

Nebraska Department of Administrative Services

Health Insurance Plan Annual Report

Presented to the Legislature's Appropriations Committee

For the Plan Year July 1, 2025 to June 30, 2026

November 2, 2026

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Dear Nebraskans,

This annual report is submitted to the Legislature by the Nebraska Department of Administrative Services (DAS) pursuant to Neb. Rev. Stat. §50-502. Its main goal is to describe benefits provided by the Health Fund to the State's public servants during plan year 2025 - 2026, and to outline the fund's financial performance during the same time period.

Providing health insurance is a key component of the State's investment in its workforce. The investment in the Health Fund for the plan year 2025 – 2026 through State contributions totaled over $246.5 million and made up 15% of $1.6 billion total rewards portfolio that includes compensation and retirement benefits. The Health Fund provides medical and prescription drug benefits to approximately 13,980 eligible public servants and their family members, covering 29,000 lives overall.

Over the last several years, DAS had three key strategic objectives:

- Align benefits with compensation and public servant engagement as part of a total rewards portfolio.
- Give value back to the public servants by holding costs low and adding new benefits.
- Efficiently manage the State's Health Fund to provide the best value for public servants and taxpayers.

Plan year 2025 – 2026 was particularly challenging for the Health Fund due to rapidly growing cost of healthcare combined with an influx of catastrophic cases.

Despite these challenges, we continued to provide a variety of competitive health benefits to public servants.

The State of Nebraska can be proud that we are administering a health care benefit program that is providing excellent benefits and supporting our public servants and their families at their moments of greatest needs.

Lee Will
Director, Nebraska Department of Administrative Services,
Chief Operations Officer

Sean Davis,
State Personnel Director

Plan Design

The State of Nebraska's health insurance program in 2025 – 2026 consisted of three self-insured health plans, the Regular Plan, the WellNebraska Plan, and the Consumer-Focused Health Plan (CFHP). Each plan included medical and prescription drug coverage for in-network and out-of-network providers, as well as wellness benefits.

What does Self-Insured mean?

The State assumes the financial risk for providing health care benefits to its employees and contracts with United Healthcare (UHC) to process the claims. Instead of paying fixed premiums to UHC, which may be inflated to include profit margins and taxes, the State collects contributions from employees and State agencies itself and deposits them in a State trust fund, using the premiums to pay health care claims for plan participants after copays and deductibles.

There are no prerequisites or requirements for public servants to participate in the Regular Plan or CFHP. To enroll in the WellNebraska/Wellness Plan for the 2025-2026 plan year, public servants and spouses were required to complete an annual physical with their primary care physician. All public servants are eligible to enroll in this plan, however, those who have completed the annual physical will benefit from incentives such as reduced premiums and lower out-of-pocket costs for certain benefits. The WellNebraska health plan without incentives is identical to the Regular health plan. Throughout this report, the Wellness plan refers to participants under the WellNebraska health plan who have met the incentive requirements. The Regular health plan encompasses those that chose the Regular Plan as well as members of the WellNebraska health plan who did not meet the incentive requirements.

The CFHP provides an option for public servants to take advantage of a Health Savings Account (HSA) to set aside pre-tax funds for future health care expenses.

The plan year ran from July 1, 2025, through June 30, 2026, with open enrollment held May 6, 2025, through May 20, 2025. All public servants were encouraged to review the pre-populated elections and select coverages/amounts for certain benefits (i.e., HSA contributions) in the WorkDay system to verify what plans they currently were enrolled in and/or to make any necessary changes.

Plan Design Changes

Effective July 1, 2025, the State implemented the following changes to the design of health plans:

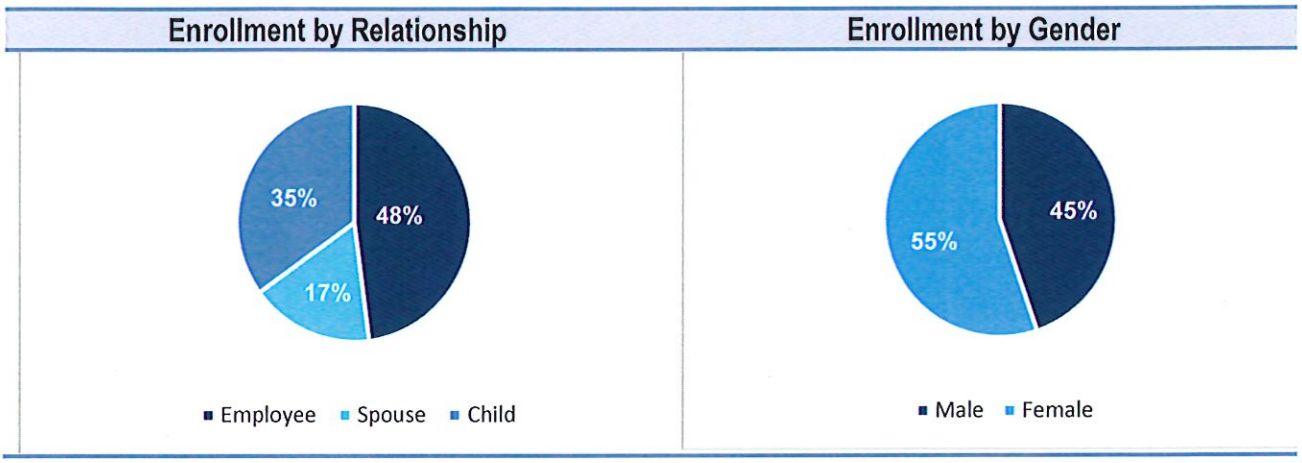
The deductible for CFHP increased from $3,200 to $3,300 in order to comply with minimum deductible requirement for HSA qualified plans. There was no corresponding increase to the family deductible. The out-of-pocket max was also increased from $4,100 to $4,300.

