corporate Benefits and Services Department by calling the HR Hotline at 402-351-3300 and select option "1" or toll free 1-800-365-1405. 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

Waiving health coverage means that you are not electing health coverage through your employment with Mutual of Omaha. If you waive coverage, you should have health coverage through another plan or you may be subject to fines/ penalties for not carrying health coverage (per the Affordable Care Act). When considering other options available to you, such as a spouse's plan, compare your options, look at physicians in the network, premiums and/or differences in coverage to find the best option for you and your family.

Many plans, including those offered to Mutual of Omaha employees, have a Coordination of Benefits plan provision. With Coordination of Benefits plan provisions, one plan will pay its full benefits first, then the other plan may only pay up to the amount what would have paid had it been the primary plan. You may find you are paying premium for two plans, but not receiving the anticipated benefits of both at the same time.

If you waive health coverage and experience a Life Event, such as a loss of other group health coverage, you can enroll in our plan by contacting us within 31 days of the event.

Health

The health plan allows you complete freedom to go to any in-network health care provider. If you use an out-of-network provider, you will have a higher out of pocket expense. This includes direct access to specialists without prior approval from the plan. When using in-network providers, you reduce your out of pocket health care expenses because providers have agreed upon certain rates for their services, deductibles are lower and the plan pays a larger percentage of the expenses. If you choose out-of-network providers, you will have higher out of pocket costs because the deductibles are higher and the plan pays a smaller percentage of the expenses.

In-network providers can be found online or by contacting Aetna Customer Service. This website and contact number for customer services is referenced on the last page of the Benefits Guide and is available on the ID card you'll receive after enrolling in the plan.

Deductible and Out of Pocket Maximum
The health plan has two deductible options available. A deductible is the amount of covered expenses that you must pay before the plan will start paying benefits.

If you reach the out of pocket maximum, the health plan will pay 100% of incurred allowed expenses for the remaining portion of the calendar year.

We will recognize prior health plan deductibles for new hires and employees of an acquired company only with respect to medical (not prescription) expenses applied to deductibles of the plan that provided coverage during the employee's first Plan Year (January 1 – December 31) of service with our Company. This does not include copays and coinsurance applied towards your prior health coverage. Explanation of Benefits (EOB's) reflecting YTD deductibles can be faxed to Aetna; Attn: Tammy Richardson at 860-907-3894.

Please note that our High Deductible $1250/ $2500 PPO plan is not a qualified plan for HSA account set up. We offer a Health Care Flexible Spending Account (FSA).

Schedule of benefits

As this is an ERISA plan, you have certain rights under the Plan. Please see the Administrative Information section of the Summary Plan Description for additional information.

Prepared for:	
Employer:	Mutual of Omaha Insurance Company
Contract number:	MSA-0867953
Control number:	0847850
Plan name:	Choice POS II - $750 & $1,250 Deductible Plan
Schedule of benefits:	1A & 1B
Plan effective date:	January 1, 2023
Plan issue date:	January 1, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-**network** and **out-of-network providers**
  - Separate limits for in-**network** and **out-of-network providers**
  - Based on a Calendar Year (January 1 - December 31) under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule.

Under this plan, your **copayment** does not apply to any **deductible**.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-**network**, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Precertification covered services reduction

This only applies to **out-of-network covered services**:
Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A $300 benefit reduction applied separately to each type of **covered service**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network	Out-of-network
Individual	$750/$1,250 per year	$1,000/$1,750 per year
Family	$1,500/$2,500 per year	$2,000/$3,500 per year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives
- Pharmacy

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Cost share waiver for tobacco cessation prescription and OTC drugs

The per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%, as long as filled with a prescription. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$3,250/$3,750 per year	$6,000/$6,750 per year
Family	$6,500/$7,500 per year	$12,000/$13,500 per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

Covered services apply to the in-network and out-of-network **deductibles**

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

Individual deductible
You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible
You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit
If you paid part or all of your **deductible** under other coverage for the Calendar Year that this plan went into effect, the **deductible** on this plan for that Calendar Year will be reduced by the amount you paid under your prior coverage for new hires and employees of an acquired company only.

Copayment
This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Per admission copayment
This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Payment Percentage
The specific percentage the plan pays after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Per admission cost share or deductible
A separate cost share or **deductible** may apply per facility. This is in addition to any other cost share or **deductible** applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 10 days (regardless of cause), only one per admission cost share or **deductible** will apply. Not more than three per admission cost shares or **deductibles** will apply for a facility type during the year. **Covered services** applied to the per admission **deductible** can't be applied to any other **deductible** required under the plan. **Covered services** applied to the plan's other **deductible** will not apply to the per admission **deductible**.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

Covered services apply to the in-network and out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	85% per visit after **deductible**	75% per visit after **deductible**

