2025 BENEFITS GUIDE

apta health

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This Benefits Guide is an overview of the benefits provided by State Law Enforcement Bargaining Council. It is not a Summary Plan Description or Certificate of Insurance. If a question arises about the nature and extent of your benefits under the plans and policies, or if there is a conflict between the informal language of this Benefits Guide and the contracts, the Summary Plan Description and Certificates of Insurance will govern. Please note that the benefits in your Benefits Guide are subject to change at any time. The Benefits Guide does not represent a contractual obligation on the part of State Law Enforcement Bargaining Council.

WHAT IS APTA HEALTH?

Dear Apta Health Member,

Congratulations! You are a member of an exciting new way of managing your healthcare. Your employer has chosen Apta Health to bring amazing benefits that are usually reserved for Fortune 500 Companies to its employees. The Apta Health program brings together some of the best healthcare vendors in the country and combines them into a single package to help you get the best care at the best prices.

Care Coordination is at the heart of our program. This unique approach to healthcare allows you access to a real, live person to talk to about your health concerns and is available **completely free of charge** whenever you need help. Think of your Care Coordinators as healthcare warriors that will fight for you to make sure you get the best care possible! They are based in Ohio, USA and available Monday through Friday, 8:30 AM to 10:00 PM Eastern Time. You can call them for anything from replacing a lost ID card, to help finding an in-network physician, to help with an upcoming medical procedure, and questions or issues with your medical bills. They are also available through your company's custom web portal, or through the Quantum Health App on the Apple App Store or Google Play. Your Care Coordinators are the best place to start whenever you have questions or need help.

Apta Health includes the standard components that you would expect from a healthcare program like a network of doctors and hospitals as well as prescription drug insurance. Your company may also choose additional components that further enhance your coverage. These additional components are included and explained in this benefit guide.

The great news is that your Care Coordinators are trained experts in all your benefits and will guide you through your benefit decisions. Your Care Coordinators will help you move along your healthcare journey and make the process as smooth as possible.

We hope you will enjoy your healthcare benefits and wish you a happy and healthy year!

Sincerely,

The Apta Health Team

MEET YOUR APTA CARE COORDINATORS

Care Coordinators are an expert team of nurses, patient services representatives and benefits specialists who are ready to help you before, during and after any health event. Think of Care Coordinators as your personal healthcare team. They fight hard to help you save money and make sure you get the best possible care for you and your family. You can contact them via the website, toll-free number listed on your ID card, or through the Quantum Health app.

CARE COORDINATORS CAN HELP WITH:

Ordering ID Cards
Claims, billing and benefit questions
Finding in-network providers
Nurse coaching to help you stay or get healthy
Reducing out-of-pocket costs
Anything that can make the healthcare process easier for you

CARE COORDINATORS ARE MOBILE

Download the Quantum Health mobile app that lets you:

- Find in-network providers
- Access your ID card
- Check claims information
- Schedule a call with a Care Coordinator
- Send texts/chat with Care Coordinators
- And so much more

ACCESS YOUR APTA HEALTH WEBSITE:
https://SLEBC.myaptahealth.com

CONTACT YOUR CARE COORDINATORS:
+1.866-274-9478

Monday–Friday,
8:30 A.M.–10:00 P.M. ET

apta health | CARE COORDINATORS BY QUANTUM HEALTH

CARE COORDINATORS ARE THE SINGLE GO-TO RESOURCE FOR ALL CUSTOMER SERVICE AND CARE MANAGEMENT REQUESTS

ENROLLMENT GUIDELINES

Welcome to the 2025 Benefits Guide for State Law Enforcement Bargaining Council. This Guide provides a quick overview of the benefits program and helps to remove confusion that sometimes surrounds Employee benefits. The benefits program was structured to provide comprehensive coverage for you and your family. Benefit programs provide a financial safety net in the event of unexpected and potentially catastrophic events.

ELIGIBILITY

You are eligible to enroll in the medical benefits program if you are a:

- State Trooper through the rank of Sergeant working 120 hours in a 28-day period.
- Game & Park Conservation Officer working 120 hours in a 28-day period
- Fire Marshal Inspector working 30 hours in a 7-day period
- Fire Marshal Investigator working 60 hours in a 14-day period

Benefits for newly hired employees will take effect the first day of the month following your sworn in date or 30 calendar days of qualified employment.

Your legally recognized spouse and your married or unmarried dependent children are eligible for medical, dental, and vision coverage if less than 26 years of age. Disabled unmarried children over age 26 may be eligible to continue benefits after approval of necessary applications.

OPEN ENROLLMENT

Open enrollment for health, dental and vision is once a year and benefit elections will take effect January 1st. Participants may add or drop coverage or make changes to their coverage at this time. Late entrants (employees or dependents who apply for coverage more than 30 days after the date of individual eligibility) are also provided an opportunity to enroll for coverage during the plan's open enrollment. The elections you make stay in effect the entire plan year, unless a qualifying life event occurs.

QUALIFYING LIFE EVENTS

Generally, you can only change your benefit elections during the annual Open Enrollment period. However, you may make changes during the plan year if you have a qualifying event.

Qualifying events include:

- Marriage
- Divorce
- Birth
- Adoption
- Death
- Loss of Coverage

Under the medical plan, Open Enrollment under your spouse's group plan will also be considered a qualifying event.

When you have a qualifying event, you have 30 days to complete and return a new enrollment/change form for health, dental, and/or vision coverage. You may be asked to provide proof of the change and/or proof of eligibility. (You have 60 days to complete and return a new enrollment/change form after coverage under Medicaid or CHIP terminates.)

BENEFIT CONTACTS

PRIMARY POINT OF CONTACT

Apta Health Care Coordinators powered by Quantum	Personal Healthcare Advocacy Team	866-274-9478 https://SLEBC.myaptahealth.com

OTHER CONTACTS

ServeYouRx	Prescription Benefit Manager	(800) 759-3203 www.ServeYouRX.com
Aetna Open Choice	PPO Network	(800) 343-3140 www.aetna.com
Delta Dental	Dental	(800) 448-3815
VSP	Vision	(800) 877-7195 www.VSP.com
The Standard Group Policy # 162274	Basic Life / AD&D Insurance Voluntary Life & AD&D LTD EAP 24/7	Life Services Toolkit Standard.com/mytoolkit Enter: assurance (800) 872-1414 medservice@assistamerica.com (800) 293-6498 www.eapbda.com Enter: eap4u
SLEBC	Flexible Spending Account	(402) 489-2081 Tara Johnson tjohnson@netroopers.com
Doctor on Demand	Telemedicine	www.doctorondemand.com Patient Support: (800) 997-6196 support@doctorondemand.com
Healthcare Bluebook	Healthcare Pricing Tool	(800) 341-0504
State Law Enforcement Bargaining Council	Tara Johnson Office Administrator	(402) 489-2081 tjohnson@netroopers.com

GLOSSARY OF TERMS

The following terms will help you better understand your benefits.

Co-pay: A Copay is the portion of the Covered Expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible: A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan.

Coinsurance: Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay.

Out-of-Pocket Maximum (OOPM): An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

PPO (Preferred Provider Organization): This type of plan utilizes network and non-network benefits.

In-Network: The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize “in-network” providers. These networks will be indicated on your Plan identification card.

Out-of-Network: Any non-contracted providers. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.

MEDICAL BENEFITS

State Law Enforcement Bargaining Council offers medical benefits through Meritain Health. This medical plan balances affordability with the freedom to go outside the network. You may choose a participating or a non-participating provider. Participating providers have agreed to provide services at a discounted fee. For out-of-network care, you are responsible for charges above the out-of-network allowance for services, in addition to the deductible and coinsurance. To find a participating provider, visit https://SLEBC.myaptahealth.com.

