
The power is MUTUAL
2020
BENEFITS
GUIDE
Mutual of Omaha
459503

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

Benefit Options

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

		Regular Status			Temporary Status
Benefit Plan	**Coverage Effective Date**	**30 hrs or more**	**20 – 30 hrs**	**< 20 hrs**	**40 or less**
Basic Employee Life & Basic Long-Term Disability	Date of Hire	X			
Health, Dental, Vision	Benefits Effective Date	X			*
Supplemental Life, Spouse Life, Child Life, Basic Accidental Death & Dismemberment, Supplemental Accidental Death & Dismemberment	Benefits Effective Date	X			
Supplemental Long-Term Disability	Benefits Effective Date	X			
Health Care Flexible Spending Account	Benefits Effective Date	X			
Dependent Care Flexible Spending Account	Benefits Effective Date	X	X	X	
Legal Services	Benefits Effective Date	X	X	X	
401(k) Plan	Benefits Effective Date	X	X	X	X
Vacation Accrual	Date of Hire	X	X	X	X
Personal Time	Following 3 months of employment	X	X		
Holidays	Date of Hire	X	X	X	X

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

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

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

Eligible Dependents

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

- Your spouse
  - A person to whom you are legally married, whether of the opposite sex or the same sex, as recognized and allowed by the laws of the state in which you become married. Copy of certified marriage license is required to establish eligibility.
- Your Child, or Foster Child, up to age 26, unless the Child meets the requirements as an Incapacitated Child
  - Your naturally-born child; a child that you have legally adopted; your step-child; your foster child who has been placed in your care pursuant to a judgment, decree or court order; or a child for whom you have been appointed legal guardian.

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

Level of Coverage Options

You can elect enrollment coverage for:

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

Enrollment

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

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

Qualified Life Events

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

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

In most situations, you may only add or delete dependents from your current coverage as the result of a Life Event change in status with the proper documentation, if required. Changes to your plan options must be consistent with the Life Event. If you increase the payroll deduction amount for Your

Health Care Flexible Spending Account with an eligible Life Event, the increased dollar amount must be used for expenses incurred after the Life Event for services to be consistent with the Life Event.

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

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

Health Options and Coverage Details

Waive Health Coverage

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

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

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

Health

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

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

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

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

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

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

We will recognize health deductibles you've met with other coverage during your first plan year (Jan. 1 – Dec. 31) of service. Explanation of Benefits (EOB's) reflecting YTD deductibles can be faxed to Aetna; Attn: Tammy Richardson at 860-907-3894.

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

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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY – SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations – For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	\$750 Individual/\$1,500 Family \$1,250 Individual/\$2,500 Family	\$1,000 Individual /\$2,000 Family \$1,750 Individual/\$3,500 Family
All covered expenses accumulate simultaneously toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	15%	25%
Payment Limit (per calendar year) (Out-of-Pocket Maximum)	\$3,250 Individual/\$6,500 Family \$3,750 Individual/\$7,500 Family	\$6,000 Individual/\$12,000 Family \$6,750 Individual/\$13,500 Family
All covered expenses accumulate simultaneously toward the preferred or non-preferred Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles (except any copays and penalty amounts) may be used to satisfy the Payment Limit. Pharmacy copay expenses do not apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements – Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Skilled Nursing Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required – excluded amount applied separately to each type of expense is \$300 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per year up to age 65, 1 exam per year age 65 and older.	Covered 100%; deductible waived	25%; after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.	Covered 100%; deductible waived	25%; after deductible
Routine Gynecological Care Exams Recommended: One exam per year. Includes routine tests and related lab fees.	Covered 100%; deductible waived	25%; after deductible
Routine & Diagnostic Mammograms Recommended: One per year for covered females.	Covered 100%; deductible waived	25%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	25%; after deductible