Visit limit per year	10	10
Limit per visit	$80	$80

Ambulance services

Description	In-network	Out-of-network
Emergency services	80% per trip, no **deductible** applies	Paid same as in-network
Description	**In-network**	**Out-of-network**
Non-emergency services	80% per trip, no **deductible** applies	80% per trip, no **deductible** applies

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services- **room and board** including **residential treatment facility**	$120 then the plan pays 85% per admission after **deductible**	$120 then the plan pays 75% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	85% per visit after **deductible**	75% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	85% per visit after **deductible**	75% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	100% per visit, no **deductible** applies	75% per visit after **deductible**

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services- **room and board** during a **hospital stay**	$120 then the plan pays 85% per admission after **deductible**	$120 then the plan pays 75% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	85% per visit after **deductible**	75% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	85% per visit after **deductible**	75% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	100% per visit, no **deductible** applies	75% per visit after **deductible**

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	In-network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	85% per item after **deductible**	75% per item after **deductible**
(including wigs)	100% per item, no **deductible** applies	100% per item, no **deductible** applies

Emergency services

Description	In-network	Out-of-network
Emergency room	$60 then the plan pays 85% per visit after **deductible**	Paid same as in-network

Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Speech therapy (ST)

Description	In-network	Out-of-network
ST	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	85% per visit after **deductible**	75% per visit after **deductible**
Visit limit per year	200	60

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	85% after **deductible**	75% after **deductible**
Description	**In-network**	**Out-of-network**
Outpatient services	85% per visit after **deductible**	75% per visit after **deductible**

Limit per lifetime for inpatient and outpatient care	185	185

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	$120 then the plan pays 85% per admission after **deductible**	$120 then the plan pays 75% per admission after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Comprehensive infertility services

Description	In-network	Out-of-network
	85% per visit after **deductible**	75% per visit after **deductible**

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	85% per visit after **deductible**	75% per visit after **deductible**

Limits

Description	In-network	Out-of-network
Limit per lifetime ART and Comprehensive services combined	$10,000 (Limit doesn't include covered pharmacy expenses) Combined for in-network and out-of-network benefits	$10,000 (Limit doesn't include covered pharmacy expenses) Combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	$120 then the plan pays 85% per admission after **deductible**	$120 then the plan pays 75% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	85% per visit after **deductible**	75% per visit after **deductible**
Other services and supplies	85% after **deductible**	75% after **deductible**

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
Up to a 31 day supply at a **retail pharmacy** and an **Extended Day Supply (EDS) retail pharmacy**	$13, no **deductible** applies	$13 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 61 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$26, no **deductible** applies	$26 then the plan pays 50%, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$39, no **deductible** applies	$39 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 91 day supply at a **mail order pharmacy**	$39, no **deductible** applies	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
Up to a 31 day supply at a **retail pharmacy** and an **Extended Day Supply (EDS) retail pharmacy**	$35, no **deductible** applies	$35 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 61 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$70, no **deductible** applies	$70 then the plan pays 50%, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$105, no **deductible** applies	$105 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 91 day supply at a **mail order pharmacy**	$105, no **deductible** applies	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
Up to a 31 day supply at a **retail pharmacy** and an **Extended Day Supply (EDS) retail pharmacy**	$60, no **deductible** applies	$60 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 61 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$120, no **deductible** applies	$120 then the plan pays 50%, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$180, no **deductible** applies	$180 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 91 day supply at a **mail order pharmacy**	$180, no **deductible** applies	Not covered

Brand-name specialty prescription drugs

Description	In-network	Out-of-network
Up to a 30 day supply at a **specialty pharmacy** or a **retail pharmacy**	$120, no **deductible** applies	Not covered

Important note:
Your cost share for **specialty prescription drugs**, under the **copayment** assistance program, will not count toward your **deductible** or **maximum out-of-pocket limit**. This includes cost shares that you, the plan or the program pay.

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network	Out-of-network
30 day supply or 12 month supply of generic and OTC drugs and devices	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
30 day supply or 12 month supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule

Generic diabetic supplies

Description	In-network	Out-of-network
Up to a 31 day supply at a **retail pharmacy** and an **Extended Day Supply (EDS) retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 61 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 50%, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 91 day supply at a **mail order pharmacy**	$0, no **deductible** applies	Not covered

Preferred brand-name diabetic supplies

Description	In-network	Out-of-network
Up to a 31 day supply at a **retail pharmacy** and an **Extended Day Supply (EDS) retail pharmacy**	$5, no **deductible** applies	$5 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 61 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$10, no **deductible** applies	$10 then the plan pays 50%, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$15, no **deductible** applies	$15 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 91 day supply at a **mail order pharmacy**	$15, no **deductible** applies	Not covered

Non-preferred brand-name diabetic supplies

Description	In-network	Out-of-network
Up to a 31 day supply at a **retail pharmacy** and an **Extended Day Supply (EDS) retail pharmacy**	$60, no **deductible** applies	$60 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 61 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$120, no **deductible** applies	$120 then the plan pays 50%, no **deductible** applies
More than a 60 day supply but less than a 91 day supply at an **Extended Day Supply (EDS) retail pharmacy**	$180, no **deductible** applies	$180 then the plan pays 50%, no **deductible** applies
More than a 31 day supply but less than a 91 day supply at a **mail order pharmacy**	$180, no **deductible** applies	Not covered

Maintenance Choice Opt-Out Program

Plan members will only be allowed to fill maintenance medications (90 day supply) at CVS mail order or CVS retail locations. If plan members wish to opt out and continue or start using non-CVS locations for a 30 day supply of maintenance medications, they must call Aetna at 1-888-792-3862.

