

2 0 1 3 - 2 0 1 4

July 1, 2013 - June 30, 2014



NEBRASKA
Administrative Services

options

benefits as individual as you

Enrollment Guide

LINK



LINK features a user-friendly design and provides you a quick & easy way to:

- View your pay stub, W-4 or W-2
- Review your leave balances
- Sign up for your Benefits
- Link to applications and systems
- Quick news and updates

Payroll & Financial Center



- Payroll access
- Address book
- A/P, A/R, & GL
- Budget
- Purchasing & Fixed assets

Employee Work Center



- Update your contact information
- View personnel data
- Edit and update positions
- Create staffing reports

Career Center



- Review State job postings
- Apply for a position
- Find resources for job seekers

Recruitment & Selection Center



- Post State jobs
- Review applications
- Create selection criteria and screening tools
- Schedule interviews

Employee Development Center



- Sign up for training
- Assign training
- Complete performance evaluations
- Create succession planning (coming soon)

visit
link.ne.gov

Reminders for the 2013-2014 Plan Year

- The federal government has mandated that Social Security numbers must be listed for all enrollees and their covered dependents enrolling in a group health plan
- All employees must re-enroll in health, dental, vision, flexible spending account plans and long-term disability to have coverage for the new plan year beginning July 1, 2013; current elections in these plans will end on June 30, 2013
- If you are currently enrolled in the long-term disability benefit, you will be required to choose a new coverage level during Open Enrollment. If you do not make an election, coverage will be waived

Open Enrollment

BEGINS:

Tuesday, May 14, 2013
at 7:00 a.m. C.D.T.

ENDS:

Tuesday, May 28, 2013
at 5:00 p.m. C.D.T.

System requirements to access the Employee Work Center:

- ✓ Adobe Flash Player of at least 10.1.53
- ✓ Internet Explorer version 7.0 or later
- ✓ Firefox 3.5

UnitedHealthcare will partner with Aon to continue the Dependent Eligibility Verification Process for the State. The ongoing Dependent Eligibility Verification Process will require all employees who are new hires or rehires as well as those current employees who incur a qualifying life status change to submit documentation to Aon in order to verify that all newly added dependents are eligible for coverage. The Dependent Eligibility Verification Process is necessary to ensure only eligible dependents are enrolled in our State plans.

When employees complete their enrollment, they will be asked to certify that the dependents and information given is true and complete to the best of their knowledge. In the event they have knowingly selected an ineligible dependent, they understand that it may result in disciplinary action up to and including termination of employment.

IMPORTANT

State Employee Wellness and Benefits continues to utilize more technology in delivering information to employees. Therefore, as in previous years, the Open Enrollment Options Guide is not being printed and distributed to State employees. The Options Guide will be available at link.ne.gov under Wellness and Benefits Resources.

IMPORTANT CHANGES FOR 2013-2014 PLAN YEAR

ALL HEALTH PLANS:

- ✓ New ID cards will be issued to all current and new members enrolled for both medical services and pharmacy services
- ✓ Speciality Physician office visit copay will differ from regular office visit copay (See page 11 for definitions)
- ✓ **Everyone must re-enroll to have coverage for July 1, 2013**

WELLNESS PLAN:

- ✓ **NEW!** Specialty Physician office visit copay will be \$35 (this includes chiropractic office visits)
- ✓ Primary Care Physician office visit copay is changing from \$20 to \$25
- ✓ Urgent Care Facility copay is changing from \$25 to \$35
- ✓ Outpatient Rehabilitation Services, including Speech Therapy, Physical Therapy, and Occupational Therapy copay is changing from \$20 to \$25
- ✓ Routine Vision Care copay is changing from \$20 to \$35

CHOICE PLAN:

- ✓ **NEW!** Specialty Physician office visit copay will be \$40
- ✓ Tier II 30-day prescription copay is changing from \$25 to \$30
- ✓ Tier III 30-day prescription copay is changing from \$40 to \$50
- ✓ Tier II Home Delivery 180-day supply prescription copay is changing from \$100 to \$120
- ✓ Tier III Home Delivery 180-day supply prescription copay is changing from \$150 to \$175
- ✓ In-Network Plan year deductible is changing to \$1,000/individual and \$2,000/family
- ✓ Out-of-Network Plan year deductible is changing to \$1,500/individual and \$3,000/family
- ✓ In-Network Out-of-Pocket maximum is changing to \$4,500/individual and \$9,000/family
- ✓ Out-of-Network Out-of-Pocket maximum changing to \$7,000/individual and \$14,000/family
- ✓ Chemotherapy/Radiation Therapy is changing from copay to 20% after deductible is met

REGULAR PLAN:

- ✓ **NEW!** Specialty Physician office visit copay will be \$40
- ✓ Primary Care Physician office visit copay is changing from \$20 to \$30
- ✓ In-Network Plan year deductible is changing to \$800/individual and \$1,600/family
- ✓ Out-of-Network Plan year deductible is changing to \$1,200/individual and \$2,400/family
- ✓ In-Network Out-of-Pocket maximum is changing to \$2,000/individual and \$4,000/family
- ✓ Out-of-Network Out-of-Pocket maximum is changing to \$3,750/individual and \$7,500/family

HIGH DEDUCTIBLE PLAN:

- ✓ **NEW!** Specialty Physician office visit copay will be \$40
- ✓ Primary Care Physician office visit copay is changing from \$25 to \$30
- ✓ Tier II 30-day prescription copay is changing from \$25 to \$30
- ✓ Tier III 30-day prescription copay is changing from \$40 to \$50
- ✓ Tier II Home Delivery 180-day supply prescription copay is changing from \$100 to \$120
- ✓ Tier III Home Delivery 180-day supply prescription copay is changing from \$150 to \$175
- ✓ In-Network Plan year deductible is changing to \$1,250/individual and \$2,500/family
- ✓ Out-of-Network Plan year deductible is changing to \$2,500/individual and \$5,000/family
- ✓ In-Network Out-of-Pocket maximum is changing to \$2,500/individual and \$5,000/family
- ✓ Out-of-Network Out-of-Pocket maximum is changing to \$5,000/individual and \$10,000/family

HEALTHFITNESS-WELLNESS PROGRAM:

- ✓ **NEW PROGRAM! Personalized Lifestyle Management Programs (5)** – Choose from one of five self-directed digital health coaching programs that provide you a personal plan, on-going guidance and plenty of resources – similar to having your very own virtual coach! Utilize today's technology (Iphones or Ipod Touch) to set smart goals and track daily activities, calories, fat grams and more!
- ✓ **EMPOWERED Coaching** – With enrollment in EMPOWERED Coaching, you can access your personal information from your mobile phone's browser (Microsoft Internet Explorer, Apple Safari, Google Android) 24/7!
- ✓ **Cardio Log** – Now 50 workouts to qualify for the Wellness Health Plan.
- ✓ **Walk This Way** – Now 800,000 steps to qualify for the Wellness Health Plan. New and improved pedometer that measures steps, aerobic steps, distance, calories, and fat grams burned. It's easy to use – put it in your pocket, bag or clip onto your hip.



AETNA LIFE INSURANCE:

- ✓ New provider for Basic Life, Supplemental Life, Dependent Life, and AD&D

LONG-TERM DISABILITY:

- ✓ New provider for long-term disability
- ✓ Current 8 plans are being replaced by 4 plans
 - 2 month Elimination Period–60% of income
 - 3 month Elimination Period–60% of income
 - 6 month Elimination Period–60% of income
 - 9 month Elimination Period–60% of income
- ✓ **All current participants must re-enroll to have coverage July 1, 2013**

Important Note for Temporary Employees

There will not be a separate publication for Temporary employees.

There are other plan design changes aside from those listed above. Please refer to the summary plan descriptions located on the Administrative Services Employee Benefits Website for complete plan design information.

WELCOME

Welcome to Open Enrollment 2013-2014. I want to take this opportunity to thank you for everything you did to make the past year a success. Transitioning to a new Open Enrollment application and a new health care administrator in the same year can be difficult, but your willingness to embrace change has made for a positive outcome.



The Employee Work Center has made signing up for benefits as a new hire or during Open Enrollment quick and easy. At the same time UnitedHealthcare has brought new and innovative tools to the health care process that allow both employees and the State to better manage the health care experience.

Wellness continues to be a major focus and our wellness program continues to receive national recognition, thanks to the thousands of you who participate in it. Earlier this year the State of Nebraska became the first state to earn the coveted C. Everett Koop National Health Award, which has very stringent requirements for demonstrating health improvements and cost savings.

Speaking of cost savings... a study conducted last year shows that for every dollar the State invests in wellness, it saves the State \$2.70 in healthcare costs. Healthier employees result in fewer medical claims.

It is important to note that wellness is not only about saving money but also about living healthier, longer, more productive lives. Investing in yourself by making small lifestyle changes when you are in your 20's, 30's, 40's or 50's, may mean living into your 60's, 70's, 80's or 90's! Invest in yourself early and often!

There are many 'steps' you can take to invest in a healthier you! In fact, walking 800,000 steps or running for thirty minutes, fifty times over the next plan year qualifies as one step toward making you eligible for the Wellness Plan. However, not every step to a more well you involves exercise or sweating. Simply substituting a bottle of water for a bottle of soda, eating a granola bar instead of a candy bar or ordering a salad instead of a double cheeseburger at your favorite restaurant also makes a difference.

Wellness is not only a health plan designed by the State, it is a lifestyle. In addition to perhaps completing the steps that qualify you for the Wellness Plan, consider investing in yourself by taking additional steps that will lead to a more well you!

As you review Open Enrollment materials, you will notice that we have made some changes to various health plans. It is important to remember that your benefits and coverage are determined by the State and not by any vendor. Please evaluate the plans carefully and take this opportunity to select the coverage that best fits your personal needs.

Open Enrollment begins on May 14, 2013 at 8:00a.m. CDT and ends May 28, 2013 at 5:00p.m. CDT. The decisions you make will take effect on July 1, 2013 and will remain in effect until June 30, 2014. Our Wellness and Benefits staff is available to assist you as needed for questions on the benefit options presented in this guide. They can be reached at 402.471.4443.