BENEFIT		
	IN-NETWORK	OUT-OF-NETWORK
Deductible	$500/single $1,000/family	$3,000/single $6,000/family
Out-of-Pocket Max (Includes deductible and copays)	$1,500/single $3,000/family	$6,000/single $12,000/family
Preventive Care	0% (Deductible Waived)	40% After Deductible
Office Visit (PCP)	$15 copay	40% After Deductible
Doctor on Demand (Telemedicine)	$15 copay	N/A
Specialist Office Visit with Referral	$30 copay	40% After Deductible
Specialist Office Visit without Referral	$60 copay	40% After Deductible
Chiropractic Services	$30 copay	40% After Deductible
Diagnostic Lab/X-ray	15% After Deductible	40% After Deductible
Imaging (CT/PET scans: MRI's)	15% After Deductible	40% After Deductible
Inpatient Hospital	15% After Deductible	40% After Deductible
Outpatient Hospital	15% After Deductible	40% After Deductible
Maternity Prenatal Delivery and All Inpatient Services	 0% (Deductible Waived) 15% After Deductible	 40% After Deductible 40% After Deductible
Hearing Aids ($2,500/ear, every 2 years)	15% After Deductible	15% After Deductible
Prescription Sunglasses (Member Only) Lenses – 1 pair/calendar year Frames - $120 max, every 2 years	0% (Deductible Waived)	0% (Deductible Waived)

Family deductible and out-of-pocket amounts are embedded. This means that an individual would not pay more than the individual deductible/out-of-pocket amounts.

MEDICAL BENEFITS (CONTINUED)

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Mental Health/Substance Abuse Office	$15 copay	$15 copay
Mental Health/Substance Abuse Inpatient/Outpatient	15% After Deductible	15% After Deductible
Emergency Room	$150 Copay then 15% After Deductible	
Emergency Transport/Ambulance	15% After Deductible	
Urgent Care	$75 copay	40% After Deductible
Prescriptions – through ServeYouRX Retail – 30-day supply Generic Preferred Non-Preferred Specialty	 $20 copay $40 copay $60 copay 30% Coinsurance	 N/A N/A N/A N/A
Mail Order – 90-day supply Generic Preferred Non-Preferred Specialty	 $40 copay $80 copay $120 copay N/A	 N/A N/A N/A N/A
What you pay and what the plan pays The above Summary of Benefits shows how much you pay for care, and how much the plan pays. It's a brief listing of what is included in your benefits plan. For more detailed information, see your summary plan description.		
Pre-Certification Requirement: A $500 penalty will apply for failure to obtain pre-certification.	• Inpatient Hospitalizations • Skilled Nursing • Facility Admissions • Home Health Care & Services • Oncology Care & Services • MRI, MRA & PET Scans • Hospice Care • Outpatient Surgeries (including Colonoscopies) • DME over $1500 • Dialysis • Transplants - Organ & Bone Marrow • Genetic Testing	

PREMIUMS

Employee Contributions
Effective January 1, 2025

MEDICAL PLAN	Premium	Employee Pays	State Pays	Bi-Weekly* Employee Pays	Bi-Weekly * State Pays
Single	$1,180.90	$200.75	$980.15	$100.38	$490.07
EE + SP	$2,348.08	$399.17	$1,948.91	$199.59	$974.45
EE + CH	$1,998.22	$339.70	$1,658.52	$169.85	$829.26
Family	$2,932.16	$498.47	$2,433.69	$249.23	$1,216.85

DENTAL PLAN	Premium	Employee Pays	State Pays	Bi-Weekly* Employee Pays	Bi-Weekly* State Pays
Single	$38.61	$22.61	$16.00	$11.30	$8.00
EE + SP	$75.76	$53.76	$22.00	$26.88	$11.00
EE + CH	$109.90	$87.90	$22.00	$43.95	$11.00
Family	$118.81	$90.81	$28.00	$45.40	$14.00

VISION PLAN	Premium	Employee Pays	Bi-Weekly Employee* Pays
Single	$15.24	$15.24	$7.62
EE + 1 (SP or 1 CH)	$24.38	$24.38	$12.19
EE + CH (more than 1)	$24.89	$24.89	$12.45
Family	$40.13	$40.13	$20.07

* Bi-Weekly includes 2 premium holidays per year

REFERRAL PROCESS FOR A SPECIALIST

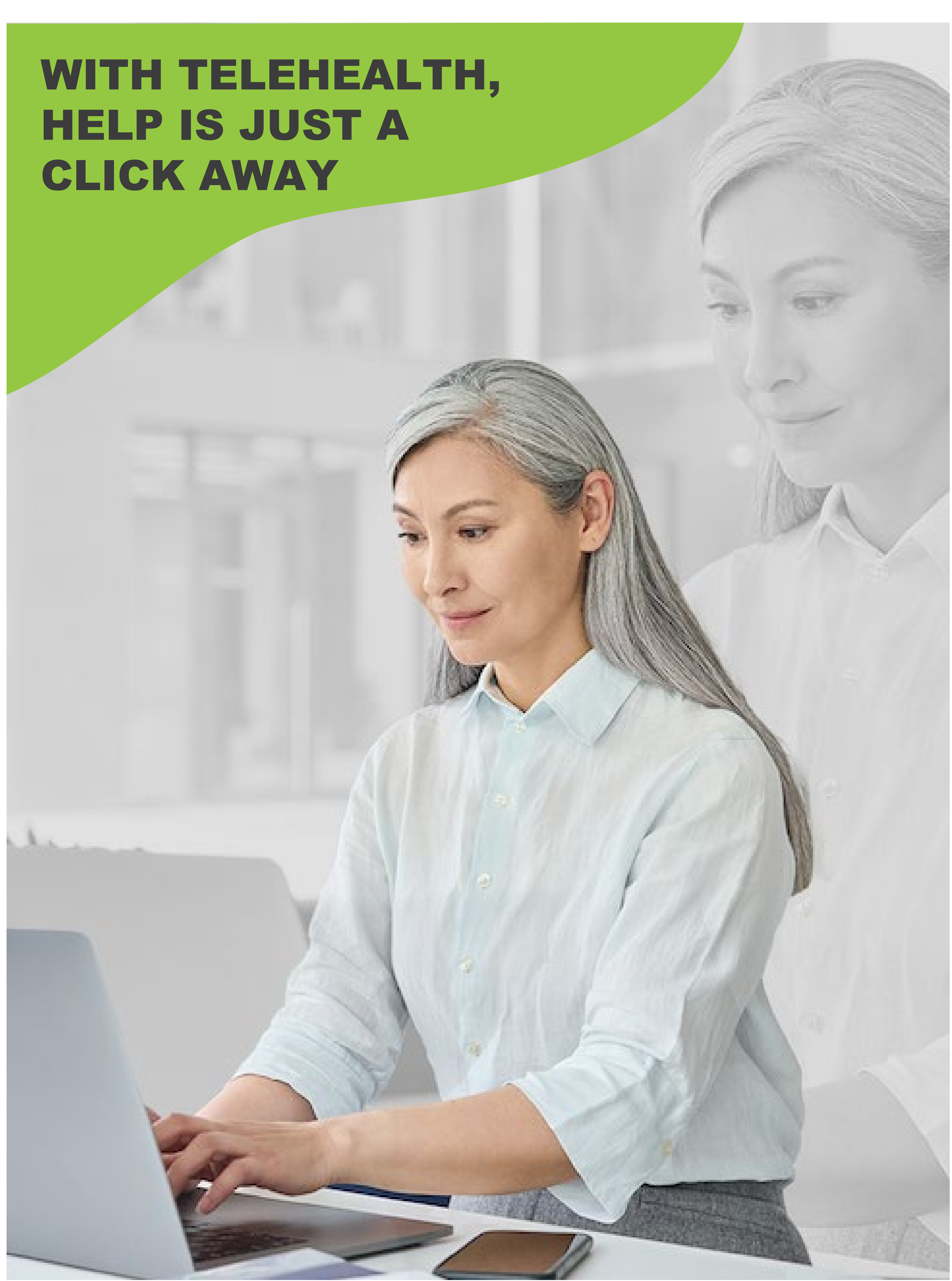
COORDINATE YOUR CARE THROUGH YOUR PRIMARY CARE PHYSICIAN (PCP)

- Obtain a referral from your PCP before seeing a specialist to save money on member out-of-pocket costs and get alerts for not fully covered benefits
- Helps avoid visits to the wrong specialist
- Helps avoid referrals to an out-of-network specialist
- Get in to see specialist faster
- All referrals obtained are valid for 12 months.
- The PCP must provide the referral to the Care Coordinators.