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	85% per visit after **deductible**	75% per visit after **deductible**

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	85% per visit after **deductible**	75% per visit after **deductible**
Physician surgical services	85% per visit after **deductible**	75% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	85% per visit after **deductible**	75% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	85% per visit after **deductible**	75% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	85% per visit after **deductible**	75% per visit after **deductible**
Specialist surgical services	85% per visit after **deductible**	75% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	85% per visit after **deductible**	75% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	85% per visit after **deductible**	75% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	75% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	75% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	75% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	75% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	75% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	75% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months

Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	75% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no **deductible** applies	75% after **deductible**
Immunization limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies	75% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	100% per visit, no **deductible** applies	75% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	75% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of

	Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 22; 1 exam every year after age 22	Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 22; 1 exam every year after age 22
Well woman GYN exam	100% per visit, no **deductible** applies	75% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 exam per year	1 exam per year

Private duty nursing

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	85% per visit after **deductible**	75% per visit after **deductible**
Visit/shift limit per year	60	60

Prosthetic Devices

Description	In-network	Out-of-network
Prosthetic devices	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Routine cancer screenings

Description	In-network	Out-of-network
Colonoscopy	100% per visit, no **deductible** applies	75% per visit after **deductible**
Colonoscopy limit	Once every five years	Once every five years
Digital rectal examination (DRE)	100% per visit, no **deductible** applies	75% per visit after **deductible**
Digital rectal examination (DRE) limit	Covered for males age 40 and over	Covered for males age 40 and over
Double contrast barium enemas (DCBE)	100% per visit, no **deductible** applies	75% per visit after **deductible**
Double contrast barium enemas (DCBE) limit	Once every five years	Once every five years
Fecal occult blood test (FOBT)	100% per visit, no **deductible** applies	75% per visit after **deductible**
Fecal occult blood test (FOBT) limit	Covered age 40 and over	Covered age 40 and over
Mammogram	100% per visit, no **deductible** applies	75% per visit after **deductible**
Mammogram limits	One per year for covered females	One per year for covered females
Prostate specific antigen (PSA) test	100% per visit, no **deductible** applies	75% per visit after **deductible**
Prostate specific antigen (PSA) test limit	Covered for males age 40 and over	Covered for males age 40 and over
Sigmoidoscopy	100% per visit, no **deductible** applies	75% per visit after **deductible**
Sigmoidoscopy limit	Once every five years	Once every five years

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical and occupational therapies

Description	In-network	Out-of-network
At the **physician** office	85% per visit after **deductible**	75% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
At the **physician** office	85% per visit after **deductible**	75% per visit after **deductible**

Physical and occupational therapies

Description	In-network	Out-of-network
Visit limit per year	60	60

Speech therapy (ST)

Description	In-network	Out-of-network
Visit limit per year	30	30

Spinal manipulation

Description	In-network	Out-of-network
At the **physician** office	85% per visit after **deductible**	75% per visit after **deductible**

Visit limit per year	30	30

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	$120 then the plan pays 85% per admission after **deductible**	$120 then the plan pays 75% per admission after **deductible**
Other inpatient services and supplies	85% per admission after **deductible**	75% per admission after **deductible**

Day limit per year	100	100

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	85% per visit after **deductible**	75% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	85% per visit after **deductible**	75% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	85% per visit after **deductible**	75% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	85% per visit after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	85% per visit after **deductible**	75% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	$120 then the plan pays 85% per transplant after **deductible**	$120 then the plan pays 75% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	85% per visit after **deductible**	75% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	100% per visit, no **deductible** applies	85% per visit after **deductible**	75% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	75% per visit after **deductible**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	75% per visit after **deductible**
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule

Important Note:
Key terms

Designated network provider
A **network provider** listed in the directory under *Best Results for your plan* as a **provider** for your plan.

Non-designated network provider
A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network **walk-in clinic provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

Health Premiums Per Pay Period (Before Tax)

Health Coverage	You Pay (Per Pay Period)
$750 Individual/$1,500 Family Deductible PPO Health Option	
Employee Only	$100.00
Employee + One	$199.50
Employee + Family	$294.50
$1,250 Individual/$2,500 Family Deductible PPO Health Option	
Employee Only	$50.00
Employee + One	$106.00
Employee + Family	$175.50

Dental Options and Coverage Details

Waive Dental Coverage

Waiving dental coverage means that you are not electing dental coverage through the Group Dental Plan. Perhaps you are covered under a spouse's dental plan. Compare your options, look at dentists in the network, premiums and/or differences in coverage in order to determine the best option for you and your family.