May the 2013-2014 Plan Year be the year that you invest in yourself by taking many "steps" to a more well you.

Sincerely,

A handwritten signature in black ink, appearing to read 'Carlos Castillo, Jr.'.

Carlos Castillo, Jr.

Table of Contents

Reminders for the 2013-2014 Plan Year	3
Important Changes for 2013-2014 Plan Year.	4
Welcome Letter	5
Introduction	7
Temporary Employees	7
Your Health Coverage	9
Your Online Resources	12
Your Pharmacy Benefit.	13
Your Prescription Drug Benefit.	17
Your Cost for Coverage	19
Health Care Premiums	20
wellnessoptions Program: Available to Those Enrolled in Any of the Four State Health Plans.	23
Medical Plan Comparison Chart	26-27
Additional Health Resources	37
Dental Benefits.	38
Vision Care Benefits	40
Flexible Spending Accounts.	41
Long-Term Disability Benefits.	44
AD&D Insurance.	45
Life Insurance Benefits.	46
Counseling Services — Your EAP	48
Continuing Your Coverage — COBRA	49
Retirees	49
Time to Enroll	51
Contact Information	Back Cover

Important Information: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official certificates of coverage. This is not a contract. If there are any inconsistencies between this summary and the official certificates of coverage, the certificates of coverage will prevail. Please refer to the certificate of coverage for exact benefits, exclusions and limitations.

INTRODUCTION

It's time once again to consider your **Options**, our competitive benefits program. Get started by carefully reading this Enrollment Guide and sharing it with your family. You'll find information about all of your benefit options, how to enroll and where to go if you have any questions.

You must re-enroll in all health, dental, vision, flexible spending account and long-term disability plans to have coverage effective July 1, 2013 through June 30, 2014. All current elections in these plans will end on June 30, 2013.

Changes will be done online through the Employee Work Center at link.ne.gov under Wellness and Benefits Resources.

Because of governmental regulations, your Social Security number and the Social Security numbers of your covered dependents who are enrolling in a group health plan must be correct and on file — be sure to check this and make any necessary changes through your agency Human Resource office.

How long do I have to make life status changes?

Any change in coverage must be made within 30 days of the change in status or you will not be able to change your coverage until the next Open Enrollment period or another qualifying status change. Documentation of the status change must be provided before the change will be approved.

If you or a covered dependent experience a qualified status change that allows you to terminate your insurance coverage, you have 30 days to complete the necessary change request and provide the proper documentation. Coverage will terminate the first of the month following the request; no refunds or retroactive terminations will be allowed.



Temporary Employees

Temporary employees are eligible to participate in the State's group health, dental and long-term disability plans if they work at least 20 hours per week and are placed in a position with a six-month assignment or longer.

Temporary employees who decline benefits and later accept a permanent position with the State will not be eligible to participate in the health, dental or long-term disability plans until the next Open Enrollment period.

Temporary employees are not eligible to participate in the State sponsored group life, vision and medical flexible spending accounts; these options are available to employees transferring from a temporary to a permanent position. Employees must enroll in these options within their first 30 days of employment; the effective date will be the first of the month following the initial 30 days of employment in the permanent position.

Temporary employees are eligible to participate in the following:

- Medical
- Dental
- Long-Term Disability (same 4 plans as Permanent employees)
- Dependent Day Care Flexible Spending Account

Term to Know

SPECIALTY VISIT COPAY:

The copay on your medical program that applies to visits with physicians who have a majority of their practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family or general medicine.

Additional definitions and information on providers can be found on page 11 of the Options Guide.



Making Changes During the Year

It's important that you carefully select your options during Open Enrollment. The choices you make during Open Enrollment remain in effect until June 30, 2014. You can make limited changes at other times during the year only as a result of a qualifying event as defined by the IRS. These qualifying events include:

- A marriage, divorce or legal separation
- If adding a spouse due to marriage, the effective date is ALWAYS the first of the month following the marriage
- The birth or adoption of a child
- The death of a spouse or dependent child
- Gain or loss of coverage for dependent child under age 26
- A change in employment status for you or your spouse if it affects your benefit eligibility

- Going from part-time to full-time or vice versa is not a qualified event unless it affects your benefit eligibility
- A change corresponding with a spouse's open enrollment period at his or her place of employment
- Being newly eligible for Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP program
- Becoming eligible for State premium assistance under Medicaid or CHIP

If you are requesting to change any of the State's insurance plans, you will only be able to change those benefits that correspond with the qualified status change.

When requesting to add/enroll in coverage due to a loss of other coverage, the effective date is the first day of the month following the loss of coverage.

Term to Know

ELIGIBLE DEPENDENT — Eligible dependents include your:

- Legal spouse
- Children up to age 26
- Children over age 26 who are mentally or physically disabled and dependent upon you for support
- Step children, if the employee is enrolled in Family Coverage
- Grandchild(ren) (for State health insurance benefits purposes only) if, and only if, the employee has legal custody, legal guardianship or court ordered custody of the grandchild(ren)
- Legal Ward (must be your Legal Ward and have court appointed guardianship)



Your Health Coverage

You have four great plans to choose from. All four health plan options are provided through UnitedHealthcare and offer both in-network and out-of-network coverage.

Visit link.ne.gov and connect to Wellness and Benefits Resources to learn more about your 2013/2014 benefits administered by UnitedHealthcare.

- Wellness Plan
- Choice Plan
- Regular Plan
- High Deductible Plan

Take a look at the chart below to see each plan's features.

What you might consider when choosing a health plan:	Wellness Plan	Choice Plan	Regular Plan	High Deductible Plan
Will I have access to the state and national network?	Yes	Yes	Yes	Yes
Do I need a referral for a specialist?	No	No	No	No
Can I access online services, tools and programs?	Yes	Yes	Yes	Yes



Questions?

Visit link.ne.gov and connect to Wellness and Benefits Resources or call UnitedHealthcare Customer Care at 1-877-263-0911.

Navigating Your Health Insurance

■ Who should I call to answer questions about my health insurance?

UnitedHealthcare (UHC) is the primary contact for all of your health insurance benefits questions, and is an important partner with the State of Nebraska in ensuring employees have affordable, meaningful health benefits. The goal is to help you and your family, *live longer, healthier lives*. For questions about your health insurance call UHC at 1-877-263-0911.

■ How does the State provide health insurance for employees and dependents?

The State of Nebraska provides health insurance for its employees through a *self-funded* health insurance program. This means the State, not an insurance company, makes decisions such as what types of coverage will be offered (within state and federal requirements) and who will be eligible for coverage. In addition to deciding on the plan structure, the State (not an insurance company) pays health care claims for employees and dependents after copays and deductibles.

Processing complex health claims for this type of program, protecting private health information and ensuring quality customer service demands extensive administrative support. For this reason, *self-funded plans* typically contract with administrators for access to discount networks, day-to-day claims processing, dedicated customer service and other support services.

■ Who currently administers the State's health insurance plan?

UnitedHealthcare has been the State's plan administrator since July 1, 2012. As part of UnitedHealth Group, a diversified health and well-being company whose mission is to help people live healthier lives and make health care work better, more than 250,000 Nebraskans receive health care services through UnitedHealthcare. The UnitedHealthcare provider network is extensive and is part of the single largest proprietary network available nationwide. Fortune magazine named UnitedHealth Group the World's Most Admired Company in the Insurance and Managed Care sector in its 2012 rankings, including ranking the company Number 1 in Innovation.

UHC Disclaimers

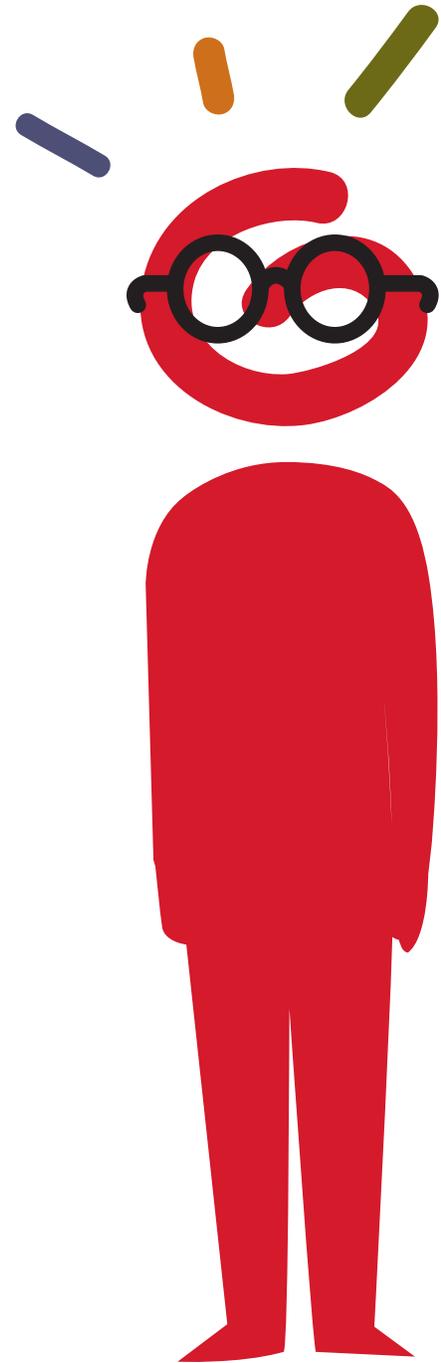
Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc., or their affiliates. Health Plan coverage provided by or through UnitedHealthcare of Nebraska, Inc.

The NurseLineSM service cannot diagnose problems or recommend specific treatment. The information provided through the NurseLine service is not a substitute for your doctor's care.

Source4Women content and materials are for information purposes only, are not intended to be used for diagnosing problems and/or recommending treatment options, and are not a substitute for your doctor's care. Lists of potential treatment options and/or symptoms may not be all-inclusive.

Healthy Mind, Healthy Body contains general health information and is not a substitute for professional health care. You should consult an appropriate health care professional for your specific needs. Some treatments mentioned in this newsletter may not be covered by your health plan. Please refer to your benefit plan documents for information about coverage.

Blackberry is a registered trademark of Research In Motion Limited. Android is a trademark of Google, Inc. iPhone is a registered trademark of Apple, Inc.