PRE-CERTIFICATION

Before you receive certain medical services or procedures, your health plan requires a doctor to confirm that these requested services are considered medically necessary under your plan. This verification process is called "pre-certification.“ Even if some services or therapies are performed in your doctor's office, you may still need a pre-certification. Pre-certification requests must be submitted by your physician directly to the Apta Care Coordinators.

SERVICES REQUIRING PRE-CERTIFICATION			
Inpatient Hospitalizations & Skilled Nursing Facility Admissions	Home Health Care and Services	Oncology Care & Services (chemotherapy, radiation therapy, etc.)	MRI, MRA and PET Scans
Hospice Care	Dialysis	Transplants – Organ and Bone Marrow	Durable Medical Equipment (DME) purchases over $1500 and all rentals
Out-Patient Surgeries (includes Colonoscopies)	Genetic Testing		
• A $500 penalty will be applied for all services rendered that do not have pre-certification completed.			


WITH TELEHEALTH,
HELP IS JUST A
CLICK AWAY

WHAT IS TELEMEDICINE & TELEHEALTH?

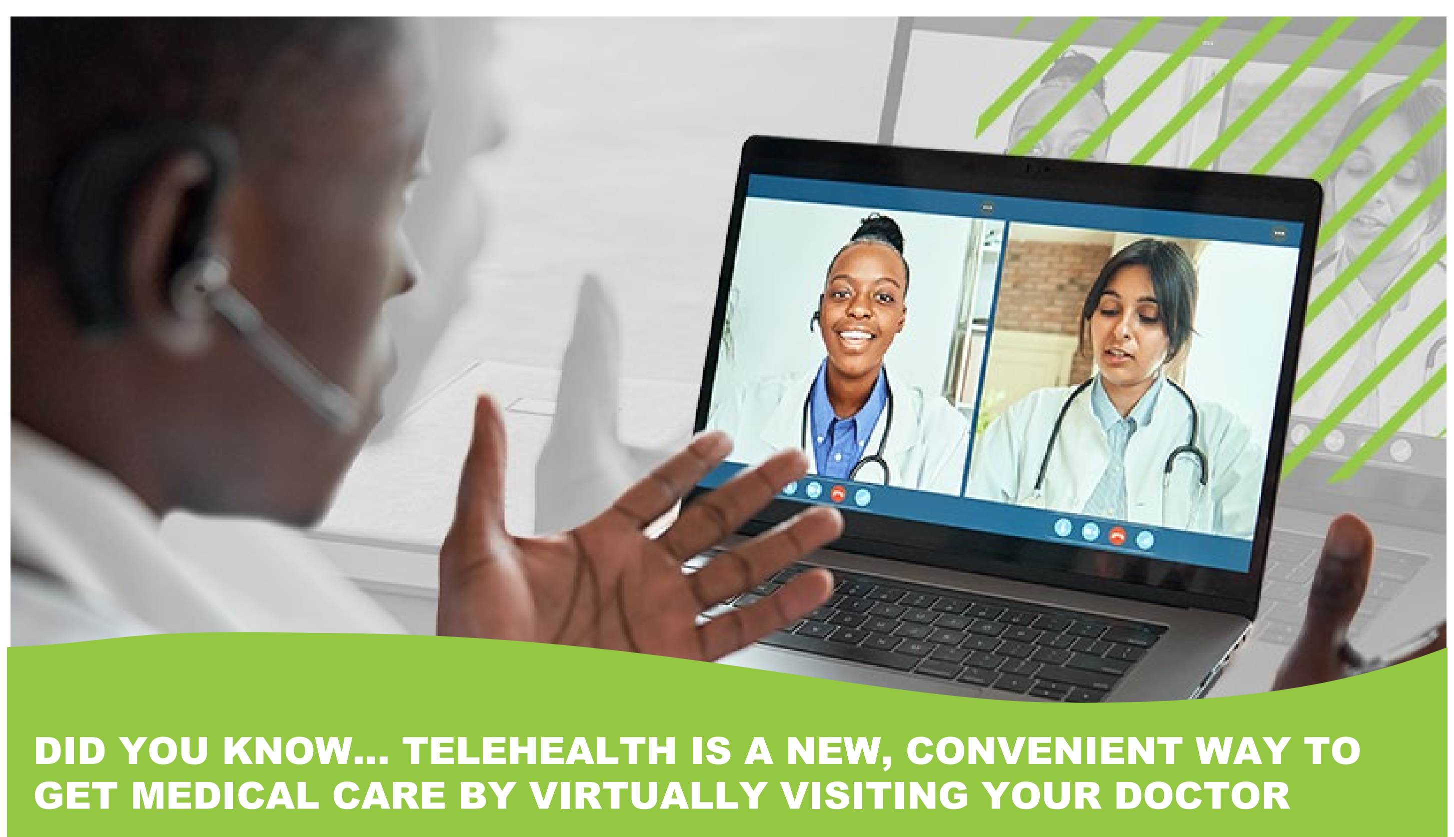
With the onset of Covid-19, telehealth has become an increasingly popular way for individuals to receive medical treatment and diagnosis without visiting a physical, clinical location such as a doctor's office or hospital.

Telemedicine and telehealth are sometimes used interchangeably to describe both clinical and non-clinical interactions with health professionals through technology. While telemedicine focuses on remote clinical assistance, telehealth also includes educational and non-clinical remote interactions through the use of various technologies such as webcams, apps, and mobile devices.

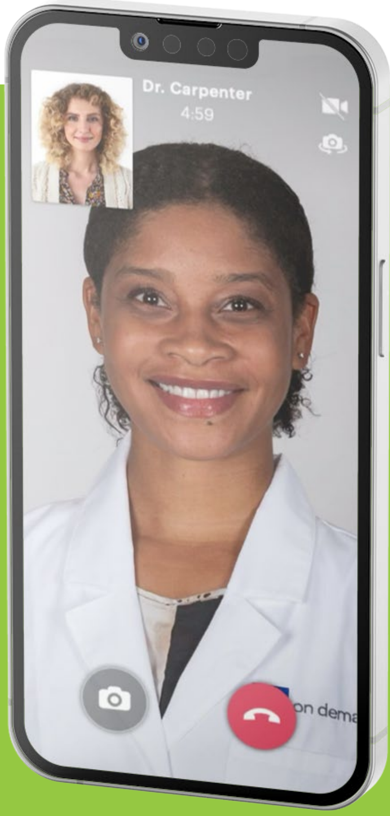
Telemedicine and telehealth provide options for meeting virtually with a healthcare provider when you are not feeling well. Using technology and apps, it is now easier than ever to meet with a physician from your home, office, or while traveling. Additionally, physicians are available outside of normal business hours and on weekends.

Meeting with a doctor through an app like Doctor on Demand is very similar to visiting your primary care physician in an office, except your interactions with the physician are through your mobile device. The doctor can give you a diagnosis based on your symptoms and even provide a prescription that can be picked up from your local pharmacy.

You can contact a doctor at any time using this benefit and there is no need to contact your Care Coordinator prior to using this service. We recommend you download the app to your phone now so that you can use this option when needed. More information is available on the next page.



dr+ on demand



MEET WITH A DOCTOR WITHOUT LEAVING YOUR HOME THROUGH YOUR MOBILE DEVICE!

Doctor On Demand medical and psychologist visits (25 minutes or 50 minutes) are as follows:

Medical Visits:

- PPO Plan - $15 Copay

Behavioral Health Consultations:

- PPO Plan - $15 Copay

Some of the medical and behavioral health conditions treated:

- Cold & Flu
- Asthma & Allergies
- Pharmacy Rx*
- Bronchitis & Sinus Issues
- Eye Issues
- Anxiety
- Depression
- Rashes & Skin Issues
- Relationship Issues
- UTI, Yeast Infections
- Upset Stomach
- Pediatric Issues

BE PREPARED FOR THE UNEXPECTED!

Download the App on Google Play for Android, or via the App Store for iPhone/iPad (be sure to check out our patient reviews while you are there).