Many plans, including those offered to Mutual of Omaha employees, have a Coordination of Benefits plan provision. With Coordination of Benefits plan provisions, one plan will pay its full benefits first, then the other plan may only pay up to the amount what would have paid had it been the primary plan. You may find you are paying premium for two plans, but not receiving the anticipated benefits of both at the same time.

If you waive health coverage and experience a Life Event, such as a loss of other group coverage, you may enroll in our plan by contacting us within 31 days of the Life Event.

Dental

Our Group Dental Plan covers preventive, basic services, major services and orthodontics. The Plan Administrator for the Group Dental Plan is Mutual of Omaha Workplace Solutions. The plan balances savings, service and customer satisfaction by providing access to the nationwide Mutually Preferred dental network.

When using in-network Mutually Preferred providers, you reduce your out of pocket dental care expenses because providers have agreed upon certain rates for their services, deductibles are lower and the plan pays a larger percentage of the expenses. If you choose out-of-network providers, you will have higher out of pocket costs because the deductibles are higher and the plan pays a smaller percentage of the expenses.

In-network providers can be found online or by contacting Customer Service at 800-927-9197. This website and contact number for customer services is referenced on the last page of the Benefits Guide and is available on the ID card you'll receive after enrolling in the plan.

Dental Deductibles

All benefits are subject to a calendar year deductible, except for preventive care. 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:

In-network	Out-of-network
$25 per person, $50 per family	$75 per person, $150 per family

Dental Coverage

Covered Services	Examples	In-Network Providers	Out-of-Network Providers
Class I	Cleanings & X-rays**	100%	100% of maximum allowance for out of network covered services
Class II	Prefabricated Crowns, Root Canals & Fillings	80% after calendar year deductible	60% of maximum allowance for out of network covered services
Class III	Cast Restoration Crowns, Dentures & Bridgework, Dental Implants	60% after calendar year deductible	50% of maximum allowance for out of network covered services
Orthodontics	Braces	60% after calendar year deductible	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	$1,500

For detailed information on covered services, see the Summary Plan Description.

**Two dental cleanings are covered per calendar year for each covered person. Four dental cleanings are provided per calendar year for any covered person who is pregnant, has diabetes or heart disease.

Predetermination of Benefits

If you anticipate a dental expense is going to be over $300, we recommend you have your dentist submit a dental Predetermination of Benefits form (Dental Claim Form), in advance, to confirm what benefits will be payable. If available, less expensive alternative treatment plans will be presented.

Dental Premiums Per Pay Period (Before Tax)

Dental Coverage	You Pay (Per Pay Period)
Dental Employee Only	$5.00
Employee + One	$11.50
Employee + Family	$21.00

Vision Option and Coverage Detail

EyeMed Vision Benefits

Mutual of Omaha offers you the ability to elect vision coverage through EyeMed Vision Care. This plan provides vision care services such as eye exams and coverage options for glasses or contacts.

To search for an EyeMed Network participating providers, reference the last page of this Benefits Guide.

EyeMed coverage provides the following benefits, discounts and savings when utilizing a participating provider:

Well Vision Exam: $25 copay every calendar year

Frame: $0 Copay, $150 allowance, covered once every other calendar year

Lenses: Covered every calendar year
- $25 Copay for Single vision, bifocal, trifocal, lenticular and progressive standard lenses.
- $0 Copay for Anti Reflective Coating-Standard, Scratch Coating-Standard Plastic and Polycarbonate-Standard lenses for dependent children
- Discounts and/or copayments on other lens options, including progressive lenses

Contact Lens: up to $40 copay for contact lens standard exam (fitting and evaluation)
- $200 allowance toward the cost of contacts, if not electing glasses.
- Covered every calendar year

EyeMed Premiums Per Pay Period (Before Tax)

EyeMed Vision Coverage	You Pay (Per Pay Period)
Vision Employee Only	$4.82
Employee + One	$6.91
Employee + Family	$12.37

Health Care Flexible Spending Account

Advantages of a Health Care Flexible Spending Account (FSA)

The Health Care FSA allows you to set aside pre-tax dollars to reimburse you for eligible out of pocket health, prescription drug, dental, and vision expenses. You may use this account for yourself and any tax dependent. You can be reimbursed up to your annual pledge for eligible expenses you've incurred during your benefits eligibility period, even before you've had that amount withheld from your paychecks.

The Health Care FSA reduces your taxable income because your contributions are deposited in the

FSA on a pre-tax basis. This means that your contribution is deducted from your paycheck before taxes are withheld. 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.

Mutual of Omaha's Health Care Flexible Spending Account does not cover over the counter expenses, even if prescribed by a physician, nor is prescribed marijuana a covered expense.