Find a Doctor or Hospital

UnitedHealthcare has more than 3,000 physicians and health care professionals, as well as over 85 hospitals in Nebraska and growing. They also have one of the largest networks in the country with more than 676,000 physicians and health care professionals and 5,190 hospitals.



Their network continues to grow as they add new physicians to their network every day. UnitedHealthcare is continuously inviting additional providers to join their network.

To get started on finding the right doctor for you

- Visit link.ne.gov
- Connect to Wellness and Benefits Resources
- Click on "Find a Doctor/Hospital"
- Choose "Find a physician/facility near you"

What can you do if your doctor is not in the UnitedHealthcare network?

If your physician is not in the UnitedHealthcare network, we encourage you to invite your doctor to consider joining the UnitedHealthcare network. For more details, visit link.ne.gov and connect to Wellness and Benefits Resources.

If your doctor is not in the UnitedHealthcare network and decides not to join the network, you may want to switch to a network provider; otherwise, services you receive from your non-network doctor will be paid at the non-network level, and your costs for the services will be higher than if you received services from a network provider.

Get trusted information when you need it

The **myNurseLine**SM program connects you to registered nurses anytime — at no extra cost to you. Just call 1-877-543-4295. The nurses and master's-level specialists can provide information on:

- Symptoms and treatment options
- Doctors and hospitals
- Health condition management and more

Difference between a Primary and a Specialty Physician

PRIMARY PHYSICIAN: A Network Physician selected by a Covered Person to be responsible for providing or coordinating all Covered Health Services which are covered under the Plan as Network benefits. A Primary Physician has entered into an agreement to provide primary care Health Services to Covered Persons. His or her practice predominately includes (but may not be limited to) pediatrics, internal medicine, obstetrics/gynecology, family or general practice.

SPECIALTY PHYSICIAN: A Physician who has a majority of his or her practice in areas other than general pediatrics internal medicine, obstetrics/gynecology, family practice or general medicine.



Why use a network provider?

All of our health plan offerings provide benefits for both in-network and out-of-network providers. Although you can choose to visit the provider of your choice at any time, you'll generally receive a higher level of benefit when you choose providers who are part of the plan network. Network providers have agreed to provide their services at negotiated, discounted rates, which saves you and the State money. Provider directories are located at link.ne.gov and connect to Wellness and Benefits Resources.

Important

To ensure you receive the great preventive Wellness coverage, make sure your doctor's office codes them correctly as 'routine.'

Your Online Resources

Personalized Online Support

You have continuous access to your health and benefits information at link.ne.gov and connect to Wellness and Benefits Resources.

From one site, you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more. It's loaded with details on your benefit plan and much more. Once you log in at link.ne.gov and connect to Wellness and Benefits Resources you can:

- View and compare benefit plan options
- Search for physicians and facilities
- Find a network doctor in your area - Search by facility or physician
- Find answers to frequently asked questions
- Learn about your pharmacy benefit
- Learn about your plan details
- Track claims
- Organize health information
- Track doctor visits, immunizations, diagnoses, prescriptions and refill schedules with the Personal Health Record
- Find a pharmacy in your area

UHC.TVSM

UHC.TV is a new online television network. It presents educational and entertaining programs about good health and living well. Get inspired to take healthy steps.

Health Care Lane[®] - Get the word on the street

Meet a lot of friendly people who will help you make sense of health coverage and get the most from your plan. And don't forget to check out Wellness Days, a fun-filled festival of good health and wellness. You will be entertained and educated on the benefits of having a plan administered by UnitedHealthcare.

Source4Women

This online community helps you manage your own health and the health of your family.

Healthy Mind Healthy Body[®] e-newsletter

Select topics that are of interest to you, and UnitedHealthcare will send the newsletter monthly to your personal email account.

Storytellers

Health care success stories by the people who lived them. Many UnitedHealthcare members have shared their success stories. Hear how UnitedHealthcare helped these members, in their own words.

Mobile Tools

You might be surprised at how much can be done with just a few simple keystrokes. UnitedHealthcare strives to make it easy to get help, wherever you are.

DocGPS[®]

Find a doctor or hospital wherever you are with DocGPS:

- Search for network doctors, clinics and hospitals
- Get directions and more
- Compatible with select BlackBerry[®], Android[™] and iPhone[®] devices

UnitedHealthcare Health4MeSM

Once you are a member, the Health4Me app provides you with instant access to critical health information from your mobile device. The confidential app features include:

- Single-registration — you can register at link.ne.gov and connect to Wellness and Benefits Resources to enable both the mobile and online app functionality
- Search for physicians or facilities
- View claims, account balances, benefit plan details and your health plan ID card
- Have an Easy Connect representative contact you to answer any questions and connect you with an experienced registered nurse 24/7

YOUR PHARMACY BENEFIT

Your State of Nebraska pharmacy benefit offers flexibility and choice in finding the right medication for you. UnitedHealthcare is your medical insurance provider and your pharmacy benefit manager is OptumRx™. OptumRx™ is an affiliate of UnitedHealth Group. Our State of Nebraska pharmacy benefit administered by UnitedHealthcare offers flexibility and choice in finding the right medication for you.

What is a covered drug?

A covered drug is a prescription medication or product covered under your benefit. Your Top 500 Medications Prescription Drug List (PDL) is a good resource to review medication coverage. Since the PDL may change periodically, we encourage you to log on to your member website at link.ne.gov and connect to Wellness and Benefits Resources then:

- Click on “Active Employees” then
- Click on “Health Plans and Prescriptions” then
- Click on “Pharmacy Plan” for new current information.

What is a Prescription Drug List (PDL)?

The PDL includes brand and generic prescription medications approved by the U.S. Food and Drug Administration (FDA). Medications are placed on different “tiers” based on their overall value. Tier 1 is the lowest-cost tier option. When selecting a medication, you and your doctor should consult the PDL.

- Tier 1 – Your lowest-cost option
- Tier 2 – Your midrange-cost option
- Tier 3 – Your highest-cost option



Choose a network pharmacy

To get the most from your pharmacy benefit, you should fill your prescriptions at either OptumRx™ Mail Service Pharmacy or one of the 64,000 retail pharmacies in the UnitedHealthcare network. Filling prescriptions at pharmacies outside the network will increase your cost and may not always be covered.



To search for a network pharmacy, visit link.ne.gov and connect to Wellness and Benefits Resources, then:

- Click on “Active Employees” then
- Click on “Health Plans and Prescriptions” then
- Click on “Pharmacy Plan” then
- Click on “Find a Pharmacy in Your Area.”

What do you do if your pharmacy is not in the network?

Your pharmacy plan offers an extensive nationwide retail pharmacy network; however, if your pharmacy is not in the retail pharmacy network, you can advise your non-network pharmacy to call 1-800-797-9798 for information regarding joining our pharmacy network.

Can you use the same local pharmacy?

Your pharmacy plan offers access to 64,000 retail network pharmacies nationwide. Present your new UnitedHealthcare health plan ID card to the pharmacy before filling or refilling a prescription.

For medications you take on a regular basis, you can fill a 180-day supply through the OptumRx™ Mail Service Pharmacy. Mail order offers the convenience of home delivery and standard shipping at no additional cost to you. Plus, you'll have lower copayments and refills to manage.

What medication limitations should you be aware of?

There are different types of medication limitations. These limitations help ensure medication safety and accuracy, as well as control overall health care costs. To look up a specific limitation of a medication, please visit link.ne.gov and connect to Wellness and Benefits Resources once you are a UnitedHealthcare member.

- **Quantity limits:** Some medications have restrictions on the amount of medication you can receive per copayment or in a period of time.
- **Notification (Prior Authorization):** Some medications require your pharmacy to confirm coverage before your prescription can be filled. For these medications, your doctor will need to provide additional information (for instance, what condition the drug is being used to treat) to determine if it is eligible for coverage. If your doctor believes you should take a medication requiring notification, he or she can request this through our Authorization Department.
- **Step therapy:** Some medications require you to try a different drug first before your requested drug is covered.

Why Are Some Medications NOT Covered/Excluded?

Certain medications may be excluded from coverage when lower-cost therapeutic or over-the-counter alternatives are available. Typically the alternative medications available have the same active ingredient as the excluded medications.

OptumRx™ Specialty and Mail Order Pharmacy

Using a specialty or mail order pharmacy is beneficial because they have experience in storing, handling, and distributing these unique medications. Specialty pharmacies also typically provide a higher level of customized care for specialty medications than traditional retail pharmacies. Specialty pharmacists and nurses have additional clinical expertise surrounding these medications and complex diseases.

UnitedHealthcare's network specialty pharmacy, OptumRx™, is your connection to quality, convenient specialty pharmaceuticals. OptumRx™ provides exceptional services for you including:

- Efficient prescription dispensing and timely delivery
- Pharmacists and licensed health care professionals available 24 hours a day to answer your questions about medications or your specific health condition
- Patient education and support services with care plan development and monitoring, if needed
- Shipping to any location in the United States for no additional charge
- Prescription shipments mailed in confidential, temperature-sensitive packaging
- Refill reminders and overall adherence monitoring
- Coaching on our Prescription Drug List including available lower cost alternatives
- Specialty medications are limited to a **one month** supply. This helps reduce waste when adjustments or changes are made to your medications. Also, when calling customer service, be sure to indicate you are calling about a specialty medication.

For questions about using OptumRx™ Specialty Pharmacy, please call the customer care number on the back of your UnitedHealthcare health plan ID card.

Specialty Pharmacy Program

When you're living with a rare or a complex condition, appropriate use of specialty medications can be critical to maintaining or improving your health – and your quality of life. The Specialty Pharmacy Program provides the resources and personalized condition-specific support you need to help you better manage your condition.

What is a specialty medication?

An injectable, oral or inhaled medication is most often considered specialty medication if it:

- Is used to treat a chronic or complex condition
- Requires extra, on-going clinical oversight and additional education for best management
- Has unique storage or shipping requirements
- Typically is not available at retail pharmacies
- Examples of specialty medications: *Humira* (can be used to treat Rheumatoid Arthritis), *Avonex* (used to treat Multiple Sclerosis), *Gleevec* (an oncology medication)

How does the program work?