MEET THE DOCTORS

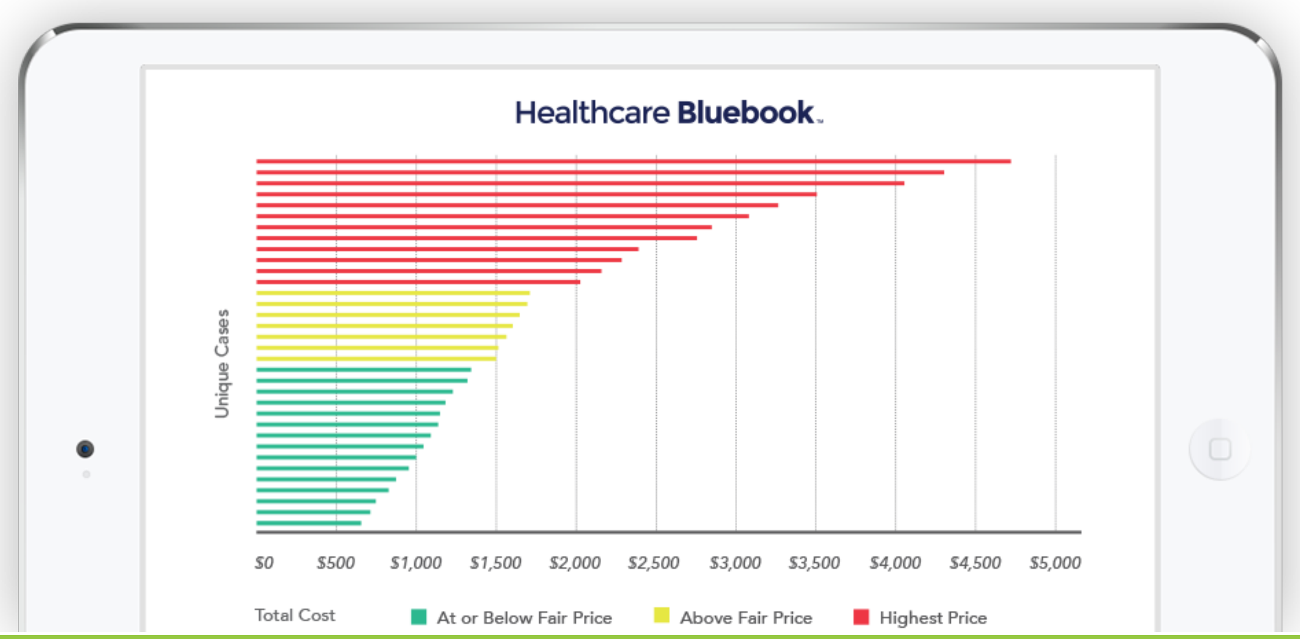
The providers at Doctor On Demand are some of the best in the country. They go through rigorous screening and ongoing quality assurance. After each video visit you can rate your experience and write a doctor review.

For more information and to sign up on the web, go to: www.doctorondemand.com

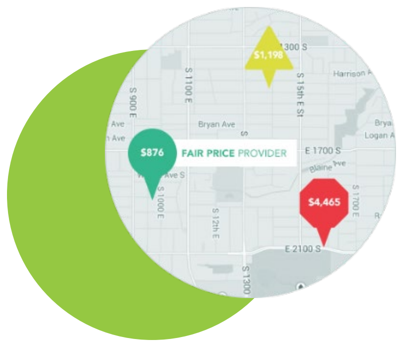
Doctor On Demand operates subject to state laws and is not currently available in AK, AR, AL and LA due to state regulations. Behavioral healthcare is available in all 50 states. Doctor On Demand is not intended to replace an annual, in-person visit with a primary care physician. *Doctor On Demand physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate.

Healthcare Blue Book is an online pricing tool which enables you to find the best prices for the healthcare services you may need. With Healthcare Blue Book, you can shop for care so that you get the most affordable care available in your area, from high quality providers.

COMPARE PROVIDERS • SHOP FOR CARE • SAVE MONEY



Download the Health Care Blue Book app and use the access code ”APTA" to set up your account.



Red = Among the most expensive providers
Yellow = Provider somewhat above the Fair Price
Green = Provider at or below the Fair Price

PRESCRIPTION DRUGS FOR LESS

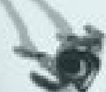
Apta Health has partnered with industry leaders in prescription benefit management, to help lower the cost of prescription drugs.

Prescription Care Coordinators work with your healthcare provider to deliver budget-friendly alternatives to high-cost medications with the same clinical outcomes as more costly drugs, ensuring the highest quality at the best cost.

What does this mean for you?
You will receive an alternative medication approved by your physician with a lower out-of-pocket expense. There's no need to contact anyone. Your Prescription Care Coordinators will reach out to you if you are a good candidate for this program.

Select Drugs and Products™ Program

The Plan's Select Drugs and Products™ Program allows you to take an active role in helping the Plan reduce your costs, while allowing the Plan to continue to offer generous healthcare benefits to all Participants. The Plan is sponsoring this program at no cost to you. If you are prescribed a drug included on the Paydhealth Select Drugs and Products™ List, you must enroll in the Program to comply with benefit requirements.



1. Paydhealth will initiate outreach to you by text message or phone call.

2. Complete the digital enrollment application which will allow Paydhealth to match you to alternate funding programs.
Note: you may be asked to provide household size and income information.

3. Your Paydhealth Case Coordinator will coordinate with you and your pharmacy to ensure you are able to get your medication in a timely manner.

A Case Coordinator is available (8:00 am to 8:00 pm CST) to guide you through the enrollment process and the program. Please respond to calls from your Case Coordinator in a timely manner.

This program keeps will not share your information with any 3rd party solicitors. If you would like to complete your application over the phone or speak with a Paydhealth Case Coordinator, please call (877) 869-7772. Common questions and answers about your Plan's Select Drugs and Products™ Program can be found on the next page.

There are two reasons why you are receiving this important message:

Your Plan has added an important program that includes the Paydhealth Select Drugs and Products™ List*.

Your Plan is continuing to offer generous specialty drug benefits while attempting to reduce costs to you and the Plan.

*The Paydhealth Select Drugs and Products™ List includes drugs typically prescribed by a specialist for multiple sclerosis, hepatitis C, Crohn's disease, hemophilia, cancer, psoriasis, rheumatoid arthritis, transplants, HIV/AIDS, and other complex conditions.

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How It Works

What is the Select Drugs and Product™ Program?

The Select Drugs and Products™ Program provides advocacy services to assist you by identifying and facilitating your enrollment in programs that may reduce or eliminate your out-of-pocket costs for eligible specialty drugs, products, and services. A Case Coordinator will contact you to guide you through the program. The Plan continues to offer generous healthcare benefits but needs your help to continue to meet this goal. Your active role in helping the Plan reduce its costs and yours is important. The Plan is sponsoring this program at no cost to you. However, you may be required to pay a portion of the cost to acquire your specialty drug, product or service depending on specific situations.

What is the Enrollment Requirement for the Select Drugs and Products™ Program?

The Plan requires you to enroll in the Select Drugs and Products™ Program by following the three-step process outlined above, which starts with a response to texts or calls from the Paydhealth Case Coordinator in a timely manner.

What happens after I enroll in the Select Drugs and Products™ Program?

After enrolling in the Select Drugs and Products™ Program, you will be asked to complete certain documentation related to the alternate funding programs identified by your Case Coordinator. This will include providing required documents and information to the alternate funding program from you and may require your prescriber's participation as well. Your timely responses will help you avoid any delays in processing your documentation.

Your Case Coordinator will help you obtain your eligible specialty drugs, products or services and reduce your out-of-pocket costs by coordinating alternative forms of funding. After your acceptance into an alternate funding program, your Case Coordinator will contact you before and after each refill to ensure there is no disruption in your treatment.

Call toll-free at 1-(877) 869-7772 to speak to a Case Coordinator, M-F, 8AM to 8PM CT.

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GoodRx – THE FREE RX SAVINGS SOLUTION

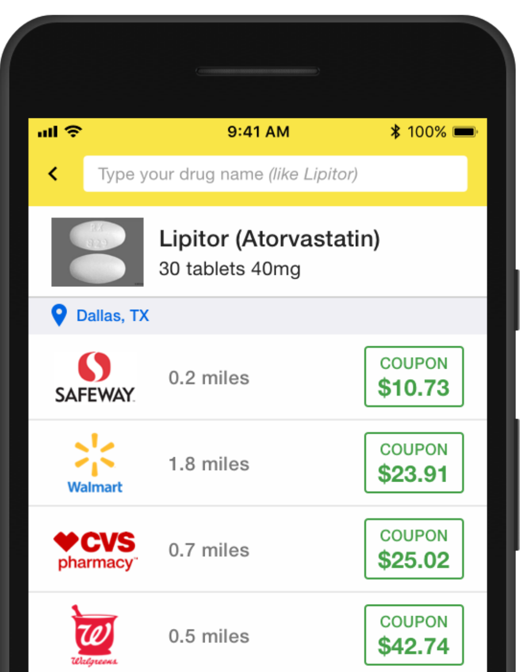
Drug prices vary widely between pharmacies.
GoodRx finds the lowest prices and discounts.