Prostate-specific Antigen Test	Covered 100%; deductible waived	25%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	25%; after deductible
Annual fecal occult blood test for member age 40 and older. Colonoscopy, Sigmoidoscopy, and Double Contrast Barium Enema (DCBE) each covered once every five years.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Not Covered	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	15%; after deductible	25%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	15%; after deductible	25%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	15%; after deductible	25%; after deductible
Walk-in Clinics	15%; after deductible	25%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	15%; after deductible	25%; after deductible
Allergy Injections	15%; after deductible	25%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services)	15%; after deductible	25%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	15%; after deductible	25%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	15%; after deductible	25%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	15%; after deductible	25%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	15% after $60 copay; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; deductible waived	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	15%; after deductible	25%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery – Hospital	15%; after deductible	25%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery – Freestanding Facility	15%; after deductible	25%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	15%; after deductible	25%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Outpatient	15%; after deductible	25%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Colorectal Cancer Screening	Covered 100%; deductible waived	25%; after deductible
Fecal occult blood test, Colonoscopy, Sigmoidoscopy, and Double Contrast Barium enema (DCBE).		
Skilled Nursing Facility	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Maximum combined in-network and out-of-network benefit limited to 100 days per year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	15%; after deductible	25%; after deductible
Limited to 200 visits per year in-network and 60 visits per year out-of-network. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care – Inpatient	15%; after deductible	25%; after deductible
Maximum combined Inpatient and Outpatient benefit is limited to 185 days/visits. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	15%; after deductible	25%; after deductible
Maximum combined Inpatient and Outpatient benefit is limited to 185 days/visits. Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	15%; after deductible	25%; after deductible
Limited to 60 eight-hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Rehabilitative Speech Therapy	15%; after deductible	25%; after deductible
Limited to 30 visits per year.		
Outpatient Physical and Occupational Therapy	15%; after deductible	25%; after deductible
Limited to 60 visits per year combined.		
Acupuncture Treatment	15%; after deductible	25%; after deductible
Limited to 18 visits per year and $50 per visit maximum.		
Spinal Manipulation Therapy	15%; after deductible	25%; after deductible
Limited to 30 visits per year and $35 per visit maximum.		
Habilitative Physical Therapy	15%; after deductible	25%; after deductible
60 visits combined with PT/OT Combine Therapy, Habilitative OT and Autism PT, Autism OT		
Habilitative Occupational Therapy	15%; after deductible	25%; after deductible
60 visits combined with PT/OT Combine Therapy, Habilitative PT and Autism PT, Autism OT		
Habilitative Speech Therapy	15%; after deductible	25%; after deductible
30 visits combined with Speech Therapy and Autism ST		
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to the Outpatient Mental Health Office Visits section	Refer to the Outpatient Mental Health Office Visits section
Autism Applied Behavior Analysis	15%; after deductible	25%; after deductible

Autism Physical Therapy	15%; after deductible	25%; after deductible
60 visits combined with PT/OT Combine Therapy, Autism OT and Habilitative PT, Habilitative OT		
Autism Occupational Therapy	15%; after deductible	25%; after deductible
60 visits combined with PT/OT Combine Therapy, Autism PT and Habilitative PT, Habilitative OT		
Autism Speech Therapy	15%; after deductible	25%; after deductible
30 visits combined with Speech Therapy and Habilitative ST		
Durable Medical Equipment	15%; after deductible	25%; after deductible
Diabetic Supplies	15%; after deductible	25%; after deductible
Generic FDA-approved Women's Contraceptives	15%; after deductible	25%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	15%; after deductible	25%; after deductible
Infusion Therapy Administered in the home or physician's office	15%; after deductible	25%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	15%; after deductible	25%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	15% after $120 copay; after deductible	25% after $120 deductible; after plan deductible
Bariatric Surgery	Not Covered	Not Covered
Gender Dysphoria/Change	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
Coverage is still required to meet Aetna's clinical criteria for coverage to be allowed		
Wigs Covered due to medical necessity.	Covered 100% of the allowed amount; or contracted provider fees; deductible waived	Covered 100% of allowed amount of usual and customary fees; deductible waived

FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	15%; after deductible	25%; after deductible
Diagnosis and treatment of the underlying medical condition		
Comprehensive Infertility Services	15%; after deductible	25%; after deductible
Preauthorized medical treatment used for the primary purpose of, or in connection with, treating infertility. Invitro fertilization and/or artificial insemination up to a maximum lifetime benefit of $2,500. Combined with Advanced Reproductive Technology		
Advanced Reproductive Technology (ART)	15%; after deductible	25%; after deductible
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Up to a maximum lifetime benefit of $2,500 combined with Comprehensive Infertility Services		
Vasectomy	15%; after deductible	25%; after deductible
Tubal Ligation	15%; after deductible	25%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Standard Open Formulary	
Generic Drugs		
Retail	$13 copay	50% of submitted cost; after applicable copay
Mail Order	$39 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$35 copay	50% of submitted cost; after applicable copay
Mail Order	$105 copay	Not Applicable