Contribution Amounts

Minimum – $60 per year
Maximum – $2,850 per year

Eligible Expenses for Reimbursement

Your FSA can help you pay for expenses that are predictable. Consider the following types of expenses:

- Health/dental out of pocket expenses
- Deductibles
- Coinsurance/ Copayments
- Prescriptions
- 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 eligible expenses for yourself and your tax dependents for the period from your benefit effective date to the end of the year. We will automatically divide your total contribution amount evenly across your eligible paychecks. Each year during the annual enrollment period, you will have the opportunity to re-enroll in the Health Care Flexible Spending Account.

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. Following the reimbursement period for the year, up to $500 of remaining balance will be rolled over to the next year. Any remaining balance over $500 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 through another plan, participation in a 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.

Submitting the Claim

Claims submitted by Monday at Noon (CST) are processed the same week. Reimbursements are directly deposited into your existing payroll deposit account on Fridays after the claim has been processed.

Please note, after December 31, 2023, you will have until March 31, 2024, to submit reimbursement claims for health care expenses incurred during 2023. After this date, remaining balances up to $500 will be available for reimbursement.

Reimbursement Methods

Online Expense Reimbursement

If you are enrolled on our health, dental and/or vision plans, your reimbursement claim can be submitted on Employee Self Service. You will receive email notification alerting you of eligible claims that have been loaded.

Paper Expense Reimbursement

Eligible expenses that are not processed through our Employee Group Insurance Plans will need to be submitted on a paper claim form. These expenses may include:

- Vision, if not covered under EyeMed
- 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 and supporting documentation are submitted to the Payroll Department for reimbursement by e-mailing them to the Payroll Hotline at payroll.hotline@mutualofomaha.com.

A copy of the paper Health Care FSA Claim Form can be found on Associate Access.

You have until March 31, 2024, to submit reimbursement claims for health care expenses incurred during 2023.

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

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). When you incur an eligible expense, you pay the expense, and then you get reimbursed.

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.

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 and a claim form to the Payroll Department by e-mailing them to the Payroll Hotline at payroll.hotline@mutualofomaha.com. If you are attaching a receipt with your claim form, remember a canceled check cannot be accepted as a receipt. A copy of the Dependent Care FSA Claim Form can be found on Associate Access.

Submitting the Claim

Claims submitted by Monday at Noon (CST) are processed the same week. Reimbursements are directly deposited into your existing payroll deposit account on Fridays after the claim has been processed. You have until March 31, 2024, to submit reimbursement claims for dependent care expenses incurred during 2023.

Employee Life Insurance

The Employee, Spouse and Child Life options are term life products. The premiums are paid on an after-tax basis. As a new hire, you may elect any level of coverage without needing to provide proof of good health. After your new hire enrollment, life restriction rules apply, meaning you will only be able to move up one level at annual enrollment, or qualified Life Event, without proof of good health at your own expense.

Basic Employee Life Benefits

- At no cost to you, the company provides a basic life insurance benefit equal to one times your Annual Benefits Salary.
- This coverage is effective your first day of employment.
- You will be asked to identify a beneficiary.
- Premiums for coverage exceeding $50,000 (basic benefit only) are considered taxable income.

As a new hire, your Annual Benefits Salary is equivalent to your annual salary, plus any transitional salary arrangement for production sales employees. Each year, Mutual of Omaha will calculate a new Annual Benefits Salary for the upcoming calendar year based on your salary as of August 31, plus your eligible earnings in the 12 months preceding that date. You may reference the Summary Plan Description for a more detailed description.

Employee Supplemental Life Options

- As a new hire, you may elect to purchase increments of 1, 2, 3 or 4 times your Annual Benefit Salary without needing to provide proof of good health.
- The maximum amount of employee group life insurance cannot be greater than $750,000 (Basic and Supplemental Life combined).

Employee Supplemental Life Costs

- Premiums are based on your age as of Aug 31 preceding your hire date. The amount of your coverage will not change during the year, even if your monthly pay changes.
- Your rates will be visible when you are completing your enrollment.
- For reference, you can calculate your premiums using the premiums on the next page.

Employee Age As of Benefits Start Date Monthly Rate per $1,000 of Coverage	
Under 30	$ .05
30-34	$ .07
35-39	$ .09
40-44	$ .10
45-49	$ .15
50-54	$ .23
55-59	$ .43
60-64	$ .53
65-69	$ .93
Over 70	$ .98

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 cannot be greater than the total amount of group life insurance carried on you, including basic and supplemental coverage.

Spouse Life Costs

	Per Pay Period Premium Based on Coverage Level Elected:			
Spouse's Age	**$10,000**	**$25,000**	**$50,000**	**$75,000**
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 and Premiums

You may purchase the following amounts of life insurance for your eligible children whom are at least 14 days old. Children may be covered through the end of the month in which they turn 26.