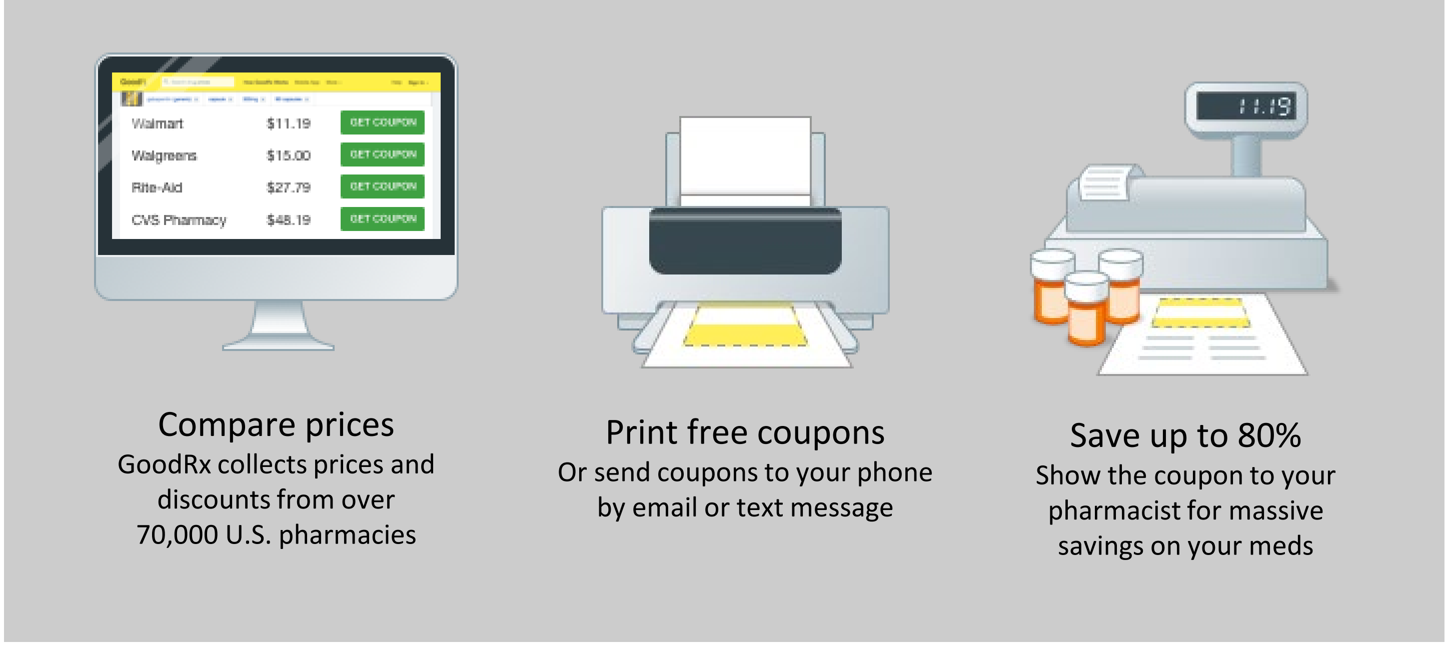
How?

1. Collects and compares prices for every FDA-approved prescription drug at more than 70,000 U.S. pharmacies

2. Finds free coupons to use at the pharmacy

3. Shows you the lowest price at each pharmacy near you





Compare prices
GoodRx collects prices and discounts from over 70,000 U.S. pharmacies

Print free coupons
Or send coupons to your phone by email or text message

Save up to 80%
Show the coupon to your pharmacist for massive savings on your meds

GLP-1

Program Through Apta Cash

What are GLP-1 Drugs?
GLP-1 drugs, or glucagon-like peptide-1 receptor agonists, are a class of medications used primarily to treat type 2 diabetes and obesity. They work by enhancing insulin secretion, slowing gastric emptying, and reducing appetite, which helps control blood sugar levels and, in some cases, promotes weight loss. Examples include medications like Wegovy and Ozempic.

What is The GLP-1 Program?
Normally the cost of GLP-1 drugs can vary widely depending on the specific medication, dosage, and insurance coverage. Without insurance, monthly costs can range from $700 to $1,200 or more. The GLP-1 program through Apta Cash allows members to obtain GLP-1 medications through a reputable and vetted pharmacy at discount.

Highlights of the program include:

- Cut monthly costs by up to 75%
- Discounted price of around $250 / month, paid by employee
- If you don’t have a prescription, Apta Cash will set up telehealth visit

Please note: The program is not available in the following locations: Alabama, Arkansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, North Carolina, West Virginia, Washington D.C. For shipment to California, the prescription must go through a separate approval process by the pharmacy.

If you are interested in learning more about the program, contact Apta Cash at: **(855) 378-0770**

Powered by medEcash

DELTA DENTAL
Delta Dental of Nebraska

Delta Dental PPO℠ &
Delta Dental Premier®

State Law Enforcement Bargaining Council

Group #000468

Plan Benefit Highlights			
Network(s)	**Delta Dental PPO℠**	**Delta Dental Premier®**	**Non-Participating***
Calendar Year Plan Maximum Per person per calendar year ***Diagnostic and preventive services do not apply towards annual max***	$1,000	$1,000	$1,000
Lifetime Ortho Maximum Per eligible covered member	$2,000	$2,000	$2,000
Deductible Per person per family per calendar year *No deductible for diagnostic and preventive services*	$50/person $150/family	$50/person $150/family	$50/person $150/family
Eligible Dependents	Spouse and dependent children up to age 26		
Covered Services	**Dental Benefit Plan Coverage**		
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Sealants	100%	100%	100%
Basic Services Space maintainers Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth and posterior (back) teeth	80%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
Major Restorative Crowns and Crown repair	50%	50%	50%
Prosthetic Repairs and Adjustments Denture adjustments and repairs Bridge repair	50%	50%	50%
Prosthetics Dentures (full and partial) Bridges	50%	50%	50%
Orthodontics Treatment for the prevention/ correction of malocclusion *Available for covered members, ages 8 to age 19*	50%	50%	50%

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

You and your family members may visit any licensed dentist, but will receive the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from.
PPO Dentist: Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist: Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
Non-Participating Dentist: Payment is based on the 90th percentile of Reasonable & Customary (R&C) charges, or the actual fee charged, whichever is less.

DELTA DENTAL

Easy, anytime access to your dental benefits

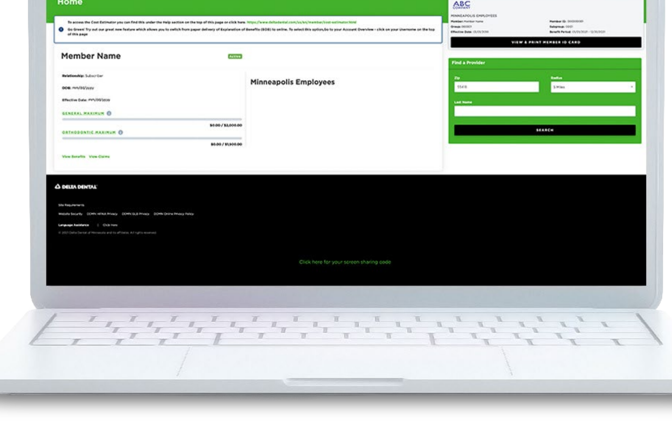
No paper needed; all your dental policy information is at your fingertips.

Delta Dental of Nebraska secure member portal

DeltaDentalNE.org/myaccount

Improved functionality and updated tools to manage your benefits.

At Delta Dental of Nebraska, we're focused on providing effective digital resources for our members that align with our sustainability initiatives. Enhancements to the member portal provide more tools for members to self serve.