Non-Preferred Brand-Name Drugs		
Retail	$60 copay	50% of submitted cost; after applicable copay
Mail Order	$180 copay	Not Applicable
Standard Specialty Drugs		
Preferred Brand Specialty	$120 copay	Not Applicable
Non-Preferred Brand Specialty	$120 copay	Not Applicable
Diabetic Supplies – Generic Drugs		
Retail	$0 copay	50% of submitted cost; after applicable copay
Mail Order	$0 copay	Not Applicable
Diabetic Supplies – Preferred Brand-Name Drugs		
Retail	$5 copay	50% of submitted cost; after applicable copay
Mail Order	$15 copay	Not Applicable
Diabetic Supplies – Non-Preferred Brand-Name Drugs		
Retail	$60 copay	50% of submitted cost; after applicable copay
Mail Order	$180 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 31-day supply from Aetna National Network	
EDS Custom Network	Extended day supply network; 32- 90-day supply covered at retail pharmacies At 3x the 31-day supply copay in the Extended Day Supply Network.	
Mail Order	Up to a 32-90-day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30-day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Aetna Standard Plan Drug List	
Influenza Vaccination Member may be responsible for the administration fee.	Covered 100%	Covered 100%
Zostavax and Shringrix Vaccine Covered for members age 50 and over.	Covered 100%	Covered 100%
Smoking Cessation Drugs Over-the-counter smoking cessation medications are covered when filled with a prescription	Covered 100%	50% of submitted cost

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.
Oral fertility drugs included.
Precertification for specialty drugs included
Step Therapy included
Generic oral contraceptive coverage at 100% at an in-network pharmacy.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student or marital status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY – SELF FUNDED

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over- the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888- 982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**

Health Premiums Per Pay Period (Before Tax)

Health Coverage	You Pay (Per Pay Period)
$750 Individual/$1,500 Family Deductible PPO Health Option	
Employee Only	$89.50
Employee + One	$177.50
Employee + Family	$262.50
$1,250 Individual/$2,500 Family Deductible PPO Health Option	
Employee Only	$45.00
Employee + One	$94.50
Employee + Family	$156.50

Dental Options and Coverage Details

Waive Dental Coverage

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

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

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

Dental

Our Group Dental Plan covers preventive, basic services, major services and orthodontics. The Plan Administrator for the Group Dental Plan is Renaissance Dental. The plan balances savings, service and customer satisfaction by providing access to the nationwide Maximum Care dental network.

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

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

Dental Deductibles

All benefits are subject to a calendar year deductible, except for preventive care. A deductible is the amount of covered expenses that you must pay before the plan will start paying benefits. Below are the calendar year dental deductibles:

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

Dental Coverage

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

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

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

Predetermination of Benefits

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

Dental Premiums Per Pay Period (Before Tax)

Dental Coverage	You Pay (Per Pay Period)
Dental Employee Only	$5.00
Employee + One	$11.00
Employee + Family	$20.50

Vision Option and Coverage Detail

EyeMed Vision Benefits

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

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

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

Well Vision Exam: $25 copay every calendar year

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

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

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

EyeMed Premiums Per Pay Period (Before Tax)

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

Health Care Flexible Spending Account

Advantages of a Health Care Flexible Spending Account (FSA)

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

The Health Care FSA reduces your taxable income because your contributions are deposited in the FSA on a pre-tax basis. This means that your contribution is deducted from your paycheck before taxes are withheld. For example, if your income was $30,000 and your out-of-pocket expenses totaled $540 and you had $45 a month deducted from your paycheck before taxes, you could save $122 in taxes over the course of the year, because your taxable income would be reduced.

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

Contribution Amounts

Minimum – $60 per year
Maximum – $2,700 per year

Eligible Expenses for Reimbursement

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

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

Setting Up Your Health Care Flexible Spending Account

Estimate how much money you will need to cover eligible expenses for yourself and your tax dependents for the period from your benefit effective date to the end of the year. We will automatically divide your total contribution amount evenly across your eligible paychecks. Each year during the annual enrollment period, you will have the opportunity to re-enroll in the Health Care Flexible Spending Account.

Important Internal Revenue Service (IRS) Requirements

- Money contributed to Flexible Spending Accounts must be used for eligible expenses incurred during the year that it is taken from your pay. Following the reimbursement period for the year, up to $500 of remaining balance will be rolled over to the next year. Any remaining balance over $500 will be forfeited.
- Eligible expenses must be incurred after the date your plan participation begins.
- Money cannot be transferred between the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.
- The amount paid out will be equal to the annual pledge anytime during the calendar year.
- If you or your dependents are enrolled in a health savings account through another plan, participation in a Health Care FSA could jeopardize the ability for you or your dependents to make contributions to the health savings account. Please contact your tax advisor for additional information.