STEP 1. Find a network specialty pharmacy

- Call the number on the back of your ID card and a representative will transfer you to a network specialty pharmacy for your specific medication. As a first time specialty user, you will also receive a letter about the program and instructions on how to transfer your medication. It is as easy as dialing one number!

STEP 2. Move your prescription to a network specialty pharmacy for your medication.

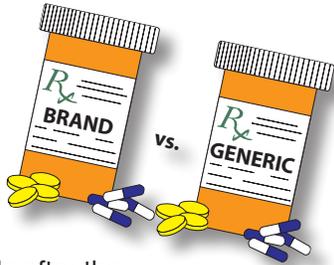
- The network specialty pharmacy will help you transfer your active prescriptions from your current pharmacy. If you're out of refills, they will contact your doctor to get a new prescription. The specialty pharmacy representative is also available for any questions you have regarding dosing, side effects, administration of the medications, etc.

STEP 3. Understanding where your specialty medication is coming from.

- Your specialty medication is limited to a one month supply, and will be sent to you from the specialty provider and not from the OptumRx™ mail service facility.

What is the difference between brand name and generic medications?

Generic medications contain the same active ingredients as brand name medications, but they often cost less. Generic medications become available after the patent on the brand name medication expires. At that time, other companies are permitted to manufacture an FDA-approved, chemically equivalent medication. Many companies that make brand name medications also produce and market generic medications.



The next time your doctor gives you a prescription for a brand name medication, ask if a generic equivalent is available and if it might be appropriate for you since generic medications are typically your lowest-cost option.

How can you get the most from your pharmacy benefit?

You can talk to your doctor about the following to help you get the most from your pharmacy benefit:

- **Mail order** – it eliminates monthly trips to the pharmacy and may save you money
- **Generic medications** – generic medications are approved by the Food and Drug Administration (FDA) as having the same high quality and strength as brand-name medications, but are normally less costly

Work with your doctor to see if generics or lower-tiered medications will work for you. Never change medications unless your doctor prescribes the medication.

Filling prescriptions through mail order

OptumRx™ Mail Service Pharmacy makes it easy to save money and time by delivering the maintenance medications you take every day directly to your door. You will receive a 180-day supply of your maintenance medications, many times for lower copayments than at other network pharmacies. There is no charge to you for shipping.

Mail order eliminates frequent trips to the pharmacy for your maintenance medication refills. In addition, there are licensed pharmacists that check your order to see if it is entered and filled correctly. They're available to speak to you directly should you have a question or concern about any prescribed medication.

Will you be required to use mail order for a 180-day supply of medication?

Yes, you will be. However, a 30-day supply of maintenance medication may be filled at a retail pharmacy, but the copay will be higher.

To start using mail order:

1. Call 1-800-562-6223, 24 hours a day, seven days a week and OptumRx™ will work directly with your doctor to set up your mail order. Just have your prescription label available when you call.
2. Or download an order form from by going to link.ne.gov and connect to Wellness and Benefits Resources then:
 - Click on "Active Employees" then
 - Click on "Health Plans and Prescriptions" then
 - Click on "Pharmacy Plan" then
 - Click on "Mail Order Pharmacy Steps and Form."

Your Prescription Drug Benefits

Wellness Plan	Tier I (Generic)	Tier II (Preferred Medications) (Formulary)	Tier III (Non-Preferred Medications) (Non-Formulary)
Retail 30-day supply	\$5 copay	\$25 copay	\$40 copay
Home Delivery 180-day supply	\$20 copay	\$100 copay	\$150 copay
Diabetic, hypertension and high cholesterol prescriptions			
Retail 30-day supply	No copay	\$15 copay	\$30 copay
Home Delivery 180-day supply	No copay	\$75 copay	\$120 copay

! Wellness plan participants are eligible, with prior enrollment in the Empowered Lifestyle coaching program and choosing Smoking Cessation as a focus area, to receive one (1) course of tobacco cessation prescription drugs for up to 12 weeks, within a rolling 12 month period, at no cost. There is a lifetime limit of three (3) courses of treatment.



Choice Plan High Deductible Plan	Tier I (Generic)	Tier II (Preferred Medications) (Formulary)	Tier III (Non-Preferred Medications) (Non-Formulary)
Retail 30-day supply	\$10 copay	\$30 copay	\$50 copay
Home Delivery 180-day supply	\$35 copay	\$120 copay	\$175 copay

Regular Plan	Tier I (Generic)	Tier II (Preferred Medications) (Formulary)	Tier III (Non-Preferred Medications) (Non-Formulary)
Retail 30-day supply	\$10 copay	\$25 copay	\$40 copay
Home Delivery 180-day supply	\$35 copay	\$100 copay	\$150 copay

Diabetic supplies covered under the prescription drug benefit include syringes, needles, lancets, blood monitor kits, test strips, blood glucose calibration solutions, urine tests, and blood test strips. Blood glucose monitors are also covered under the pharmacy benefit, but continuous blood glucose monitors are currently excluded. Insulin pumps and sensors are covered under the medical benefit as Durable Medical Equipment. Many insulin pump supplies are covered under the pharmacy benefit. Please call customer service to confirm and be sure you know the exact part and part number needed.

Which insulin pump supplies are covered and which are not? Most insulin pump supplies that are considered “replaceable” (reservoirs, needles, tubing) are covered under the pharmacy benefit and are available through mail service. If the insulin pump supply you need is not currently in stock in the mail service facility, you will be notified that there could be a slight delay (approximately 11-14 days) while they obtain the product for you. If you have any questions, call customer service at 1-877-263-0911. **(Currently the OMNIPOD disposable pump is not covered.)**

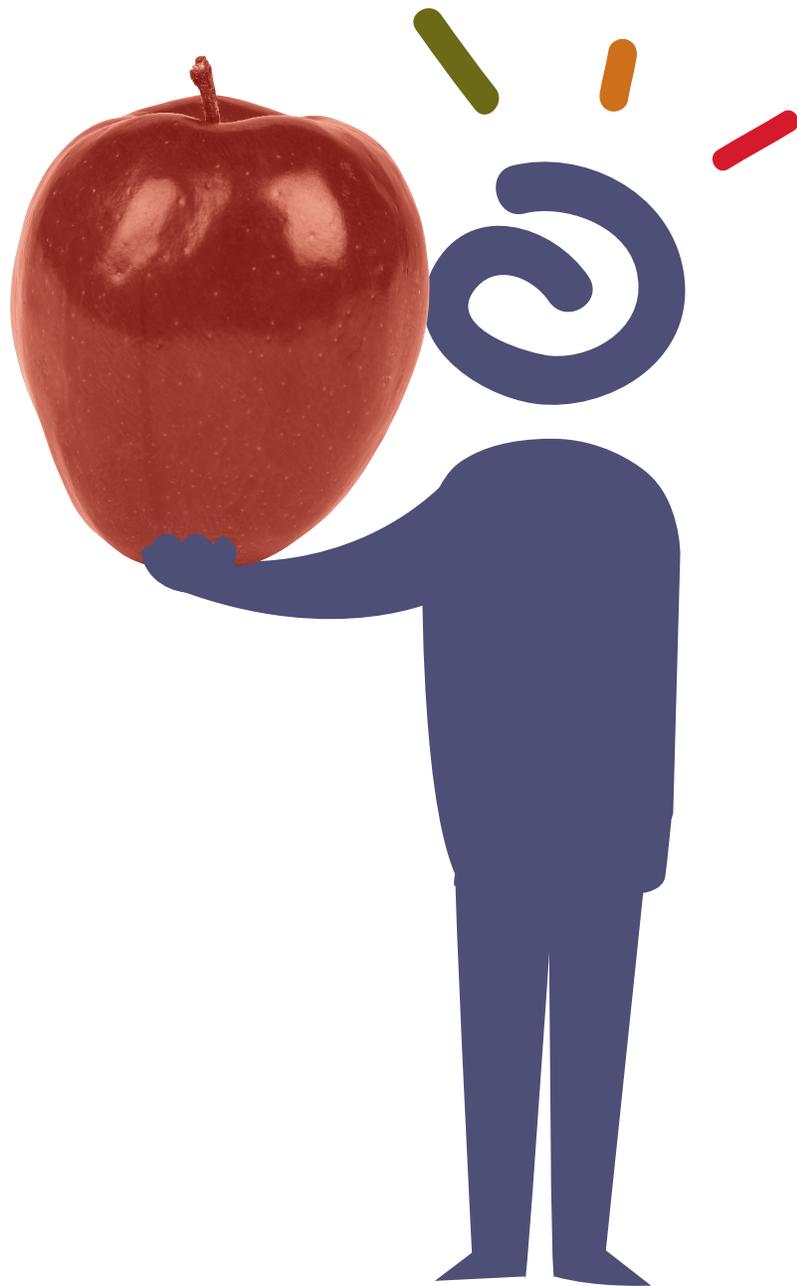
Wellness Health Plan Design Offerings

A healthy lifestyle is certainly a key ingredient to living a healthy, long life. But it is not a guarantee that you will ever be 'exempt' from a serious condition or illness. As a result, it is important to get regular checkups and screenings as recommended by your healthcare provider. The Wellness Health Plan offers low premiums and high quality coverage related to prevention and early detection, including 100% coverage for a wide range of age and gender based screenings.



Wellness Health Plan

- All blood work (including preventive) is covered up to \$500
- No age restrictions for preventive screenings
- Thyroid testing
- Bone density testing (age restriction was removed)
- Routine and follow-up mammograms covered at 100%
- Routine and follow-up colonoscopies covered at 100%
- Cholesterol medications at a reduced copay or no cost for generics
- Hypertension (high blood pressure) medications at a reduced copay or no cost for generics
- Hemoglobin A1C testing twice per year
- Adult and child immunizations
- Flu shots at no cost (on-site flu shots where available)
- Maternity services
- Well baby exams
- Routine pap smear
- Routine prostate cancer screening
- Diabetes vision screening
- Diabetic prescriptions at a reduced copay
- With enrollment in the EMPOWERED Health Coaching program, Wellness Health Plan participants are eligible with prior approval, to receive (1) course of tobacco cessation prescription drugs for up to 12 weeks, within a rolling 12 month period, at no cost. There is a lifetime limit of three (3) courses of treatment



YOUR COST FOR COVERAGE

The tables on page 20 show the cost of medical plan coverage for July 1, 2013 through June 30, 2014 for full-time employees. If you work less than 40 hours a week, consult your agency Human Resource office for part-time rates.