The summary of plan designs is shown in the table below:

	Regular	Wellness	Consumer Focused
Medical Benefits			
Deductible *(Individual / Family)*	$1,400 / $2,600	$800 / $1,600	$3,300 / $5,200
Coinsurance (EE)	20%	20%	20%
PCP / Specialist	$35 / $45	$25 / $40	Deductible & Coinsurance
Maternity	Deductible & Coinsurance	$0	Deductible & Coinsurance
OOP Maximum *(Individual / Family)*	$4,000 / $8,000	$2,700 / $5,400	$4,300 / $8,200
Prescription Drug Benefits			
Tier 1	$5	$5	20% after Deductible
Tier 2	$40	$30	
Tier 3	$60	$50	
OOP Maximum	$2,250 / $4,500	$2,000 / $4,000	Combined with Medical

Enrollment and Eligibility

Neb. Rev. Stats. §84-1601 and §84-1604 allow for permanent full-time and part-time public servants who work a minimum of 20 hours per week to participate in the State's health plans. Such public servants are eligible for coverage on the first of the month following 30 days of employment. In addition, Neb. Rev. Stats. §84-1601 and §84-1604 also allow temporary public servants working a minimum of 20 hours per week and hired into an assignment that is six months or longer eligibility for coverage in the State's health plans after the standard waiting period. State retirees can continue coverage in a State health insurance plan until they are Medicare-eligible, at age 65, as allowed in the State of Nebraska Classified System Personnel Rules and Regulations, Chapter 16.010; and the NAPE/AFSCME (NAPE) and State of Nebraska Labor Contract, Article 13.2.



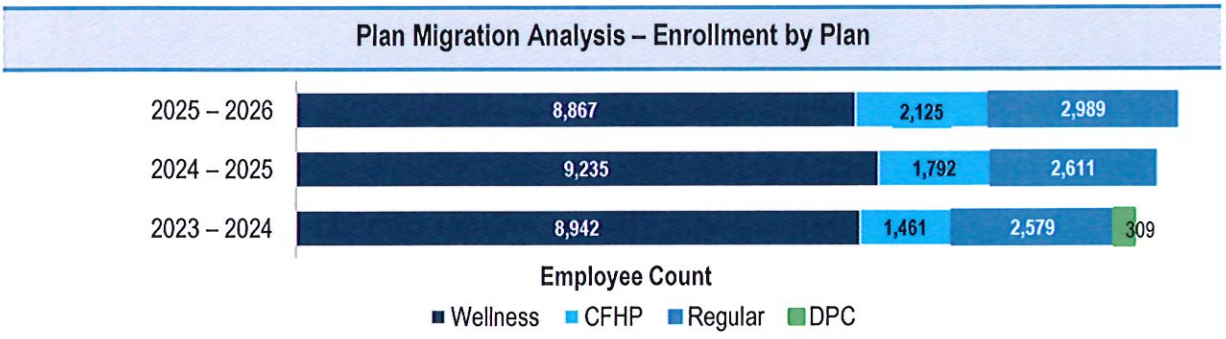
Per the charts above, the plan averaged 13,981 public servants enrolled in the 2026 plan year, which included approximately 172 retirees and 33 COBRA participants.

The total number of covered lives in the Health Fund, including spouses and dependents, was 28,958, which increased 2.5% from the 2024 – 2025 plan year.

Approximately 55.2% of public servants were female and 44.8% were male. The average age of members enrolled was 34.4, down slightly from last year's average of 34.8.

During plan year 2025-2026, the Regular Plan and CFHP saw increases in their respective membership, while the Wellness plan saw a decline in membership. The CFHP had the biggest increase in membership, percentage wise, with an increase of 18.6%. The Regular Plan also had a large enrollment increase of 14.5%. The Wellness Plan had an enrollment decrease of 4.0%.

Plan migration and enrollment by plan for the last three plan years are shown in the graph below:



The DPC plan was discontinued following FY 24.