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

Coverage	Per Pay Period
$10,000	$0.35
$15,000	$0.70
$20,000	$1.40

Accidental Death & Dismemberment Insurance (AD&D)

Accidental Death and Dismemberment benefits will be paid if you die, become dismembered or paralyzed as a result of an accident. This is a separate benefit from Life Insurance. An accident is defined as a sudden and unexpected event in which you or your dependent is injured, and the injury is not due to a disease or sickness.

Basic AD&D Benefits

The company provides $25,000 of employee AD&D coverage at no cost to you.

Supplemental AD&D Options

- You may purchase additional Supplemental AD&D benefits for yourself and your eligible dependents from $50,000 to $250,000 in $50,000 increments.
- If you enroll in family coverage, coverage for spouse or children is as follows:

Employee	Spouse (40%)	Children (10%)
$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 the per pay period after tax premiums for the following options you may purchase:

	Employee Only	Employee + One or Employee
$50,000	$ .75	$1.00
$100,000	$1.50	$2.00

$150,000	$2.25	$3.00
$200,000	$3.00	$4.00
$250,000	$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)
- There is a six-month period before benefits are payable

As a new hire, your Annual Benefits Salary is equivalent to your annual salary, plus any transitional salary arrangement for production sales employees. Each year, Mutual of Omaha will calculate a new Annual Benefits Salary for the upcoming calendar year based on your salary as of August 31, plus your eligible earnings in the 12 months preceding that date. You may reference the Summary Plan Description for a more detailed description.

Long-Term Disability Supplemental Options and Costs

- 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 $20,000)
- If you elect the additional 10% of coverage, your portion of the cost will be paid with before tax dollars from your pay.
- The premium rates will be visible on your enrollment. The pay period rate is equal to your monthly Annual Benefits Salary x .0030/2.

Short-Term Disability Plan

The Short-Term Disability (“STD”) Plan provides short-term income replacement benefits for eligible employees who are determined by the Health Services Department to have an absence due to an illness and are unable to perform the duties of their assigned jobs.

If you are experiencing or anticipating a short-term disability, you will be assigned a case manager from Health Services to assist you with this benefit.

Eligibility – Employees are eligible for STD coverage following 12 months of continuous employment.
Amount of Benefit for Eligible Employees – In the event of an eligible absence, you will receive 70% of base pay after meeting the 5-day waiting period.

Maximum Benefit Period – Up to 125 days in a rolling 12-month time period, which includes holidays. This period can be used to fill the waiting period for Long-Term Disability.

Detailed information about this plan can be found on Associate Access under Career & Life/Time Off/Short-Term Disability. This does include how STD is calculated for employee who have variable pay.

Paid Time Off Benefits

Paid Time Off benefits available:

- Holidays
- Personal Time
- Vacation
- Parental Leave

Holidays

Employees normally scheduled to work on company observed Holiday are eligible for Holiday Pay.

Mutual of Omaha Insurance Company observes 11 Holidays each year. If all 11 Holidays are not on the Holiday Schedule below, then the remaining Holidays will be considered Floating Holidays and they will be added to your Personal Time balance to be used at your discretion. The Cultural Celebration holiday will always be a floating holiday and will be added to your Personal Time balance each year.

Holiday Schedule for 2023

Mutual of Omaha Insurance Holidays
New Year's Day
Martin Luther King, Jr. Day
Memorial Day
Day before Independence Day
Independence Day
Labor Day
Thanksgiving Day
Day after Thanksgiving Day
Christmas Day
Two Additional Personal Days

Personal Time

All regular new hire employees will receive eight hours and a pro-rated amount of Personal Time on your date of hire. The chart below lists the full amount (8 hours + pro-rated amount) based on the month you are hired. Following your first year of employment, you will receive an allotment of personal time each year in January. Personal time does not rollover from year to year.

Personal time can be used for sick time, and at your discretion, with manager's approval, for any time away from work.

Personal Time – New Hire amount based on Standard Hours worked:

Hire Month	40 hrs/week	30 – 39 hrs/week
1/1/2023	56	42
2/1/2023	51.50	38.50
3/1/2023	47	35
4/1/2023	42.50	31.50
5/1/2023	38	28
6/1/2023	33.50	24.50
7/1/2023	29	21
8/1/2023	24.50	17.50
9/1/2023	20	14
10/1/2023	15.50	10.50
11/1/2023	11	8
12/1/2023	8	8
1/1/2024	56	42

Due to how the holidays fall in 2023 and 2024, the above chart reflects the additional pro-rated personal time granted due to unused floating holidays and based upon the number of hours an employee is scheduled to work. Regular employee with standard hours of less than 20 will not receive any floating holidays.

Vacation

New employees will begin to accrue vacation on their benefits effective date. Vacation time can be used at your discretion, and with manager's approval, for any time away from work.