Submitting the Claim

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

Please note, after December 31, 2020, you will have until March 31, 2021, to submit reimbursement claims for health care expenses incurred during 2020. After this date, remaining balances up to $500 will be available for reimbursement.

Reimbursement Methods

Online Expense Reimbursement

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

Paper Expense Reimbursement

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

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

Paper claim forms and supporting documentation are submitted to the Payroll Department for reimbursement.
A copy of the paper Health Care FSA Claim Form, can be found on Associate Access or HR@Home as referenced on the last page of this Benefits Guide.

You have until March 31, 2021, to submit reimbursement claims for health care expenses incurred during 2020.

Dependent Care Flexible Spending Account

Advantages of a Dependent Care Flexible Spending Account (FSA)

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

Contribution Amounts

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

Minimum – $60 per year
Maximum – $5,000 per year

Eligible Expenses

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

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

Eligible Dependents

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

Setting Up Your Dependent Care Flexible Spending Account

Estimate how much money you will need to cover your expenses for the rest of this year to determine your annual contribution amount. Remember vacation and school breaks (including the summer months). When you incur an eligible expense, you pay the expense, and then you get reimbursed.

Each year during annual enrollment period, as required by law, you will have the opportunity to re-enroll in the Dependent Care Flexible Spending Account.

Important Internal Revenue Service (IRS) Requirements

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

Reimbursement Method

Once you incur and pay the expense, submit the expense to the Payroll Department. Use a reimbursement claim form and submit to PL – Payroll-Flexible Spending Accounts. If you are attaching a receipt with your claim form, remember a canceled check cannot be accepted as a receipt. A copy of the Dependent Care FSA Claim Form, can be found on Associate Access or HR@Home as referenced on the last page of this Benefits Guide.

Submitting the Claim

Claims submitted by Monday at Noon (CST) are processed the same week. Reimbursements are directly deposited into your existing payroll deposit account on Fridays after the claim has been processed. You have until March 31, 2021, to submit reimbursement claims for dependent care expenses incurred during 2020.

Employee Life Insurance

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

Basic Employee Life Benefits

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

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

Employee Supplemental Life Options

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

Employee Supplemental Life Costs

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

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

Spouse Life Insurance

Spouse Life Options

You may purchase the following amounts of life insurance:

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

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

Spouse Life Costs

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

Child Life Insurance

Child Life Options and Premiums

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

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

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

Accidental Death & Dismemberment Insurance (AD&D)

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

Basic AD&D Benefits

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

Supplemental AD&D Options

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

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

Supplemental AD&D Costs

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

	Employee Only	Employee + One or Employee
$50,000	$ .75	$1.00
$100,000	$1.50	$2.00
$150,000	$2.25	$3.00
$200,000	$3.00	$4.00
$250,000	$3.75	$5.00

Long-Term Disability (LTD)

Basic Long-Term Disability Benefits

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

- At no cost to you, the company provides basic monthly pay replacement of 60% of your Annual Benefit Salary (not to exceed a maximum monthly benefit of $10,000)
- There is a six-month period before benefits are payable

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

Long-Term Disability Supplemental Options and Costs

- You may purchase an additional 10% of supplemental LTD coverage for a total monthly pay replacement of 70% of your Annual Benefit Salary (not to exceed a maximum monthly benefit of $20,000)
- If you elect the additional 10% of coverage, your portion of the cost will be paid with before tax dollars from your pay.
- The premium rates will be visible on your enrollment. The pay period rate is equal to your monthly Annual Benefits Salary x .0030/2.

Short-Term Disability Plan

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

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

Eligibility – Employees are eligible for STD coverage following 12 months of continuous employment.

Amount of Benefit for Eligible Employees – In the event of an eligible absence, you will receive 70% of base pay after meeting the 5-day waiting period.

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

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

Paid Time Off Benefits

Paid Time Off benefits available:

- Holidays
- Personal Time
- Vacation
- Parental Leave

Holidays

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

Mutual of Omaha Insurance Company observes 9 Holidays. 7 are fixed days, meaning they occur every year on the same day, and 2 holidays are "Floating" and the day observed may vary from year to year.

Holiday Schedule for 2020

Mutual of Omaha Insurance Holidays
New Year's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Day after Thanksgiving Day
Christmas Day
Two Additional Personal Day*

*** Floating Holidays for 2020**

Personal Time

Regular employees will receive a pro-rated amount of Personal Time after meeting eligibility. Following your initial eligibility, you will receive an allotment of personal time each year in January. Personal time does not rollover from year to year.