You pay your portion of the cost for coverage with pre-tax dollars. That means your share of the cost is deducted from your pay before taxes are withheld. Because your taxable income is reduced, you pay less in taxes.

The rates shown are monthly rates. **Employees who are paid bi-weekly will pay half of the total shown here each pay period.**

It is your responsibility to review your pay stub to ensure that the proper deductions are taken. You are responsible for the cost of the proper employee share of your elected benefits. A payroll error does not absolve you of responsibility for payment of the proper share of the cost.

Did You Know?

By providing different coverage levels based on the number of dependents you cover, the State provides you with premium options based on your individual situation.

The State contributes 79% of the total cost of your health care benefit!



Health Care Premiums – July 1, 2013 – June 30, 2014

Health Care Premiums for Employee Only (Single Coverage) – Monthly			
	Your Cost	State Cost	Total Premium
Wellness Plan	\$88.38	\$332.44	\$420.82
Choice Plan	\$137.04	\$515.54	\$652.58
Regular Plan	\$104.84	\$394.40	\$499.24
High Deductible Plan	\$65.16	\$245.12	\$310.28
Ameritas Dental	Basic Option	\$21.16	
	Premium Option	\$23.68	
EyeMed Vision	Basic Option	\$5.16	
	Premium Option	\$7.98	

Health Care Premiums for Employee + Spouse (Two Party Coverage) – Monthly			
	Your Cost	State Cost	Total Premium
Wellness Plan	\$234.54	\$882.30	\$1,116.84
Choice Plan	\$363.72	\$1,368.28	\$1,732.00
Regular Plan	\$278.26	\$1,046.76	\$1,325.02
High Deductible Plan	\$172.94	\$650.56	\$823.50
Ameritas Dental	Basic Option	\$42.36	
	Premium Option	\$47.40	
EyeMed Vision	Basic Option	\$8.28	
	Premium Option	\$12.78	

Health Care Premiums for Employee + Dependent Children (Four Party Coverage) – Monthly			
	Your Cost	State Cost	Total Premium
Wellness Plan	\$181.52	\$682.84	\$864.36
Choice Plan	\$281.48	\$1,058.92	\$1,340.40
Regular Plan	\$215.34	\$810.12	\$1,025.46
High Deductible Plan	\$133.84	\$503.48	\$637.32
Ameritas Dental	Basic Option	\$61.04	
	Premium Option	\$68.32	
EyeMed Vision	Basic Option	\$8.44	
	Premium Option	\$13.04	

Health Care Premiums for Employee + Spouse + Dependent Children (Family Coverage) – Monthly			
	Your Cost	State Cost	Total Premium
Wellness Plan	\$313.70	\$1,180.08	\$1,493.78
Choice Plan	\$486.48	\$1,830.04	\$2,316.52
Regular Plan	\$372.16	\$1,400.04	\$1,772.20
High Deductible Plan	\$231.30	\$870.12	\$1,101.42
Ameritas Dental	Basic Option	\$66.32	
	Premium Option	\$74.24	
EyeMed Vision	Basic Option	\$13.58	
	Premium Option	\$21.00	

Controlling healthcare costs requires a partnership and ownership of personal health.

You Should Know . . .

■ **Women's Health and Cancer Rights Act of 1998** — Your State sponsored health coverage provides benefits for mastectomy-related services and complications resulting from a mastectomy (including lymphedemas). These benefits include reconstruction and surgery to achieve breast symmetry and prostheses. Normal copays, deductibles and coinsurance may apply.

■ **Legal Divorce** — If you cover your spouse and/or dependent children on your State health insurance, your divorce is considered final **six months after** the decree is rendered. Changes to your coverage will be effective on the first day of the month following the six month waiting period.

If your divorce decree requires you to provide coverage for your dependent children, the children may continue coverage if they are currently enrolled in the plan. If the children are not currently enrolled for coverage, you must submit a copy of the divorce decree along with a new enrollment form adding the eligible children.

If you have never had coverage with the State, you may apply for coverage when the divorce is final. You must submit the divorce decree along with your enrollment form and a certificate of creditable coverage. Your ex-spouse is not eligible for coverage under the State's plan once the divorce is final, however, he or she is eligible to continue coverage under COBRA if he or she was covered immediately prior to the divorce becoming final.

For more information, contact your agency Human Resource office.

■ **LB551 – Dependents up to Age 30** – Effective January 1, 2011, an employee may elect to continue coverage to age 30 for a dependent child who would otherwise lose coverage when he/she ceases to meet the health plan's student criteria or attains an age which exceeds the plan's limiting age, provided that the following criteria are met:

- The child remains financially dependent upon the employee; and
- The child was covered as an Eligible Dependent at the time coverage would have terminated.

In order to elect **continuation coverage** for a child under age 30 the dependent must currently be covered under the plan and lose coverage due to the eligibility criteria (see page 8) and the employee must:

- Complete and return the enrollment form to their agency Human Resource office. The enrollment form is available at their agency Human Resource office.

The premium for continuation coverage will be equal to the plan's full, unsubsidized single adult premium. The employee will be responsible for paying the full premium each month through payroll deduction and are pre-tax.

The coverage will terminate if:

- The employee requests the termination because they no longer meet the criteria
- The employee's coverage with UnitedHealthcare terminates
- The covered dependent:
 - ... Marries
 - ... Is no longer a resident of Nebraska
 - ... Receives coverage under another health benefit plan or self-funded employee benefit plan
 - ... Attains age 30

Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage cannot be reinstated once it has been terminated.



- **Mental Health Parity Act** — The Mental Health Parity and Addiction Equity Act of 2008 prohibits separate treatment limits for mental illness and substance abuse. It requires equivalent cost sharing and out-of-pocket expenses for these benefits. Coverage must have the financial requirements as any other illness including: deductibles and coinsurance.

Services must still be provided by a qualified physician or licensed psychologist, licensed special psychologist, licensed clinical social worker, licensed mental health practitioner or auxiliary providers supervised by a qualified physician.

Benefits for ALL inpatient admissions must be pre-certified.

Please refer to your Summary Plan Description booklet and Schedule of Benefits for exact benefit language.

- **Changes to HIPAA Special Enrollment Provisions under the Children's Health Insurance Program Reauthorization Act** —

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer new special enrollment opportunities. Effective April 1, 2009, plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

There are also new notice and disclosure requirements associated with CHIPRA.

- Employers must notify all employees of their potential eligibility for the subsidies under Medicaid or CHIP. Employers are not required to provide these notices until the first plan year after the model notices are issued (January 1, 2013 for calendar year plans).
- In order for States to evaluate an employment-based plan to determine whether premium reimbursement is a cost effective way to provide medical or child medical assistance to an individual, plans are required to provide, upon request, information about their benefits to State Medicaid or CHIP programs. States may begin requesting this information from plans beginning with the first plan year after the model disclosure form is issued (January 1, 2013 for calendar year plans).

Individuals need to contact their State's Medicaid or CHIP program to determine if they are eligible for Medicaid or CHIP, and to see if their State will subsidize group health plan premiums. If they are eligible for a premium subsidy, they need to contact their plan administrator or employer to take advantage of the new special enrollment opportunity and enroll in the group health plan.

Individuals needing assistance or with questions about the application of these provisions to their employment-based group health plan can call toll free 1-866-444-3272 (EBSA) to speak to a Benefits Advisor.

wellnessoptions PROGRAM

Leading the Nation!

When the State of Nebraska launched the **wellnessoptions** program, it became one of the first states to offer an integrated wellness program which is tied to health plan coverage. As a result of wellness program efforts and outcomes, the State of Nebraska is demonstrating a strong example for others to follow by earning several prestigious national awards – the 2010 and 2012 Gold Well Workplace by the Wellness Council of America, and the Innovations Award from The Council of State Governments. Just recently, the State of Nebraska became the first state to earn the coveted C. Everett Koop National Health Award, which has the most stringent requirements for demonstrating health improvements and cost savings. The great news is that due to these health improvements and increased use of preventive screenings, the State of Nebraska is controlling healthcare costs which benefit us all, including the 1.8 million taxpayers across the state. After several years of double digit healthcare cost increases, the annual healthcare cost experience is finally stabilizing which benefits all those enrolled in any of the four State health care plans.

National research has illustrated that reducing individual health risk factors results in a reduction of health care costs. Now we know that this relationship is also occurring here at the State of Nebraska. Specifically, the analysis of medical and pharmacy costs has demonstrated that our wellness program yielded \$4.2 million in reduced medical and pharmacy claims spending when comparing wellness program participant's health cost experience to non-wellness participants. For every \$1.00 spent on the wellness program, \$2.70 is returned in health care savings.

Use health care rather than sick care!

Wellness Programs Are Available To Those Enrolled In Any Health Plan

In 2009, the State of Nebraska launched a wellness program, called **wellnessoptions**, with the following goals in mind: 1) to create a healthier workforce by encouraging healthy behaviors and the use of preventive care benefits; 2) controlling health care costs.

As a result, employees and spouses enrolled in any of the four State of Nebraska health plans are eligible to participate in any of the **wellnessoptions** programs, regardless if you choose to qualify for the Wellness Health Plan. Wellness programs include:

- **NEW PROGRAM! Personalized Lifestyle Programs** – Choose from one of five self-directed digital health coaching programs that provide you a personal plan, on-going guidance and plenty of resources – similar to having your very own virtual coach! Program options include: 1) Balance - manage weight, 2) Breathe - quit smoking, 3) Move - increase physical activity, 4) Nourish - improve nutrition, and/or 5) Relax - manage stress

***High tech tip!** Utilize today's technology (Iphones or Ipod Touch) to set smart goals and track daily activities, calories, fat grams and more! Simply click on 'Step by Step' within the Personalized Lifestyle programs – Balance, Move or Nourish, then click on Tracking Options and follow the online directions.*

- **Cardio Log** – Based on feedback, wellness participants expressed interest in logging a greater variety of workouts. With Cardio Log, you can track a variety of sports, fitness classes, cardiovascular, strength training and flexibility workouts.