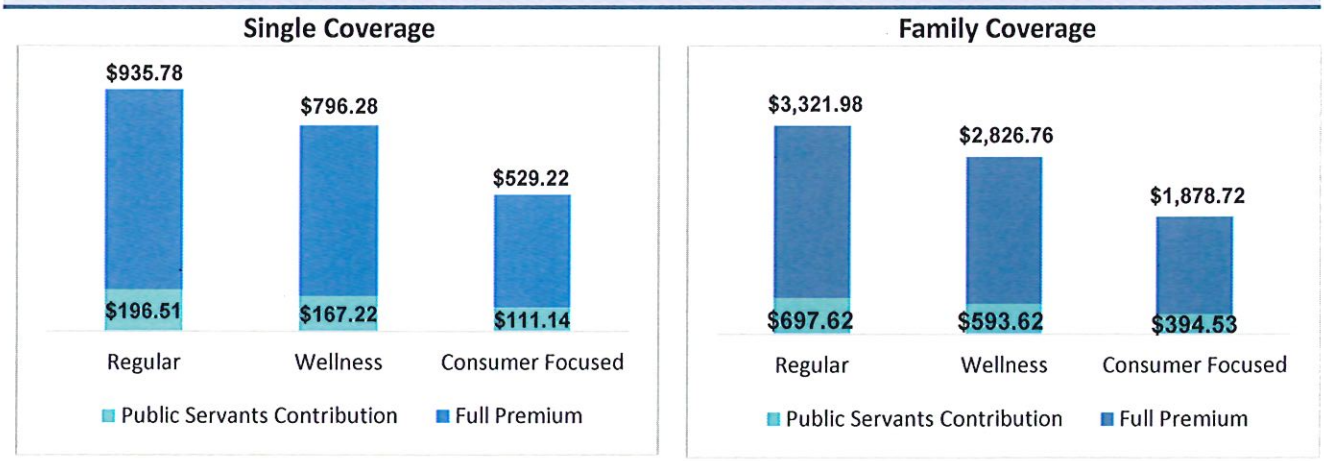
Plan Premiums and Contributions

The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from public servants through payroll deductions and combined with State contributions.
In accordance with Neb. Rev. Stat. §84-1611, the State pays 79% of monthly rates and active, full-time public servants pay 21%. Neb. Rev. Stat. §84-1604 requires that part-time public servants (20-29 hours a week) receive only a proportion of the State contribution. Part-time public servants pay 21% of the monthly rate plus a pro-rated amount of the State's share. Retirees pay 100% of the monthly rate and COBRA participants pay 100% of the monthly rate plus a 2% COBRA administration fee.

Health plan contributions are reviewed each year. Monthly premium rates for all State health plans are determined by reviewing actual claims history, projected enrollment, and projected health plan costs. Each health plan is analyzed individually for plan design and plan usage. In FY 2026, the rate changes were non-uniform. The Wellness Plan premium increased 11%, compared with 8% for the Regular and Consumer Focused Plans. The higher rate increase for Wellness Plan reflects that premiums have been lagging behind the plan's underlying costs, and the additional 3 points begin to close that gap.

Premium rates were approved in February 2025, and communicated to public servants in April 2025, prior to Open Enrollment.

Premium Rates for Single and Family Coverage for Plan Year 2025 – 2026



Plan Management and Fund Management

DAS assures the State's health plans and all other benefit programs comply with state and federal guidelines and provides financial management to the health plan. DAS consults with experts in health plan management including Segal, the State's actuary and healthcare consulting firm, UHC, the State's Third-Party Administrator (TPA) as well as PBM (Pharmacy Benefit Manager), and their attorneys to constantly monitor changes in health plan management and assure the plan and all required documentation is in compliance.

Regulatory Mandates	Health Plan Documents
• State Statutes • Department of Insurance • ACA • IRS • COBRA • HIPAA • Medicare • Employment Laws - FMLA, USERRA, ADA, Title VII, GINA • No Surprises Act • Transparency in Coverage	• Summary Plan Document (SPD) • Summary of Benefits & Coverage (SBC) • Section 125 Plan Document • Business Associate Agreements • Benefits Administration Manual for State HR Partners • Wellness & Benefits Options Guide • Wellness & Benefits Website

Neb. Rev. Stat. §84-1613 established the State Employees Insurance Fund #68960 to pay medical and pharmacy claims, and administrative fees. This Fund is administered by DAS, and reserve targets are adjusted annually using cost projections from Segal for the most recent plan years.

Reserves are imperative to the successful management of a self-insured health plan with about 29,000 covered lives. The Health Insurance History Fund #68922 is a subsidiary fund of the State Employees Insurance Fund #68960 and contains the Claims Fluctuation Reserve (CFR). The Health Insurance History Fund #68922 is designed to pay for the costs of coverage of unusual or high-volume claims that may occur. The Health Insurance History Fund #68922 also contains the amount to finance the operation of Program 606, Wellness and Benefits Administration, as approved by and stated in the biennium budget bill. The amount required for Program 606 operation was transferred by the State Treasurer from the Health Insurance History Fund #68922 to the Health and Life Benefit Administration Fund #28010, established in Neb. Rev. Stat. §84-1616.

During the 2025 – 2026 plan year, a payment was made for the Patient-Centered Outcomes Research Institute (PCORI) fee as prescribed by the Affordable Care Act (ACA). This institute is a government-sponsored organization charged with funding comparative effectiveness research that assists consumers, clinicians, purchasers, and policy makers to make informed decisions intended to improve healthcare at both the individual and population levels. This fee is paid every July. In July 2026, the State paid $79,297 for the PCORI fee for the plan year ending June 30, 2025.