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

Personal Time – New Hire Eligibility provided:

Start date	Eligibility Date	Standard Hours 40 hrs/week	Standard Hours 30-39 hrs/week
		Insurance Employees	Insurance Employees
November, 2019	3/10/20	46.75	35
December, 2019	4/10/20	42	31.50
January, 2020	5/10/20	37.25	28
February, 2020	6/10/20	32.75	24.50
March, 2020	7/10/20	28	21
April, 2020	8/10/20	23.25	17.50
May, 2020	9/10/20	18.75	14
June, 2020	10/10/20	14	10.50
July, 2020	11/10/20	9.50	7
August, 2020	12/10/20	4.75	3.5
September, 2020	1/25/21	48	36
October, 2020	2/10/21	44	33
November, 2020	3/10/21	40	30

Due to how the holidays fall in 2020 and 2021, the above chart reflects the additional pro-rated personal time granted, based upon the number of hours an employee is scheduled to work, in place of the floating holiday(s).

Vacation

Mutual of Omaha provides eight hours of vacation to employees on their date of hire that becomes available to use on their first pay advice after their benefits effective date. New employees will begin to accrue vacation on their benefits effective date. Vacation time can be used at your discretion, and with manager's approval, for any time away from work.

Years of Service	Annual Vacation Accrual Rate	Hourly Accrual Rate	Vacation Limit
Up to 1 yr of service	14 days per year	0.053846	20 days
1 yr to 5 yrs of service	15 days per year	0.057692	20 days
5 yrs of service	18 days per year	0.069231	23 days
10 yrs of service	20.5 days per year	0.078846	25.5 days
15 yrs of service	23 days per year	0.088462	28 days
25 yrs of service	28 days per year	0.107692	33 days

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

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

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

Accrual Rate Based on Months of Service	9-day Pay Period (72 hrs worked)	10-day Pay Period (80 hrs worked)	11-day Pay Period (88 hrs worked)	12-day Pay Period (96 hrs worked)
0 to 12	3.88 hrs	4.31 hrs	4.74 hrs	5.17 hrs
13 to 59	4.15 hrs	4.62 hrs	5.08 hrs	5.54 hrs
60 to 119	4.98 hrs	5.54 hrs	6.09 hrs	6.65 hrs
120 to 179	5.68 hrs	6.31 hrs	6.94 hrs	7.57 hrs
180 to 299	6.37 hrs	7.08 hrs	7.78 hrs	8.49 hrs
300 +	7.75 hrs	8.62 hrs	9.48 hrs	10.34 hrs

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

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

Benefits Effective Date	Pay Advice w/1st Award of Vacation
01/01/2020	01/25/2020
02/01/2020	02/25/2020
03/01/2020	03/25/2020
04/01/2020	04/25/2020
05/01/2020	05/25/2020
06/01/2020	06/25/2020
07/01/2020	07/25/2020
08/01/2020	08/25/2020
09/01/2020	09/25/2020
10/01/2020	10/25/2020
11/01/2020	11/25/2020
12/01/2020	12/25/2020
01/01/2021	01/25/2021
02/01/2021	02/25/2021

Parental Leave

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

401(k) Long-Term Savings Plan

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

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

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

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

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

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

You are always 100% vested in your contributions and are immediately 100% vested in company

matching contributions (subject to gains and losses). However, if you are eligible for ERC, those contributions are subject to a three-year graded vesting schedule as shown below:

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

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

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

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

Investment Election Changes: You may make changes to your asset allocations of contributions, as well as transfer your existing account balances to different investment alternatives, by logging onto your account through the Internet or by calling Mutual of Omaha Retirement Services at 1-888-917-7191. Information and directions will be emailed to you prior to your first contribution and can also be found on Associate Access.

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

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

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

Voluntary ARAG Legal Services

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

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

Web Sites, Links and Contact Information References

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

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

Renaissance Dental (Maximum Care network):
www.myrenbenefits.com
888-358-9484

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

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

Refer to the Summary Plan Description, found on Associate Access or
http://www.mutualofomaha.com/hr@home for a complete explanation of all your group benefits.

Benefits Hotline:
Local (402) 351-3300
Toll Free (800) 365-1405
Benefits.Hotline@mutualofomaha.com

Payroll Hotline:
for questions on FSA processing: Local
(402) 351-3300
Toll Free (800) 365-1405