- **Walk This Way** – Boost your activity level by wearing a free pedometer and tracking your steps online. Use a new and improved pedometer that measures steps, aerobic steps, distance, calories, and fat grams burned. It's easy to use – put it in your pocket, bag or clip onto your hip.



Congratulations Wellness Program Participants!

Wellness program participants are making progress and seeing health improvements as shown by aggregate health assessment and biometric screening data, including:

- **EMPOWERED Coaching™: Lifestyle Management**
Work with your own personal health coach to support and guide you in making lifestyle changes in any of the following areas:

- Physical Activity
 - Aerobic Exercise
 - Flexibility
 - Strength
- Healthy Eating
 - Unhealthy Fats
 - Fruits
 - Overeating
 - Skipping Meals
 - Sodium
 - Sugary Drinks
 - Vegetables
 - Whole Grains
- Smoking Cessation
- Stress Management

High tech tip! With enrollment in EMPOWERED Coaching, you can access your personal information from your mobile phone's browser (Microsoft Internet Explorer, Apple Safari, Google Android) 24/7! To access the mobile interface, click on My Settings (left hand tool bar on the **wellnessoptions** home page), and then My Mobile. Please check the "Allow Mobile Access" checkbox and press "Save". Then, simply type in the following URL on your phone's browser: m.hfit.com/stateneb

- **EMPOWERED Coaching™: Condition Management**

Individuals with a chronic condition can work with a coach to help manage their health, feel better and enjoy the best quality of life. Support is available to those diagnosed with any of the following conditions:

- Asthma
- Back Pain
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Depression
- Diabetes
- Heart Failure (HF)

- **The reduction of individual risk factors** experienced within the following areas of health improvements are:

- Increased levels of physical activity
- Increased vegetable & fruit consumption
- Cholesterol reduction
- Tobacco cessation
- Lower blood pressure
- Improved ability to manage stress

- **More participants moving from a high risk population to a low risk population.**

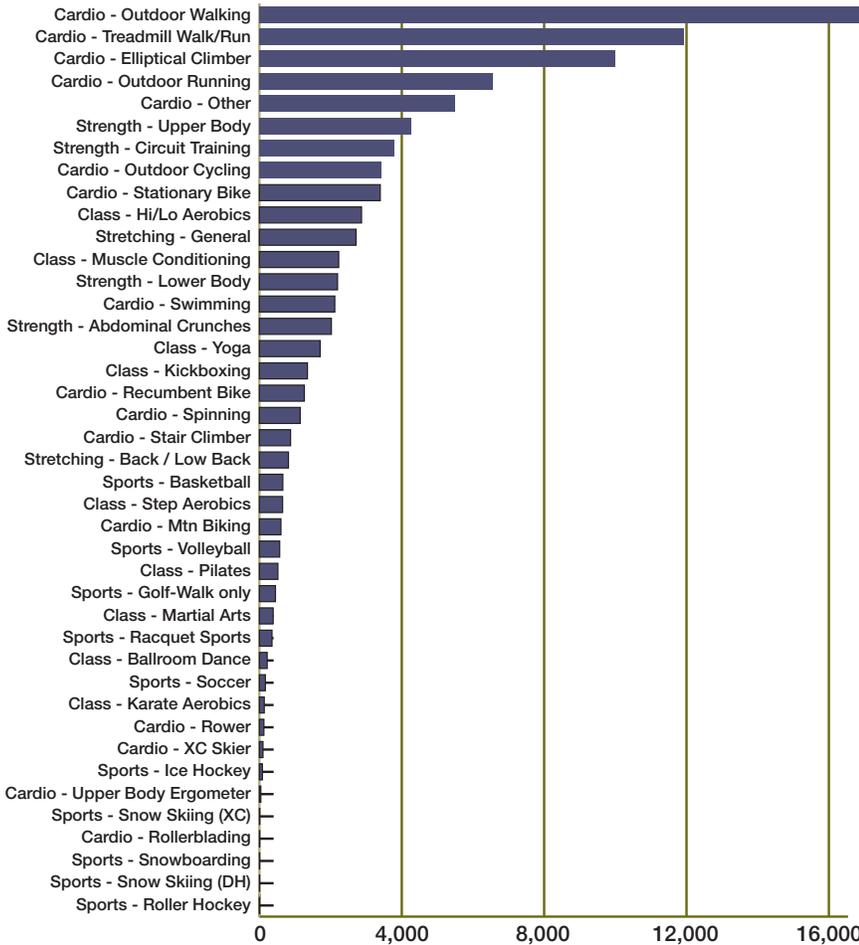
- **Completion of preventive screenings have SIGNIFICANTLY increased** resulting in early detection of many cases which the following conditions:

- **Colorectal Cancer:** 664 cases of benign polyps were detected (93 times less costly when caught in an early stage!)
- **Breast Cancer:** 8 new cases of early stage cancer were detected (3.5 times less costly when caught in an early stage!)
- **Cervical Cancer:** 56 pre-cancerous lesions were detected (67 times less costly when caught in the early stage!)
- Other conditions newly diagnosed:
 - 1,841 new high cholesterol cases diagnosed
 - 2,831 new high blood pressure cases diagnosed

One area that we need to work on is decreasing our current obesity rate. The current obesity rate among our workforce exceeds the national obesity rate.



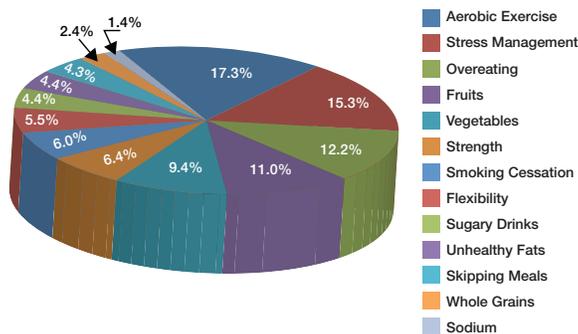
Top Cardio Log Entries



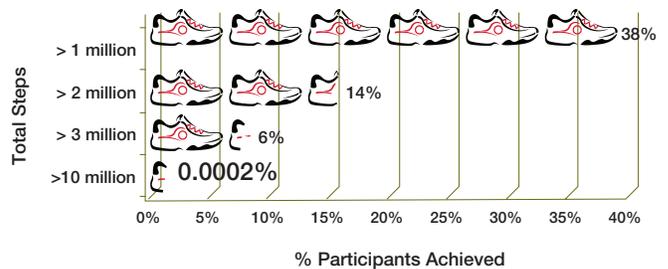
- ✓ 154 wellness program participants quit using tobacco!
- ✓ 74% of wellness program participants now exercise three or more days per week... that's a 4% increase from last year!
- ✓ 80% of wellness program participants now consuming more than three fruits/vegetables per day... that's a 7% increase from last year!
- ✓ Over 200,000 Cardio Log Activities were submitted!
- ✓ Walk This Way participants submitted over 6,000,000,000 steps! This equates to over 104 times around the earth's circumference.

- Last year, over 9,000 employees and spouses have enrolled in a wellness program...that's 20% higher than the previous year!
- 46% of all eligible employees participated in a wellness program last year!

Lifestyle Coaching Focus Area Distribution (n=2,323)



Walk This Way Over-Achievement Rates (n=5,879)



(Wellness continues on page 28)

	Wellness Plan		Choice Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan/lifetime maximum	Unlimited		Unlimited	
Plan Year deductible (must be satisfied before benefits are paid)	\$400/individual \$800/family max	\$600/individual \$1,200/family max	\$1,000/individual \$2,000/family max	\$1,500/individual \$3,000/family max
Out-of-pocket maximum (not including deductible, if applicable)	\$1,400/individual \$2,800/family max	\$3,400/individual \$5,200/family max	\$4,500/individual \$9,000/family max	\$7,000/individual \$14,000/family max
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit/consultation	\$25 copay	30% after deductible	\$30 copay	40% after deductible
Specialty Office visit	\$35 copay		\$40 copay	
Allergy testing / serum	No copay		20% after deductible	
Allergy shots	No copay		No copay	
Maternity Services (beyond initial visit)	No copay		20% after deductible	
Pathology Services	Paid at 100% up to \$500. After \$500, 20% deductible			
Surgery, Radiology & Pathology (office)	20% after deductible			
Chemotherapy/Radiation Therapy				
Routine Vision Exam plus Refraction	\$35 copay	Not covered		Not covered
PREVENTIVE EXAMS				
Flu Shots	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.
Annual exam (includes foot exams for diabetics)				
Child immunizations				
Adult immunizations				
Pneumococcal Immunizations				
Well baby exams				
Diabetes vision screening				
Mammogram				
Pap smear				
Colonoscopy				
Prostate cancer screening	No copay	30% after deductible	20% after deductible	40% after deductible
EMERGENCY CARE				
Ambulance	No copay	30%; deductible waived	20% after deductible	40% after deductible
Urgent care center	\$35 copay	30% after deductible	20% after deductible	
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient hospital	20% ⁽¹⁾ after deductible	30% ⁽¹⁾ after deductible	20% ⁽¹⁾ after deductible	40% ⁽¹⁾ after deductible
Ambulatory Surgical Center	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Approved skilled nursing facility				
Outpatient hospital services (diagnostic lab., radiology)				
Durable medical equipment				
Home health care, Hospice care			20% after deductible	40% after deductible
Chiropractic Office visit ²	\$35 copay (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	20% after deductible (maximum 60 sessions/plan yr)	40% after deductible (maximum 60 sessions/plan yr)
Outpatient rehabilitation services (includes OT, PT, and ST) ^{2,3}	\$25 copay (maximum 60 sessions/plan yr)			
BEHAVIORAL HEALTH SERVICES				
Inpatient mental health and substance abuse treatment	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient mental health and substance abuse treatment	20% after deductible	30% after deductible	20% after deductible	40% after deductible

1. Insurance carrier must be notified within 24 hours of all inpatient hospital admissions. Please see SPD for details.

2. Chiropractic, OT, PT, and ST visits remain combined to 60 sessions a plan year.

3. Chiropractic and outpatient rehabilitation services (OT, PT, and ST) visits are distinct, separate visits that apply to the total maximum of 60 sessions a plan year.