Segal, in conjunction with DAS, prepared an Incurred But Not Paid (IBNP) Analysis Report, a Premium Rate Analysis Report, and a Claims Fluctuation Reserve (CFR) Analysis Report for the State. These reports were

reviewed at meetings conducted between the Wellness and Benefits Administrator, Personnel Director, Director of DAS, Budget Division, and the Governor to establish plan contribution funding, maintain effective plan designs, and help determine reserve levels.

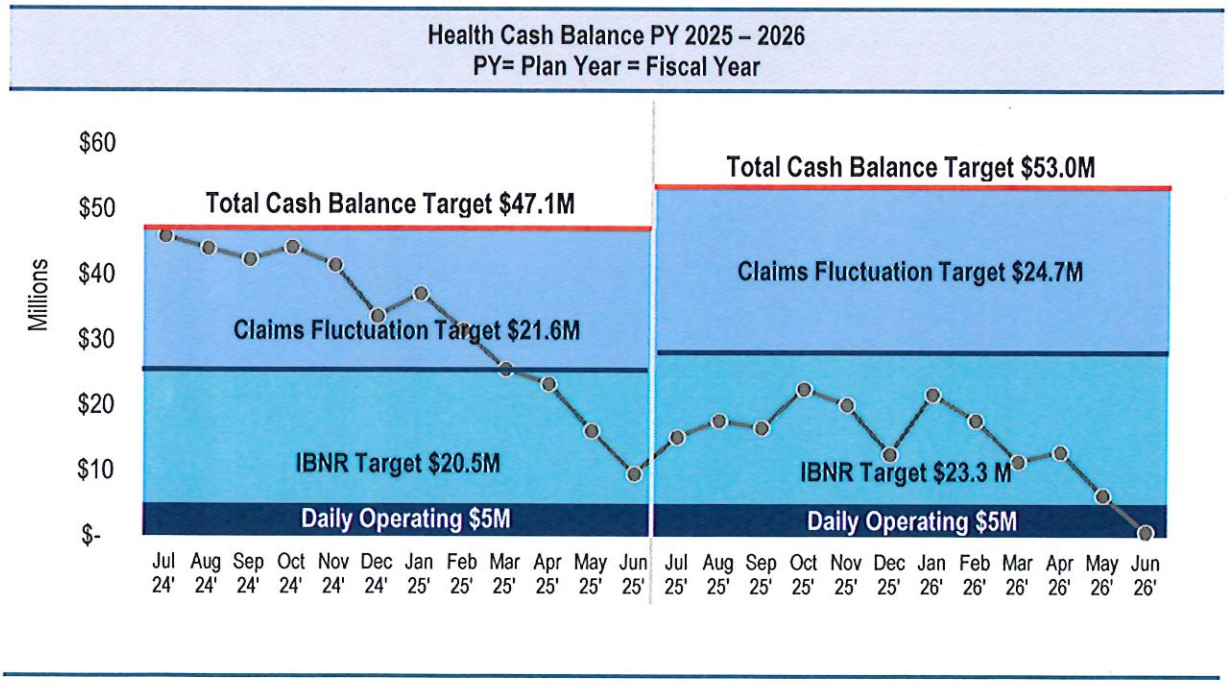
The Total Cash Balance Target includes three different pieces:

- Claims Fluctuation Reserve calculated by Segal based on a 90% confidence interval.
- Incurred But Not Paid Reserve set at 7% of actual claims.
- Daily Operating Target of $5 Million.

The Fund Balance grew well above the targeted level between plan years 2018-2019 and 2022-2023 due to favorable experience, slowed demand for elective services during the pandemic, and reimbursements received from the Coronavirus Relief Fund. To bring the Fund Balance closer to the Target, DAS implemented plan design improvements, premium holidays and special programs, and kept contribution rate increases well below market levels. These actions brought the Fund Balance to approximately the Target level of $47.1 million at the beginning of plan year 2024-2025. During the second half of that plan year, an influx of catastrophic claims and high pharmacy trends accelerated the decline. Without a corresponding increase in revenue, the Fund Balance fell to $9.5 million by June 30, 2025, well below the Target.

In plan year 2025-2026, higher funding rates and a State Agency surcharge of 18.5% raised contributions which helped stabilize the Fund. Total expenses still surpassed revenue, with medical and pharmacy trend near record high levels. The Fund Balance closed FY 2025-2026 at $0.7 million on June 30, 2026.

The Cash Balance Target and actual monthly cash balance for plan years 2024 - 2025 and 2025 – 2026 are shown in the table below:



A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2025, and June 30, 2026, respectively, are shown below.