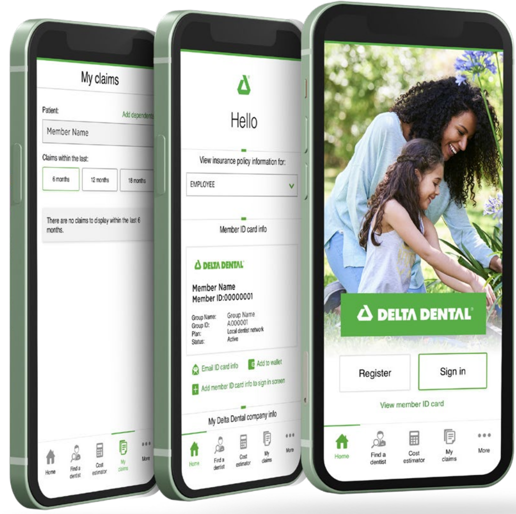
Features:

Coverage details

Claims status and history

Digital Explanation of Benefits (EOBs)

Digital ID card



Delta Dental mobile app

Manage your oral health anytime, anywhere.

We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are.

Features:

Find a dentist

Cost estimator

Claims status and history

Digital ID card

Logging on has never been easier

The Delta Dental Mobile App and Delta Dental Member Portal uses single sign on, meaning only one username and password for both!

Once you have registered your account on the Delta Dental Member Portal, members can sign in to the Delta Dental App using the same username and password. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental Mobile App or member portal.

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Delta Dental PPO Plus Premier™

Delta Dental is proud to offer both Delta Dental PPO™ and Delta Dental Premier® networks: the unique dual network known as Delta Dental PPO Plus Premier™. This gives members the opportunity to choose from a broader selection of dentists. No other national dental carrier can match the breadth of our network or the value we provide.

Delta Dental PPO™

Delta Dental PPO™ is one of the nation's largest dental networks with more than 113,500 in-network dentists. This network is available to any employer group and ofers additional savings to patients with options for enhanced benefits and lower out-of-pocket costs.

Delta Dental Premier®

Delta Dental Premier® is the largest dental network in the country with more than 155,000 in-network dentists. In fact, more than four-out-of-five dentists in the nation have agreed to accept Delta Dental's pre-negotiated fees for dental procedures.

There are advantages—and cost savings—for seeking treatment from a Delta Dental in-network dentist:

- The dentist has agreed to accept our allowable charge as payment in full for covered dental care. An in-network dentist is not allowed to bill more than our allowable charge.
- A Delta Dental in-network dentist will also file the claim directly with us. We will make payment directly to the in-network dentist and you will receive an explanation of benefits detailing your financial responsibility for any deductible or coinsurance amounts.

If dental services are received from an out-of-network dentist:

Reimbursement for the services will be paid directly to you, and you are responsible for paying your dentist. The allowances for services you receive from an out-of-network dentist may be significantly less than what Delta Dental would pay a Delta Dental in-network dentist. You may pay more out of pocket and will be responsible for the full-billed amount.

How to verify that your dentist is a Delta Dental in-network dentist:

By checking with your dentist or Delta Dental Customer Service (see the back of your ID card for the phone number), you are assured that your dentist is currently participating in the network. Consult your benefit booklet for more information regarding your specific plan design. We suggest you verify a dentist's participation status with Delta Dental or your dental ofce before each appointment.

It's easy to see if your dentist participates in the Delta Dental PPO™ or Delta Dental Premier® network. Use our Find a Dentist tool at DeltaDentalNE.org or call Customer Service at 1-800-448-3815.

The Power of Smile™

Learn more about how your oral health connects to your overall health at: DeltaDentalNE.org

Delta Dental of Nebraska

DDNE.8.30.22

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Two Networks, More Choices

At Delta Dental, we're proud to ofer both Delta Dental PPO™ and Delta Dental Premier® networks. The unique dual network, known as Delta Dental PPO Plus Premier™, gives you the opportunity to choose from a broader selection of dentists. No other national dental carrier can match the breadth of our national network.

Delta Dental PPO™ gives you the lowest out-of-pocket costs. In-network dentists agree to accept lower fees for procedures, providing larger discounts that result in savings for Delta Dental members.

Delta Dental Premier® is one of the largest dental networks in the country.

Seeing an out-of-network dentist is always an option. However, by seeing an out-of-network dentist, you will be missing out on the discounts available to you.

Efective Discounts set Delta Dental apart from other dental carriers. Our large network size, network utilization and direct relationships with our dentists all contribute to Delta Dental's ability to deliver the industry's leading efective discount.

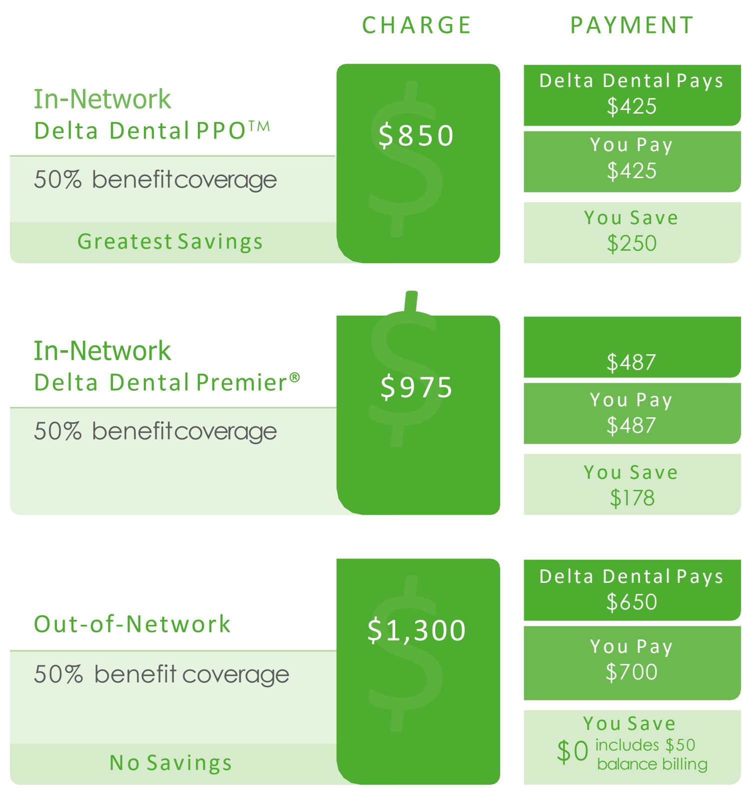
Find a Delta Dental Network Dentist
It's easy to see if your dentist participates in the Delta Dental PPO™ or Delta Dental Premier® network.

Visit our website at DeltaDentalNE.org and select "Find a Dentist" or call Customer Service at 1-800-448-3815.

Network Cost Savings Example

The illustrative cost of a crown is $1,350.

How much will **you save** and how much will **you pay** out-of-pocket?



All examples shown are for illustrative purposes only and assume the member's applicable deductibles have been met. Benefit coverage and out-of-network reimbursement may vary by plans, procedures and dental benefit contracts. Please review your benefit summary for complete details.

The Power of Smile™
Learn more about how your oral health connects to your overall health at:
DeltaDentalNE.org

Delta Dental of Nebraska

DDNE.8.30.22

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A Look at Your VSP Vision Coverage

With VSP and STATE LAW ENFORCEMENT BARGAINING COUNCIL, your health comes first.

Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!
Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe
Calvin Klein
COLE HAAN

FLEXON
LONGCHAMP PARIS

and more

See all brands and offers at vsp.com/offers.