EXAMPLE: John sees a chiropractor on a regular basis. In August, he sees a Physical Therapist 6 times and an Occupational Therapist 3 times. He has used a total of 9 sessions of the 60 he is allowed in a plan year. He has 51 visits available for the chiropractor or outpatient rehabilitation services for the rest of the calendar year.

Regular Plan		High Deductible Plan	
In-Network	Out-of-Network	In-Network	Out-of-Network
Unlimited		Unlimited	
\$800/individual \$1,600/family max	\$1,200/individual \$2,400/family max	\$1,250/individual \$2,500/family max	\$2,500/individual \$5,000/family max
\$2,000/individual \$4,000/family max	\$3,750/individual \$7,500/family max	\$2,500/individual \$5,000/family max	\$5,000/individual \$10,000/family max
\$30 copay	30% after deductible	\$30 copay	40% after deductible
\$40 copay		\$40 copay	
20% after deductible		30% after deductible	
Covered at 100% for children under age 5 only		Covered at 100% for children under age 5 only	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.
Not covered		Not covered	
20%; deductible waived	30%; deductible waived	30%; deductible waived	40%; deductible waived
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible		20% after deductible	
20% ⁽¹⁾ after deductible	30% ⁽¹⁾ after deductible	30% ⁽¹⁾ after deductible	40% ⁽¹⁾ after deductible
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	40% after deductible (maximum 60 sessions/plan yr)
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible	30% after deductible	30% after deductible	40% after deductible

Important Information: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official certificates of coverage. This is not a contract. If there are any inconsistencies between this summary and the official certificates of coverage, the certificates of coverage will prevail. Please refer to the certificate of coverage for exact benefits, exclusions and limitations.

wellnessoptions Earns Two More National Wellness Awards



The State of Nebraska **wellnessoptions** program became the first state to earn the coveted 2012 C. Everett Koop National Health Award, which includes stringent requirements for demonstrating health improvements

and cost savings. C. Everett Koop award applications are independently reviewed and rigorously scored by some of the nation's leading experts and researchers in the area of health management. Reviewers place the most scoring emphasis program evaluation and results.



For the second time, the State of Nebraska **wellnessoptions** program has been awarded the Gold Well Workplace Award presented by the Wellness Council of America for its efforts and outcomes. The State of Nebraska is the only state to win this award multiple times.

Wellness Health Plan Premium Savings

The State of Nebraska has self-funded health plans. This means that both the employee and State of Nebraska share the costs associated with all health and prescription costs. Employees contribute to health care costs by paying premiums, which accounts for 21% of health care costs. The State of Nebraska pays the remaining 79% of your health care costs.

Health plans that experience higher utilization are going to cost employers and employees more. As you can see, your health care utilization and choices affect everyone!

Health care premium costs among each of the four health plans are independently determined based on each plan's utilization experience. As a result, those who are taking the time to invest in their personal health by qualifying for the Wellness Health Plan will be rewarded with lower premium costs. CONGRATULATIONS!

As the chart depicts below, you can save hundreds, even thousands of dollars by changing from a higher cost plan to the Wellness Health Plan.

Annual Employee Wellness Health Plan Premium Savings				
2013-14 Wellness Health Plan Savings Comparison				
Plan Name	Single	Two-Party	Four-Party	Family
Choice Health Plan	\$1,644.48	\$4,364.64	\$3,377.76	\$5,837.76
Wellness Health Plan	\$1,060.56	\$2,814.48	\$2,178.24	\$3,764.40
You Save	\$583.92	\$1,550.16	\$1,199.52	\$2,073.36
Regular Health Plan	\$1,258.08	\$3,339.12	\$2,584.08	\$4,465.92
Wellness Health Plan	\$1,060.56	\$2,814.48	\$2,178.24	\$3,764.40
You Save	\$197.52	\$524.64	\$405.84	\$701.52

Is the Wellness Health Plan a match for you?

- Are you willing to **invest** in your personal health?
- Are you willing to **take the time** to participate in various wellness programs?
- Are you willing to take the time to **learn the 3 STEPS and deadlines**?
- Is **prevention and early detection** important to you?
- Do you have a vested interest in a **shared responsibility to control health care costs**?
- Are **low premium costs** important to you?

Controlling healthcare costs requires a partnership and ownership of personal health.

2014-15 Wellness Health Plan Qualifying Overview

Participants choosing to elect or remain in the Wellness Health Plan must complete 3 STEPS on an annual basis in order to qualify for the upcoming plan year. At the beginning of each annual cycle, participants will choose and enroll in a wellness program (STEP 1), and then finish each annual cycle by completing a biometric screening option (STEP 2) and the online Insight Health Assessment (STEP 3).

Both the enrolled employee and enrolled spouse (if applicable) must complete the following 3 STEPS during the current plan year in order to qualify for the following Wellness Health Plan (2014-15 plan year).

STEP 1. This Spring – Wellness Program

- Enroll in your choice of at least one Wellness Program from April 1, 2013 thru December 27, 2013
- Complete your choice of one Wellness Program by March 28, 2014

STEP 2. Next Spring (April 1 - May 30, 2014)
Complete your annual Biometric Screening option

STEP 3. Next Spring (April 1 - May 30, 2014)
Complete your annual online Insight Health Assessment

Annual Cycle for Qualifying into Enrollment for the Wellness Health Plan (3 Steps)																			
Steps	Wellness Criteria	Program	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Step 1	Enroll in Wellness Program	Personalized Programs	Step 1: Wellness Program Enrollment Period										Finish completing program			Step 2		Step 3	Quality for Wellness Health Plan
		Cardio Log																	
		EMPOWERED Coaching																	
		Walk This Way																	
		Condition Management																	
Step 2	Biometric Screening Options	Onsite Screening																	
		Alternative Means Form																	
		Home Kit Screening																	
Step 3	Health Assessment	On-Line																	

NOTE: BOTH the enrolled employee AND covered spouse (if applicable) must complete all 3 STEPS on the annual basis to qualify for the Wellness Health Plan

2014-15 Wellness Health Plan Qualification Detail

STEP 1. Enroll and begin participation in your choice of at least one Wellness Program (beginning April 1, 2013)

To qualify for enrollment into the 2014-15 Wellness Health Plan, enroll in your choice of at least one of the following wellness programs any time before December 27, 2013 and complete it before March 28, 2014:

■ Personalized Lifestyle Programs (5)

Choose from one of five self-directed digital health coaching programs that provide you a personal plan, on-going guidance and plenty of resources – similar to having your very own virtual coach! Program options include: 1) Balance - manage weight, 2) Breathe - quit smoking, 3) Move - increase physical activity, 4) Nourish - improve nutrition, and/or 5) Relax - manage stress.

HIGH TECH TIP! Utilize today's technology (Iphones or Ipod Touch) to set smart goals and track daily activities, calories, fat grams and more! Simply click on 'Step by Step' within the Personalized Lifestyle programs – Balance, Move or Nourish, then click on Tracking Options and follow the online directions.

Wellness Health Plan criteria: Enroll in at least one Personalized Lifestyle Program option on the **wellnessoptions** website by December 27, 2013 and complete the enrollment consultation, 30 day and 90 day check-in evaluations before March 28, 2014.

■ Walk This Way

Whether you are currently inactive or active, boost your activity level by wearing a pedometer and tracking your steps online.

Wellness Health Plan

criteria: New and previous Walk This Way participants must enroll online before December 27, 2013 on the **wellnessoptions** website and log a minimum of 800,000 steps online before March 28, 2014.



■ Cardio Log

One of the best ways to maintain or improve your health is to engage in physical activity each day. Participants can record a large variety of physical activities whether it is sports, fitness classes, cardiovascular, strength training, flexibility workouts and more.

NEW! 2014-15 Wellness Health Plan criteria: Log a minimum of 50 completed workouts from April 1, 2013 through March 28, 2014 from the 'Health Home' page on the **wellnessoptions** website. You must begin logging your workouts online before December 27, 2013. A qualifying workout must be a minimum of 30 minutes per day. One or multiple sessions submitted on the same day that total 30 minutes or more equals only one qualifying workout. (Examples of one qualifying workout include: one 30-minute session per day OR two 15-minute sessions per day OR three 10-minute sessions per day. Two 30-minute sessions in one day would only equal one qualifying workout). It is the employee's responsibility to ensure that all fields on the log are completed accurately and that each day's workouts total 30 minutes or more in order to get credit for a qualified workout. Please be aware that the number of "sessions" indicated on the **wellnessoptions** website does not necessarily equal the number of qualifying workouts.

■ EMPOWERED Coaching™: Condition Management

Individuals with a chronic condition (Heart or Respiratory Conditions, Diabetes, Depression, Back Pain) can work with a coach, in conjunction with your physician, to help manage your health, feel better and enjoy the best quality of life.

Only new Condition Management participants need to enroll before December 28, 2013; current participants can continue calls and do not need to re-enroll.

Wellness Health Plan criteria: Enroll before December 27, 2013 by calling 1-866-956-4285 Option 2 and complete 3 or more phone calls with your health coach before March 28, 2014.

For more information on all programs, Wellness Health Plan qualification requirement and more, visit the **wellnessoptions** website or call 1-866-956-4285.

■ **EMPOWERED Coaching™: Lifestyle Management**

Work with a coach to support and guide you in making lifestyle changes by selecting among 13 different focus areas related to physical activity, healthy eating, stress management and smoking cessation. Participants can enroll at the time of your Health Advisor call OR by calling 1-866-956-4285 Option 2 OR by going to the **wellnessoptions** website ('My Coach' left toolbar selection).

HIGH TECH TIP! *With enrollment in EMPOWERED Coaching, you can access your personal information from your mobile phone's browser (Microsoft Internet Explorer, Apple Safari, Google Android) 24/7! To access the mobile interface, click on My Settings (left hand tool bar on the **wellnessoptions** website Health Home page), and then My Mobile. Please check the "Allow Mobile Access" checkbox and press "Save". Then, simply type in the following URL on your phone's browser: m.hfit.com/stateneb.*

Wellness Plan Health criteria: New and previous EMPOWERED participants must enroll before December 27, 2013 and complete 3 or more phone calls with your health coach before March 28, 2014.