State of Nebraska Health Insurance Fund
Summary of State Employees Insurance Fund #68960 Activity
Comparison of Plan Years Ending June 30, 2026 and 2025

	Plan Year			
	2025 – 2026	2024 – 2025	$ Change	% Change
Revenue				
Contributions	$291,621,535	$227,341,641	$64,279,894	28%
Pharmacy Rebates	$37,292,676	$30,600,727	$6,691,949	22%
Investment Income	$413,804	$589,765	$(175,961)	-30%
Misc Fund Close Out	$968,021	$1,617,514	$(649,493)	-40%
Total Revenue	**$330,296,036**	**$260,149,647**	**$70,146,389**	**27%**
Distributions				
Medical Claims & IBNP	$230,198,472	$206,483,740	$23,714,733	11%
Pharmacy Claims	$102,693,467	$86,564,473	$16,128,993	19%
Administration Fees	$5,836,531	$5,759,640	$76,891	1%
Flex/HSA $500 Cont	$0	$(4,420)	$4,420	-100%
Total Distributions	**$338,728,470**	**$298,803,433**	**$39,925,037**	**13%**
Fund Net Increase/(Decrease)	**$(8,432,434)**	**$(38,653,786)**		

State of Nebraska Health Insurance Funds
as of June 30, 2026 and 2025

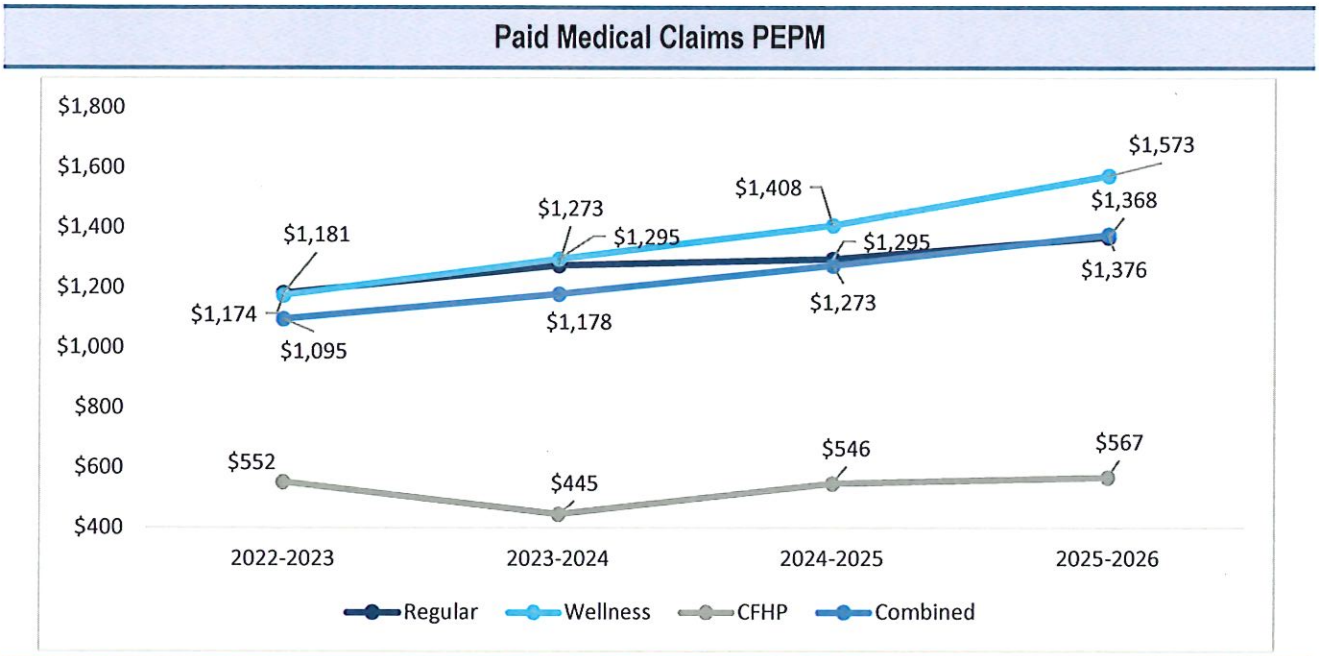
	6/30/2026	6/30/2025	$ Change	% Change
State Employees Insurance Fund #68960	$723,074	$6,545,682	$(5,822,789)	-89%
Health Insurance History Fund #68922	$3,143	$3,001,282	$(2,998,139)	-100%
Total Reserve Fund Balance	**$726,217**	**$9,547,145**	**$(8,820,928)**	**-92%**

Medical Claims Review

Medical claims were administered by UHC and include costs associated with hospital stays, outpatient services, emergency care, behavioral health care, physician office visits and preventive health care, among other services.

The State Employees Insurance Fund has paid $235 Million in reported medical claims in fiscal year 2025 – 2026. This amount includes $216 Million for claims that were incurred and paid during plan year 2025-2026, as well as $19 Million for claims that were incurred during plan year 2024-2025 but paid in the following year.

Total amount of medical claims grew by approximately 11.7% from the prior year driven by an increase in enrollment of 2.5% and a surging cost of care. The illustration below captures the net paid Per Employee Per Month (PEPM) for claims paid during the last four plan years:



For the purposes of this graph, DPC plans are combined with CFHP for applicable years.