+

Up to

40%

Savings on lens enhancements‡

Enroll through your employer today.
Contact us: **800.877.7195** or vsp.com

Your VSP Vision Benefits Summary

STATE LAW ENFORCEMENT BARGAINING COUNCIL
and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2025

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$20 Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$20**	See frame and lenses
FRAME+	• $170 Featured Frame Brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club frame allowance • $80 Costco frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Progressive lenses • Anti-glare coating • Tints/Light-reactive lenses • Scratch-resistant coating • UV protection • Average savings of 30% on other lens enhancements	$0 $0 $0 $0 $0	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average of 15% off the regular price; discounts available at contracted facilities. **Exclusive Member Extras for VSP Members** • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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TruHearing Hearing Aid Discount Program

VSP® Vision Care members can save up to 60% on the latest brand-name prescription and over-the-counter hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

TruHearing®
truhearing.com/vsp

Hearing loss is growing in the workplace

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, 38 million Americans need hearing aids, 70% of the people with hearing loss don't treat it, and only 30% seek treatment.[1] And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

Ninety-six percent of customers surveyed would recommend TruHearing to their friends and family.[2]

More than just great pricing

TruHearing also provides members with:

- One year of follow-up visits for fittings, adjustments, and cleanings
- A 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid on all non-rechargeable aids

Plus, members get:

- Access to a national network of more than 7,000 hearing healthcare providers
- Straightforward, nationally fixed pricing on a wide selection of the latest brand-name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if your organization already offers a hearing aid allowance, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Over-the-counter hearing aids are also available through phone or online orders.[3]

Here's how it works:

Contact TruHearing.
Members and their family call **877.396.7194** and mention VSP.

Schedule exam.
TruHearing will answer questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

1. Kochkin S. MarkeTrak VIII: The key influencing factors in hearing aid purchase intent. Hearing Review. 2012; 19(3):12–25. "Quantifying the Obvious: The Impact of Hearing Instruments on Quality of Life." The Hearing Review. Kochkin and Rogin. Jan 2000. **2.** Based on a 2018 satisfaction study of VSP members. **3.** Over-the-counter hearing aids are different from prescription hearing aids.

VSP is providing information to its members, but does not offer or provide any discount hearing program. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information, please visit **vsp.com/offers/special-offers/hearing-aids/truhearing**. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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Classification: Public

Group Term Life Insurance and AD&D Coverage

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death.
Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by the State of Nebraska through the State Law Enforcement Bargaining Council.

Benefits

Basic Life Coverage $40,000

Basic AD&D Coverage for a covered accidental loss of life, the coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.

Age Reductions Reduces to 65% at age 65 and to 50% at age 70.

Other Basic Life Features and Services

Accelerated Benefit / Right to Convert
Repatriation Benefit / Waiver of Premium
Portability of Insurance
Travel Assistance
Life Services Toolkit / Free On-Line Will Preparation
Child Education / Day Care / Spouse Education

Other Accidental Death & Dismemberment Features

Seatbelt / Airbag Additional Benefit
Additional Line-of-Duty Benefit / Additional Occupational Assault Benefit
Additional Felonious Assault Benefit / Additional Public Transportation Benefit
Rehabilitation / Therapeutic Counseling

Waiver of Premium

If you become totally disabled while insured; remain disabled for 6 months and continue to pay premiums during that period; and are less than age 60, your life insurance will continue until the day you retire or you reach age 70. If total disability ends, you may exercise the conversion privilege.

Conversion

If your insurance terminates because you are no longer employed full-time, your insurance may be converted to an individual life insurance policy if you apply and include payment of the first premium within 31 days of termination.
Conversion does not require proof of medical insurability.

Additional Group Life and AD&D Insurance

Help protect your loved ones from financial hardship.

Life insurance coverage is designed to help provide financial support and stability to your family should you pass away. You can also cover your eligible spouse and child(ren).
Accidental Death & Dismemberment (AD&D) insurance provides an extra layer of protection if you die or become dismembered in an accident.

This plan offers:
- Competitive group rates
- The convenience of payroll deductions
- Benefits if you are dismembered, become terminally ill or die

How Much Can I Apply For?

Your combined Basic Life and Additional Life amounts cannot exceed a maximum of 6 times your annual earnings. The coverage amount for your spouse cannot exceed 50% of your Additional Life coverage.

For You: $10,000 to $300,000 in increments of $10,000
For Your Spouse: $5,000 to $150,000 in increments of $5,000
For Your Child(ren): $10,000

What is the Guarantee Issue Maximum?

Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.

For You: Up to $100,000
For Your Spouse: Up to $25,000
For Your Child(ren): $10,000

What does My AD&D Benefit Provide?

If you elect AD&D insurance coverage, the benefit amount is the same as the Additional Life insurance benefit.

This benefit is available for employee elections but not for Spouse or Children

Waiver of Premium	Your Basic and Additional Life premiums may be waived if you: • Become totally disabled while insured under this plan • Are under age 60, and • Complete a waiting period of 180 days If these conditions are met, you Basic and Additional Life insurance coverage may continue without cost until age 65, provided you give us satisfactory proof that you remain totally disabled.
Conversion	If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health, as long as you apply within 30 days of termination.

How Much Your Insurance Costs

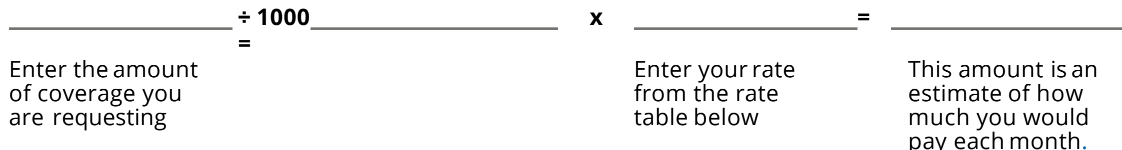
Your Basic Life insurance is paid for by the State of Nebraska through the State Law Enforcement Bargaining Council. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

If you buy coverage for your spouse, the monthly rate is $0.160 per $1,000.

If you buy Dependents Life coverage for your child(ren), your monthly rate is $0.200 per $1,000, no matter how many children you're covering.

Age (as of Jan 1, 2025)	Your Rate (per $1,000 of Total Coverage)
<30	$0.081
30–34	$0.084
35–39	$0.096
40–44	$0.144
45–49	$0.206
50–54	$0.351
55–59	$0.577
60–64	$0.784
65–69	$1.395
70–74	$3.042
75+	$11.535

Use this formula to calculate your premium payment:



If you elect AD&D insurance with your Additional Life insurance, your monthly AD&D rate is $0.060 per $1,000 of AD&D benefit added to the above rates.

For Full Rate Tables, refer to your enrollment packet or contact Tara Johnson, SLEBC Office Administrator.

Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by State Law Enforcement Bargaining Council (SLEBC).

Benefits

Monthly Benefit	60 percent of the first $8,333 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	180 days
Definition of Disability	For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder: • You are unable to perform with reasonable continuity the material duties of your own occupation, and • You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation. You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.
Maximum Benefit Period	If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins.

Other Features and Services

- 24- hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Family Care Expense Adjustment
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone or through video.

EAP services can help with:

Depression, grief, loss and emotional well-being

Family, marital and other relationship issues

Life improvement and goal-setting

Addictions such as alcohol and drug abuse

Stress or anxiety with work or family

Financial and legal concerns

Identity theft and fraud resolution

Online will preparation and other legal documents

Contact **EAP**

888.293.6948
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **healthadvocate.com/standard3** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

1 The EAP service is provided through an arrangement with Health Advocate℠, which is not affiliated with The Standard. Health Advocate℠ is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

When Is The EAP Available?

Over-the-phone consultation and online access to EAP services are always available. Simply call the toll-free number or log on to **www.eapbda.com.** In emergency situations, you may call the toll-free number to speak with a master's-degreed clinician who can also connect you to emergency services.

Your program also includes up to three face-to-face assessment and consultative sessions per issue. A clinician will work with you to schedule appointments according to your needs.

What Can WorkLife Services Do For Me?

WorkLife services can save you countless hours by researching and providing referrals for important needs like:

- Child care and elder care
- Education
- Adoption
- Pet care
- Daily living
- Travel

A broad range of educational materials and guide books on dependent care topics are also available.

How Much Does It Cost?

The EAP and WorkLife services are provided to you in connection with your employer-sponsored group insurance from The Standard. If you accept a referral to services that are not a part of your EAP program, you may be responsible for the costs associated with those services.

All The Help You Need Online

The EAP provides the following online services:

- Informative guides and articles
- Monthly webinars and bulletins
- Ability to search on your own for:
  - Child care or elder care services
  - Pet care
  - Adoption resources
- Detailed maps for every search
- Self-assessments
- Healthy lifestyle guidance, from tools for diet and fitness to smoking cessation
- Videos and articles on topics like understanding depression, nutrition advice and preparing for childbirth
- Financial and legal information, including a program for completing a simple will and identity theft consultation recovery and prevention services
- Detailed calculators used to help solve common financial concerns, such as computing college finances

FLEXIBLE SPENDING ACCOUNT (FSA)

The General-Purpose Health Flexible Spending Account allows you to set aside up to $3,300 in pre-tax dollars to pay most out-of-pocket medical, dental or vision expenses not paid by insurance; including deductibles and copayments. Please refer to the next page for a list of eligible expenses or refer to the most recent version of IRS publication 502.