Years of Service	Annual Vacation Accrual Rate	Hourly Accrual Rate	Vacation Limit
Up to 5 yrs of service	15 days per year	0.057692	20 days
5 yrs of service	18 days per year	0.069231	23 days
10 yrs of service	20.5 days per year	0.078846	25.5 days
15 yrs of service	23 days per year	0.088462	28 days
25 yrs of service	28 days per year	0.107692	33 days

Vacation balances do rollover from year to year. Accrual continues unless you reach the vacation limit. This limit is equivalent to your accrual rate plus 5 days. We will notify you if you are nearing your limit.

Vacation is earned and accrued each pay period. The amount you receive may vary based on the number of days, or hours worked, within the pay period.

To calculate your accrual each pay period, count the workdays between the 1st and the 15th or between the 16th and the last day of the month. The number of workdays in that pay period will determine your accrual. Below is an example of accrual rates per pay period, if working a standard 40-hour work week.

Accrual Rate Based on Months of Service	9-day Pay Period (72 hrs worked)	10-day Pay Period (80 hrs worked)	11-day Pay Period (88 hrs worked)	12-day Pay Period (96 hrs worked)
0 to 59	4.15 hrs	4.62 hrs	5.08 hrs	5.54 hrs
60 to 119	4.98 hrs	5.54 hrs	6.09 hrs	6.65 hrs
120 to 179	5.68 hrs	6.31 hrs	6.94 hrs	7.57 hrs
180 to 299	6.37 hrs	7.08 hrs	7.78 hrs	8.49 hrs
300 +	7.75 hrs	8.62 hrs	9.48 hrs	10.34 hrs

If you work less than 40 hours per week, count the number of hours worked during the pay period and multiply by the hourly Accrual rate.

Your vacation balance will be visible on your pay advice and can be accessed using the Vacation Planner. You will see your first vacation balance on the paycheck received on the 25th of the month following your benefits effective date.

Benefits Effective Date	Pay Advice w/1st Award of Vacation
01/01	01/25
02/01	02/25
03/01	03/25
04/01	04/25
05/01	05/25
06/01	06/25
07/01	07/25
08/01	08/25
09/01	09/25
10/01	10/25
11/01	11/25
12/01	12/25

Parental Leave

Parental Leave provides up to four weeks of paid parental leave based upon the number of hours the employee is regularly scheduled to work per week (two weeks coded as Parental Leave and two weeks as additional vacation) per maternity/adoption occurrence for eligible employees with one full year of continuous employment. Parental Leave will need to be taken within six months of the birth or adoption.

401(k) Long-Term Savings Plan

Our 401(k) plans are long term savings plans set up to assist you for saving for retirement, and we encourage you to save appropriately.

All employees are eligible to participate in the 401(k) plan upon your benefits effective date.

You may contribute a total of 0-75% of your earnings on a Pre-Tax or After-Tax basis each pay period. Employee contributions in partial fractional percentages are not allowed.

If you were accruing benefits under the Mutual of Omaha Retirement Income Plan as of December 31, 2016, the company will match 50% of your contributions, up to the first 7% of your eligible earnings.

If you were not accruing benefits under the Mutual of Omaha Retirement Income Plan as of December 31, 2016 or were hired or rehired as an employee on or after January 1, 2017, Mutual of Omaha will match $1 for $1 on the first 6% of your contributions. Mutual of Omaha will also contribute an additional 2% of your compensation earned during the Plan year just for being an employee. This additional 2% contribution will be known as the Employer Retirement Contribution (the "ERC").

The company matching contributions and ERC are deposited at the same time as your contributions.

You are always 100% vested in your contributions and are immediately 100% vested in company matching contributions (subject to gains and losses). However, if you are eligible for ERC, those contributions are subject to a three-year graded vesting schedule as shown below:

Years of Service	**% Vested**
One	33%
Two	66%
Three	100%

Initial Enrollment: To begin your contributions in conjunction with your benefits effective date, your initial enrollment will be part of your electronic benefits enrollment process.

Employee Contribution Changes: You may make changes in your employee contribution percentage after your initial enrollment by going to Associate Access. Select Career & Life and then select 401(k).

Changes to your employee contribution percentage are processed in conjunction with each pay period and will be processed as soon as administratively feasible.

Investment Election Changes: You may make changes to your asset allocations of contributions, as well as transfer your existing account balances to different investment alternatives, by logging

onto your account through the Internet or by calling Mutual of Omaha Retirement Services at 1-888-917-7191. Information and directions will be emailed to you prior to your first contribution and can also be found on Associate Access.

Prior to age 59½, our plan does allow for loans and hardship withdrawals as defined by the IRS.

Your employee contributions to the Plan plus any amount deferred under other qualified retirement plans cannot exceed a maximum set by the Internal Revenue Service for each calendar year. The maximum employee contribution limit does not include catch-up contributions, which is for employees over age 50.

Our plans do accept rollovers from other qualified plans. You can do this at any time. There are forms to be completed and information on Associate Access.