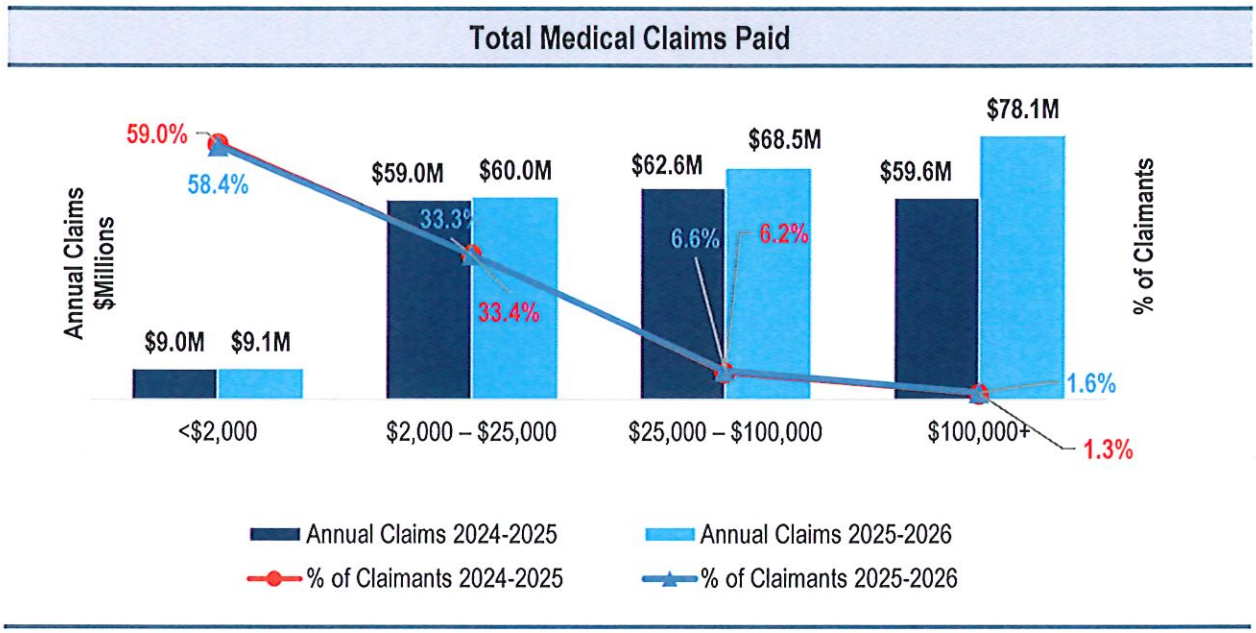
The Wellness Plan has the highest per capita cost due to its rich plan design. Keeping cost sharing provisions level while costs grow means that the State Fund covers a larger and larger percentage of overall expenses every year.

On the other hand, the Consumer Focused Health Plan has the lowest per capita cost due to higher member cost-sharing and lower risk profile of the plan population.

On a paid basis, the combined PEPM of $1,376 for medical claims paid for all three plans between July 1, 2025 and June 30, 2026 is 8.1% higher than the PEPM cost from the same time period for plan year 2024 - 2025. On the incurred basis, year-to-year PEPM increase amounted to 10.5%this is slightly higher than market trend of 10%.

Consistent with 2024 – 2025, treatment for musculoskeletal conditions, circulatory systems, and neoplasms (cancer) were the top cost drivers of medical claims. Combined, these three diagnoses drove 28% of total medical claims.

A small percentage of participants incurred a high proportion of total medical claims. As illustrated by the graph below, 1.6% of the plan's population had claims over $100,000 in plan year 2025-2026, and together they accounted for $78.1 million, or about 36% of the $215.6 million in claims incurred and paid during the year. In 2024-2025, 1.3% of the population exceeded $100,000, totaling $59.6 million. Medical cost inflation continues to shift claims to higher brackets. The bulk of the growth came from the volume in claims over $100,000.



Note that this analysis only includes claims that were incurred and paid during plan year 2025-2026 and amounted to approximately $215.6 million.

Pharmacy Claims Review

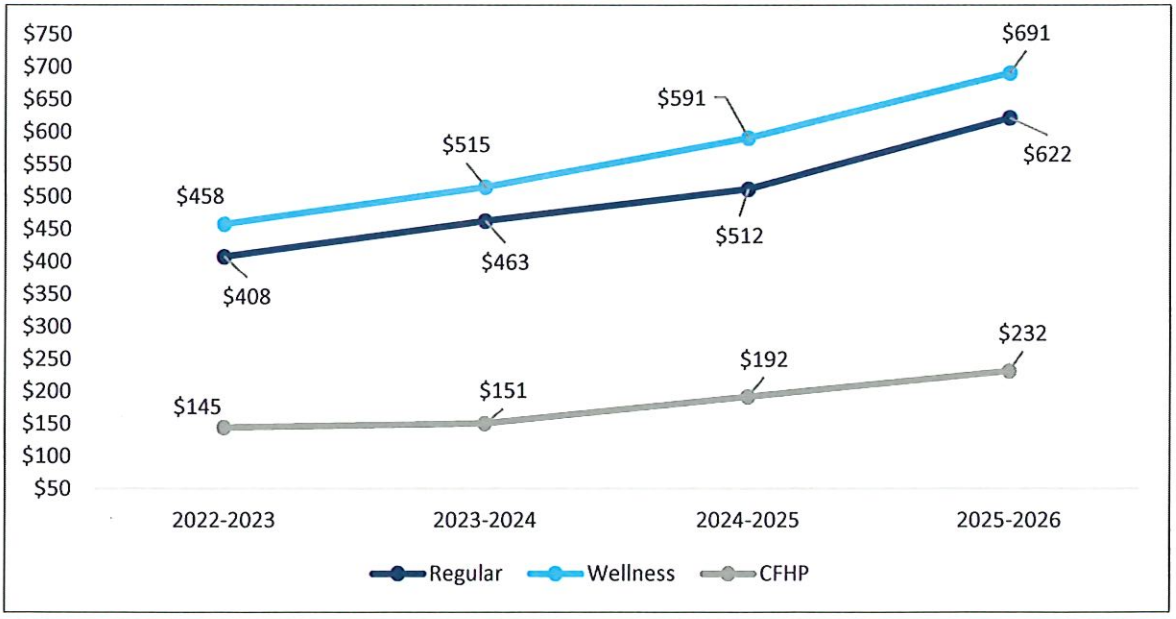
Pharmacy claims were administered by OptumRx, an affiliate of UHC, and the plan's Pharmacy Benefit Manager (PBM). The plan paid about $102.7 Million of prescription drug claims in 2025 – 2026, an 18.6% increase from the previous year. This increase is above the projected cost trend of 11.0%. Due to a slight increase in enrollment, the overall increase on the aggregate PEPM for Pharmacy is around 16.0% on a paid basis and 15.4% when calculated on an incurred basis, both of these are well above market trend of 10.5%.