You decide how much to deposit into your account. Your election amount is evenly deducted pre-tax from your paycheck throughout the plan year. When you have an expense that qualifies, you pay the bill, submit a claim, and you are reimbursed with tax-free dollars from your account.

If you don’t use all the pre-tax dollars you deposited in your account(s), you will forfeit any balance in the account(s) at the end of the plan year. You have 90 days after the plan year ends to submit claims for expenses incurred during that plan year.

Dependent Care Account

The Dependent Care account allows you to set aside tax-free dollars to pay for qualified dependent care expenses, such as daycare, that you would normally pay with after-tax dollars. Qualified dependents include children under age 13 and/or dependents who are physically or mentally unable to care for themselves. If your spouse is unemployed or doing volunteer work, you cannot set up a dependent care account. You must meet the following criteria in order to set up this account:

- You and your spouse both work; OR
- You are the single head of household; OR
- Your spouse is disabled or a full-time student.

The IRS allows you to contribute the following amounts
(each calendar year), depending on family status:

- If you are single, the lesser of your earned income or $5,000
- If you are married, you can contribute the lesser of
  - Your (or your spouse’s) earned income
  - $5,000 if filing jointly or $2,500 if filing separately

Plan Year
January 1, 2025, through December 31, 2025

Once Enrolled, You May Not Change Your Election
You cannot change your annual election after the beginning of the plan year.
However, there are certain limited situations when you can change your elections
if you have qualified change in status.

Flexible Spending Account – Eligible Expenses
Your Health Care Reimbursement Flexible Spending Account lets you pay for
medical care expenses not covered by your insurance plan with pre-tax dollars.
The expenses must be primarily to alleviate a physical or mental defect or illness
and be adequately substantiated by a medical practitioner. The products and
services listed on the next page are examples of medical expenses eligible for
payment under your FSA, to the extent that such services are not paid by your
medical and/or dental insurance plan.

FLEXIBLE SPENDING ACCOUNT ELIGIBLE EXPENSES

ELIGIBLE EXPENSES

These are only examples, and this list is not all-inclusive – it only provides some of the more common expenses. Additional information is available in IRS Publication 502.

Common Eligible Medical Expenses:

- Eyeglasses, eye exams, sunglasses
- (prescription)
- Over-the-counter drugs
- Menstrual care products
- Eye surgery
- Fertility enhancement
- HMO expenses
- Hearing aids, batteries, and exams
- Hospital services
- Immunizations, vaccines, flu shots
- Laboratory fees
- LASIK eye surgery
- Medicines (prescribed)
- Obstetric services
- Optometrist
- Orthodontia
- Prescription drugs
- Psychiatric care
- Psychologist
- Speech therapy
- Stop smoking programs
- Surgery/operations
- Therapy
- Vasectomy
- Wheelchair
- X-rays

Dual Purpose Expenses That Potentially Qualify:

The expense must be for a specific medical reason and be accompanied by a prescription.

- Vitamins
- Supplements
- Massage therapy
- Herbal supplements
- Natural medicines
- Aromatherapy
- Weight-loss program
- Health club dues

Health Care Reform & Over-the-Counter Items:

Over-the-Counter Medicine and Drugs do not require a prescription to be eligible for reimbursement under the plan.

- Allergy medications
- Antacids
- Anti-diarrhea medicine
- Bug-bite medication
- Cold medicine
- Cough drops and throat lozenges
- Diaper rash ointments
- Hemorrhoid medication
- Incontinence supplies
- Laxatives
- Muscle/joint pain products/rubs
- Nicotine medications, gum, patch-es
- Pain relievers
- Sinus medications, nasal sprays, nasal strips
- Sleep aids
- Wart removal medication
- Band-aids/bandages
- Cold/hot packs for injuries
- Condoms
- Contact lens solutions
- Diabetic supplies
- First aid kits
- Medical alert bracelets/necklaces
- Pregnancy test kits
- Thermometers

Ineligible Expenses:

- Cosmetic surgery
- Long term care
- Hair transplant/re-growth
- Maternity clothes
- Nutritional supplements
- Personal use items: such as toiletries, cotton swabs, toothbrush, toothpaste, facial care, shampoo
- Teeth whitening
- Drunk driving classes

Dependent Care Eligible Expenses:

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you. The care must be necessary for you or your spouse to be gainfully employed or to go to school. Care may be provided by anyone other than your spouse or your children under the age of 19. Expenses for schooling, kindergarten, over-night care, and nursing homes are not reimbursable. See IRS Publication 503.

- The maximum you can elect, in a calendar year, is equal to the smallest of the following:

- $5,000 – Married and filing federal taxes jointly or a single parent
- $2,500 – Married and filing separate federal tax return

- The amount contributed year-to-date, is available for reimbursement.

IMPORTANT NOTICES

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). To be eligible for these Special Enrollment rights you must have completed a waiver when you were first eligible stating that you were declining because of other group health insurance coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

Women's Health & Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, benefits under this Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Charges, as you determine appropriate with your attending Physician: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications of the mastectomy, including lymphedema. The amount you must pay for such Covered Charge (including Copayments and any Deductible) are the same as are required for any other Covered Charge. Limitations on benefits are the same as for any other Covered Charge.

Patient Protection Notice

State Law Enforcement Bargaining Council generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Apta Care Coordinators at 866-274-9478.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Apta Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Apta Care Coordinators at 866-274-9478.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice of Privacy Practices (the "Notice") describes the legal obligations of State Law Enforcement Bargaining Council and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:
(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources at 402-489-2081.

Effective Date
This Notice is effective September 23, 2013.

Our Responsibilities
We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by internal company email.

How We May Use and Disclose Your Protected Health Information
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

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

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official-

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to
provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.
Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures
Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights You have the following rights with respect to your protected health information:
Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing and submitted to Tara Johnson at PO Box 6729, Lincoln, NE 68506. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.
- If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request to Human Resources at 402-489-2081. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request to Human Resources at 402-489-2081. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact Human Resources at 402-489-2081.

Complaints. If you believe that your privacy rights under this Notice have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources at 402-489-2081 or PO Box 6729, Lincoln, NE 68506. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

You may also file a written complaint directly with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201, or the appropriate Regional Office of the Office for Civil Rights. You may also call them at 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Tara Johnson at 402-489-2081.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name State Law Enforcement Bargaining Council			4. Employer Identification Number (EIN) 38-3789851
5. Employer address P.O. Box 6729			6. Employer phone number 402-489-2081
7. City Lincoln	8. State NE	9. ZIP code 68506	
10. Who can we contact about employee health coverage at this job? Tara Johnson			
11. Phone number (if different from above)	12. Email address tjohnson@netroopers.org		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full-time State Troopers who work 120 hours in a 28-day period, full-time Fire Marshal Inspectors who regularly work 30 hours in a 7-day period, full-time Marshal Investigators who regularly work 60 hours in a 14-day period, full-time Conservation Officers who regularly work 120 hours in a 28-day period, and full-time Administrative Support who regularly work 30 hours in a 5-day period.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Your legally recognized spouse, your child until the end of the month in which he/she attains age 26, your child age 26 or older who meets incapacitated child requirements, and any child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

MEDICARE PART D NOTICE

Important Notice from State Law Enforcement Bargaining Council About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with State Law Enforcement Bargaining Council and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. If neither you nor any of your dependents are eligible for or have Medicare, this notice does not apply to your or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Prime Therapeutics Management has determined that the prescription drug coverage offered by the State Law Enforcement Bargaining Council Employee Benefit Plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, you and your dependents will be able to get this coverage back at the next annual open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with State Law Enforcement Bargaining Council and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through State Law Enforcement Bargaining Council changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.
You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 15, 2024
State Law Enforcement Bargaining Council
Tara Johnson
PO Box 6729, Lincoln, NE 68506
402-489-2081

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