Voluntary ARAG Legal Services with ID Theft Protection

The Mutual of Omaha Voluntary Legal Services Plan offers legal expense insurance through ARAG. If you enroll in the voluntary legal services plan, you will receive access to consult with an attorney in person or via phone and have access to a range of online resources.

Option	Coverage Provided
UltimateAdvisor $9.77 per pay period	Identity Theft Protection, Consumer Protection, Criminal Matters, Real Estate Matters, Debt-Related Matters, Wills and Estate Planning, Divorce and DIY Documents

Voluntary Accident Insurance

Accident insurance provides a lump-sum cash benefit for injuries you or an insured family member sustains as a result of an accident. This benefit can help safeguard your savings by paying out-of-pocket medical expenses as determined by the plan, supplementing daily living expenses and covering lost income from unpaid time off work. Voluntary Accident Insurance coverage is effective on your benefits effective date.

Current Voluntary Accident Pay Period Premiums

Employee Only	$4.70
Employee + 1	$7.45
Employee + Family	$11.34

Visit Associate Access for more benefit information on the Voluntary Accident Insurance.

Voluntary Critical Illness Insurance

A Critical Illness insurance policy can provide the extra security you need to help lessen the financial impact associated with the treatment and recovery from a serious illness as determined by the plan. Critical Illness insurance helps take care of your bills so you can focus on what's most important – recovery. Voluntary Critical Illness Insurance coverage is effective on your benefits effective date.

Current Voluntary Critical Illness Pay Period Premiums

Age	$5,000	$10,000	$15,000	$30,000
0-29	$0.55	$1.10	$1.65	$2.20
30-39	$1.00	$2.00	$3.00	$4.00
40-49	$2.20	$4.40	$6.60	$8.80
50-59	$4.63	$9.25	$13.88	$18.50
60-69	$9.63	$19.25	$28.88	$38.50

Visit Associate Access for more benefit information on the Voluntary Critical Illness Insurance.

Voluntary Hospital Indemnity Insurance

Hospital Indemnity Insurance supplements an employee's existing health insurance coverage. It pays a benefit to the insured to use as they wish to help them pay for any out-of-pocket expenses, they may incur due to a hospital stay.

Current Voluntary Hospital Indemnity Pay Period Premiums

Employee Only	$4.50
Employee + 1	$9.50
Employee + Family	$12.25

Visit Associate Access for more benefit information on the Voluntary Hospital Indemnity Insurance.

Nationwide Pet Insurance

Pets become part of your family. When something happens, you want to do everything possible to help them, but it can be expensive. Mutual offers pet insurance to help put your mind at ease and help you be prepared when you need it most. This an optional benefit.

Nationwide® covers a wide range of medical problems and conditions related to accidents and illnesses, including cancer. It's available for dogs, cats, birds and exotic pets. There is also an

additional wellness care option for vaccinations, flea/tick prevention and more. And you can use any veterinarian worldwide even specialists and emergency care providers.

Enrollment can happen anytime during the year. You can also change or cancel your pet insurance coverage at any point. Just remember pre-existing conditions are not covered. If you have questions about the coverage or enrollment, call Nationwide at 877-738-7874.

Visit Associate Access for more benefit information on Nationwide Pet Insurance.

Amplifon Hearing Discount Program

Do you or a family member live with hearing loss? Mutual of Omaha offers a comprehensive, affordable hearing care program through Amplifon Hearing Health Care, one of the nation's largest providers of hearing discounts. There are no premiums or no sign up needed for this program. It is available to you at any time as an active employee.
All you have to do to get started in order to get the discounts is call 888-713-7655 and Amplifon will find a provider near you. A patient care advocate will explain the Amplifon process, get your mailing information and assist you in making the appointment with a hearing care professional. Amplifon will send information to you and the provider prior to the appointment.

Visit Associate Access to find out the benefits Amplifon has to offer to Mutual of Omaha employees and their family members.

Web Sites, Links and Contact Information References

Aetna:
www.aetnanavigator.com
1-855-210-0024

When searching for a provider, make sure you Select “Aetna Choice POS II (Open Access)”

PrudentRX (Specialty Prescription Drugs)
800-578-4403

Maintenance Choice Opt-Out Program
1-888-792-3862 (Aetna)

Workplace Solutions Dental (Mutually Preferred network)
www.mutualofomaha.com/dental
800-927-9197

EyeMed Provider Link (Insight network)
www.eyemed.com
866-804-0982

401(k) Account Information
www.getretirementright.com
888-917-7191

Refer to the Summary Plan Description, found on Associate Access for a complete explanation of all your group benefits.

Benefits Hotline
Local (402) 351-3300 and select option “1”
Toll Free (800) 365-1405
Benefits.Hotline@mutualofomaha.com

Payroll Hotline
for questions on FSA processing: Local
(402) 351-3300 and select option “3”
Toll Free (800) 365-1405
Payroll.Hotline@mutualofomaha.com