What are specialty drugs?
Specialty drugs are high-cost prescription medications that are used to treat complex, chronic, or rare health conditions. They are often biologics, which are drugs derived from living cells, and can be injectable, infused, or oral.

The use of specialty drugs is a growing cost trend that continues to put pressure on the State's finances. During plan year 2025-2026 specialty drugs were responsible for 50.0% of overall pharmacy spend. Their overall cost amounted to $51.4 Million, that is $11.5 Million or 28.9% higher than the previous plan year.

The chart below illustrates the paid PEPM pharmacy claims by plan.

Paid Pharmacy Claims PEPM



For the purposes of this graph, DPC plans are combined with CFHP for applicable years.

Roughly 24,600 participants utilized pharmacy benefits in the health plan, filling about 382,700 prescriptions. The average cost per prescription of $268.34 for the State was a 14.7% increase from the $234.05 paid in the prior year. On average, each member filled 13.20 prescriptions annually. This is a 1.0% increase from last year's average of 13.08 prescriptions filled annually. The average prescription drug cost per member to the State was $295.28, a 15.8% increase from $255.09 last year. The rapid growth is driven by increased utilization of specialty and GLP-1 medications.

Tier 1 includes mostly generics plus some low-cost brand-name drugs, with copays limited to $5 for the Wellness and Regular plans. Higher cost brand-name drugs are placed in Tiers 2 and 3 with higher copays. Encouraging participants to choose generic prescriptions, primarily in Tier 1, reduces costs for both public servants and the plan.

	2025 – 2026	2024 – 2025	% Change
Annual Scripts per Member	13.20	13.08	1.0%
Generic Utilization	84.2%	84.3%	-0.2%
Average Cost per Member	$295.28	$255.09	15.8%
Specialty Cost per Member	$147.74	$117.47	25.8%
Non-Specialty Cost per Member	$147.54	$137.61	7.2%
Employee Cost Share	5.3%	5.8%	-8.4%

Catastrophic Cases

A catastrophic case is defined as a situation when claims incurred by a single member during the course of the year exceed a certain threshold. The State of Nebraska historically considered $75,000 a catastrophic threshold.

Due to their large size, catastrophic cases have significant impact on the claim experience.

The table below shows number and amount of claims that exceeded catastrophic threshold of $75,000 for plan years 2023-2024 through 2025-2026.

	2025 – 2026	2024 – 2025	2023 – 2024
Number of Claimants over $75K	854	761	655
Total Amount of Claims over $75K	$146,841,373	$116,858,128	$104,863,174
Average Claim Size	$171,945	$153,559	$160,096

Both quantity and size of catastrophic claims increased in plan year 2025 -2026, putting additional pressure on the State's finances.

Compared to the previous year number of claims increased by 12.2%, while the average claim size grew by another 12.0%. Total claim volume in catastrophic category increased by 25.7%.

Medical cost inflation is a big driver of catastrophic case count, as it pushes more claimants over the threshold by increasing the cost of each service they use. Therefore, it makes sense to increase the catastrophic threshold every few years to make sure only true catastrophic cases are included in the analysis.

If medical trends accumulated over the last ten years were accounted for, the catastrophic threshold of $75,000 in 2016 would be closer to $150,000 today. The following table represents the catastrophic case experience during the last three plan years under the $150,000 threshold:

	2025 – 2026	2024 – 2025	2023 – 2024
Number of Claimants over $150K	290	235	220
Total Amount of Claims over $150K	$89,043,716	$63,037,015	$60,804,369
Average Claim Size	$307,047	$268,243	$276,383

The number of catastrophic cases increased by 23.4% in plan year 2025-2026 (55 cases) with an even larger increase in total claim volume of 41.3%. The average claim size increased by 14.5% from the previous plan year. Plan year 2024-2025 saw only a small increase of 15 new cases, which is equivalent to 7%, with average claim size declining by 3%, and total amount paid only growing by 4%.

It is worth noting that the number of claims over $500K doubled in the last year. There were only 15 such cases in 2024-2025 with a total amount of $10.1 million. During plan year 2025-2026 number of claimants in this category reached 30 and overall claim volume grew to $26.1 million.

Special Programs

Maternity

On July 1, 2020, the State offered enhanced maternity benefits to the participants enrolled in the Wellness plan.

Initially all medically necessary outpatient maternity related services were covered at 100%. In-network inpatient medically necessary hospital charges that are maternity related, including inpatient well baby nursery, had a $500 copay and then were paid at 100% of eligible charges. The benefit was primarily aimed at reducing childbirth-related medical expenses for State public servants. The secondary goal was to encourage plan participants to seek timely care, which reduces the rate of pregnancy complications, leads to healthier babies, and lowers expenses for the State.

At the beginning of plan year 2023 – 2024 the decision was made to further improve the program by eliminating the $500 copay and making all maternity-related care free to Wellness plan participants.

During this plan year (the sixth year of the program), 374 babies were born to plan participants.

Tri-Care Stipend

A Tri-Care Stipend was offered by the State at the first-time during plan year 2023-2024 Open Enrollment Period.

The program allows public servants who are eligible for Tri-Care benefits through prior military service to elect to receive a stipend that would cover their Tri-Care premium in lieu of the State's health benefits.

Public servants had to satisfy three criteria to become eligible for Tri-Care stipend:

- Full-time current employee of the State of Nebraska.
- Retired military service member with 20 or more years of Active Service, Guard or Reserves
- Eligible for and enrolled in TRICARE.

Electing this option completely eliminates healthcare-related expenses for eligible public servants.

During plan year 2025 - 2026 (the third year of the program), 80 public servants elected to receive the Tri-Care stipend.

Real Appeal

Real Appeal is a weight loss wellness program provided by UHC that was added as of April 1, 2018. Since the beginning of the program the State saw 5,711 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions. Approximately 34.8% of participants have lost weight after 16 weeks on the program with average reported weight loss amounting to 2.1% of body weight per person.

According to the Real Appeal report with data through June 30, 2026, the program scored 4.76 out of 5 satisfaction rating in a national survey of 14,774 participants.

Looking Ahead

Despite difficult financial circumstances, the State continues to focus on providing public servants with a quality health insurance program with a focus on wellness and disease prevention.

To ensure the plan's long-term sustainability, DAS took several decisive steps at the start of plan year 2026-2027 to preserve its solvency.

The State conducted a Request for Proposal in order to compare and compete for better rates and results from the plan's Third-Party Administrator. Blue Cross Blue Shield of Nebraska replaced United Healthcare as plan administrator and pharmacy benefit manager on July 1, 2026.

The Wellness Plan was terminated at the end of plan year 2025 – 2026. Two narrow network options, Premier Select BlueChoice and Blueprint Health, were added to the remaining health plans. The narrow options are regional networks of highly efficient providers available in densely populated counties of the State. Electing a narrow network option allowed public servants to keep their premium increases lower and ensure that their health services are priced competitively. Those who desired to keep the traditional broad provider network had an option to do so albeit for a higher price.

In addition, a few plan changes were adopted for the Regular Plan: copays for PCP and specialist office visits were increased from $35 to $45 and $45 to $55, respectively. The urgent care copay increased to $75 from $45. A new specialty tier with a copay of $100 was established for specialty drugs. For CFHP, the deductible for the individual tier went up from $3,300 to $3,400 to comply with the minimum deductible requirement for HSA qualified plans. Family deductible was not impacted.

Maternity benefit was preserved and can still be used by members of the Regular Plan regardless of their network choice.
Segal provided the State with actuarial cost projections for plan year 2026-2027. Rates reflect underlying healthcare cost trends, demographic changes, changes to provider discounts, and prescription drug formulary. The addition of narrow network options is expected to lower costs for both the State and public servants who elect them. As a result, rate increases vary by plan and network selection. Employee Only rates for plan years 2025 – 2026 and 2026 – 2027 are shown in the table below. The percentage changes were consistent between all coverage tiers.

Plan:	Regular		Consumer Focused	
2025-2026 EE Only Premium	$935.78		$529.22	
	Broad Network	Narrow Network	Broad Network	Narrow Network
2026-2027 EE Only Premium	$1,076.16	$915.72	$635.06	$540.44
% Change	**15.0%**	**-2.1%**	**20.0%**	**2.1%**
Member Share/State Share	21%/79%	21%/79%	21%/79%	21%/79%

The State is continually reaching out to BCBSNE, Segal and others to identify, analyze and provide the best features and options for public servants and taxpayers. Cutting-edge practices, particularly in the area of specialty drug management and utilization will continue to be a primary focus for the State. New initiatives to reverse the increasing trend of diabetic health for plan members also will be a priority.
In addition to a competitive health and wellness program, DAS also works to ensure that public servants and their families are able to participate in other group benefits including dental, vision, employee assistance

program, flexible spending accounts, life, short-term, and long-term disability. A quality benefit package is offered that is designed to attract and retain a best-in-class State of Nebraska workforce.