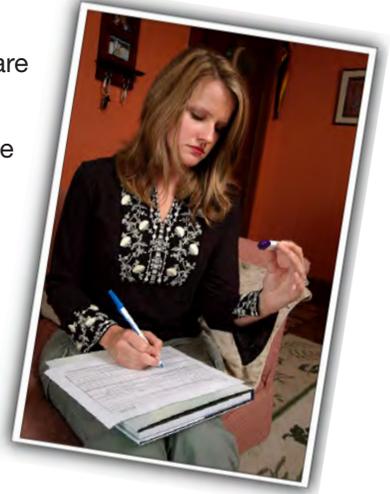
NOTE: You may use message boards for correspondence, but you must talk with your coach 3 or more times via telephone to qualify for the Wellness Health Plan.



STEP 2. Complete one annual Biometric Screening option (Starting April 1, 2014)

Starting April 1, 2014, a total of three different confidential biometric screening options are available, including:

- **Onsite screenings** will be offered at approximately 30 State of Nebraska locations
- **Home kits** can be requested to obtain a finger-stick blood draw kit mailed to your home
- An **Alternative Means Screening (AMS)** form will be available to submit recent biometric screening results (height, weight, blood pressure, total cholesterol, HDL, LDL, triglycerides, glucose) from appointments scheduled with your personal physician.



STEP 3. Complete your annual online Insight Health Assessment (April 1 – May 30, 2014)

- Complete the annual online Insight Health Assessment, which is located on the **wellnessoptions** website Health Home page within the 'Complete your HEALTH ASSESSMENT' section, then select 'Click here to complete your Health Assessment'.
- The online Insight Health Assessment includes 82 confidential questions regarding your lifestyle choices. Select the 'Save/Finish' button at the end.

IMPORTANT: If you enroll in the Wellness Health Plan during Open Enrollment and fail to meet the **THREE STEP** criteria, you will automatically be defaulted to the Regular Plan at the appropriate tier, based on the effective date, which will result in a premium adjustment.

Check Your Checkmark!

The **wellnessoptions** website has an easy to read Wellness Plan Checklist to help you track the completion of the three necessary steps to qualify for the Wellness Health Plan. After you log-in with your unique user name and password, please review your own Wellness Plan Checklist. Selecting the 'Completed Criteria Activity' gold taskbar will also provide you further detail regarding your completed qualifying activities. The Checklist will update itself on July 1, 2013 to reflect 2014-15 Wellness Health Plan qualification criteria. Use this tool to guide you towards qualifying for the Wellness Health Plan!



Your Wellness Plan Checklist

[Click here for further details](#)



Completed Criteria Activity

For 2014-15 Plan Year

(If checked ✓, step is completed)

- Step 1:** Met criteria for ONE of the following Wellness Programs:
(≥ means greater than or equal to)
 - Coaching – ≥ 3 calls (EMPOWERED or Condition Mgt.)
 - Personalized Lifestyle Programs 30 & 90 Days Check-In Evaluation
 - Walk This Way – ≥ 800,000 steps
 - Cardio Logs – ≥ 40 workouts (≥ 30 minutes per day)
- Step 2:** 2013 Biometric Screenings
- Step 3:** 2013 Health Assessment
- My three 2014-15 Wellness Plan steps are complete!**

Learn more about the 2014-15 Wellness Plan qualifications.

For **wellnessoptions** website log-in support, call

1-866-956-4285
option 1.



Thanks Wellness Champions!

The Wellness & Benefits Department works with a team of Wellness Champions from several different agencies and state-wide locations to provide constructive feedback and help with promoting and supporting a culture of wellness. We are proud to announce that we have now recruited over 140 volunteers as State of Nebraska Wellness Champions! Wellness Champions encourage healthy behaviors in hopes to positively impact the quality of life for the State of Nebraska

workforce and their families while controlling health care costs. They are also instrumental in providing their thoughts with several Wellness Health Plan design enhancements. If you have a strong desire to help others, model a healthy lifestyle and want to help build a culture of wellness in your work area, check out the Wellness Champion section in the **wellnessoptions** website under 'wellnessoptions' (left toolbar) on the Health Home page.

2012 Annual Governor's Wellness Champion Award Winners Going Above & Beyond



Bill Hetzler – Department of Labor



Mike Scanlan - Department of Health and Human Services



Carly Salak – Game & Parks Commission

Wellness Wall of Fame Recognition

Periodically, we learn about success stories from participants who have or are taking control of their lives and are making some pretty amazing lifestyle changes resulting in significant health improvements. For many, it is a life changing experience – almost a second outlook on life. The purpose of the Wellness Wall of Fame recognition is to encourage, recognize, educate and create a standard of excellence for promoting healthy lifestyles by encouraging active living and healthy choices that shape the future of a culture of wellness within the State of Nebraska

workforce. In hopes of motivating others, these stories are displayed on the Wellness Wall of Fame, which includes obtaining a picture with the Governor (if possible), receiving a personal letter from the Governor, and attending the Governor's Annual Wellness Award Luncheon!

To see all of the Wall of Fame recipients, go to the [wellnessoptions](#) website Health Home page and click on 'wellnessoptions' (left toolbar), then Wall of Fame.



Name: Paul Norrid
Agency: Corrections



Governor Heineman and Paul Norrid

Upon visiting my doctor for back pain, they ran some other tests and found that I had high blood pressure, high triglycerides and that I was also borderline diabetic. I had already told my doctor about the State of Nebraska employee wellness program, and she thought it was wonderful that I was planning to participate.

Upon participating in the [wellnessoptions](#) program, I changed my diet and began exercising - eating more fruit, vegetables and whole grains. I eat almost no processed foods with very little fast food. My 6 year old daughter and I ride bikes together almost every day. Even on days when I don't want to, it's hard to tell your daughter that you don't want to go with her when she looks forward to the time together. I receive support and assistance from Angela, my Health Coach, (choosing smoking cessation, aerobic exercise and stress management focus areas) in addition to 'actively' participating in the Walk this Way program, having just exceeded 1 million total steps.

I have been able to lose over 35 pounds in 3 months. I have also quit smoking with the assistance of the smoking cessation prescription benefit with the Wellness PPO plan. I have not smoked for over 3 months and have no cravings whatsoever. And for the back pain which started this whole experience – the pain went away after losing the first 10 pounds and has not had any pain since!

The smoking cessation prescription benefit was the main reason I signed up for the Wellness PPO Medical plan. I was planning to mainly use the smoking cessation benefit, but participating in the [wellnessoptions](#) program resulted in improving many other health issues that I didn't even know was possible.

I feel at least 10 years younger. It's also nice to be able to walk up a flight of stairs or walk across the parking lot without feeling winded. In addition, being in better shape has given me the ability to manage stress better.



Annual Governor's Wellness Award Banquet



The Governor continues to enthusiastically support and promote wellness initiatives for the State of Nebraska. Each year, the Governor recognizes individuals and agencies for going above and beyond in promoting and establishing a healthy lifestyle during the Annual Wellness Award Banquet. All of the Wall of Fame recipients are recognized each year, in addition to the State of Nebraska Agency Wellness Champions.



Governor Heineman: "Champion of Nebraska Wellness Program"

The Wellness Champion Award recipients for the 2012 Governor's Wellness Awards Banquet were **Mike Scanlan (DHHS)**, **Carly Salak (Game & Parks)**, and **Bill Hetzler (Dept. of Labor)**. Each year, the Wellness Champion award recipients are selected for their involvement, actions and efforts that:

- Contribute towards achieving wellness goals
- Promote and supports wellness in their work areas and lifestyles
- Demonstrate a positive attitude that inspires and motivates others

The 2012 Agency Wellness Awards included:

- Large Agency Wellness Award – **Department of Education**
- Small Agency Wellness Award – **State Patrol**
- Honorable Mention Agency Wellness Award – **Department of Corrections**

Each year, the Governor's Agency Wellness Award goes to the small and large agencies that have the highest objective score among the following three factors:

- Current Wellness Program Participation: % participation among all those who are eligible to participate within each agency
- Wellness Program Participation Growth: % participation change from the current year to the previous year
- Health Improvements: based on agency aggregate health assessment and biometric data comparing the average number of risk factors from the current year to the previous year

The Honorable Mention Agency Wellness Award was presented to the agency that has not yet met the objective measures achieved by the large and small agencies but are taking steps within their agency towards building a culture of wellness.



Governor's Honorable Mention Agency Wellness Award Winner
Department of Corrections

What is Allowed on Company Time?

The following items **are allowed** for participation on company time: Open Enrollment, Health Assessment, Biometric screenings, sending and receiving e-mails to/from HealthFitness to/from your work e-mail.



The following items **are not allowed** on company time: Health Advising calls, EMPOWERED Lifestyle Management Coaching calls, Condition Management Coaching calls and Walk This Way participation. Specifically, pedometers can be worn during the workday on company time; however, physical activities outside of normal work requirements (example: going for a walk) must be done on personal time (lunch time or break). If in doubt, refer to your Personnel policy, or ask your supervisor.

NOTE: Submitting activities are allowed on a State computer, but are to be done on personal time (lunch time or break). Participation is in no way to be considered part of or arising out of employment for the purposes of workers' compensation or for any other purpose.

Confidentiality is a Top Priority

Privacy of personal information is a top priority with wellness programs. HealthFitness maintains the confidentiality of all personal health information in accordance with federal regulations. That means your personal health information, which is obtained by HealthFitness, will not be released to the State of Nebraska.

No Penalties for Poor Health

The Wellness Health Plan qualification criteria is based on active participation and completion of specific wellness programs, and is not based on your individual health factors, health assessment results or biometric screening results. That means you will not be penalized for having or reporting poor health behaviors, lifestyle risks or conditions.

Federal regulations prohibit a group health plan from discriminating among individuals based on their health status. This means that group health plans cannot charge individuals different premiums or impose different costs (i.e., through deductibles or co-pays) based on the absence or existence of a health factor. Because the State of Nebraska does not condition eligibility for the Wellness Health Plan upon a participant's ability to meet a health standard, the program meets the nondiscrimination requirements under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

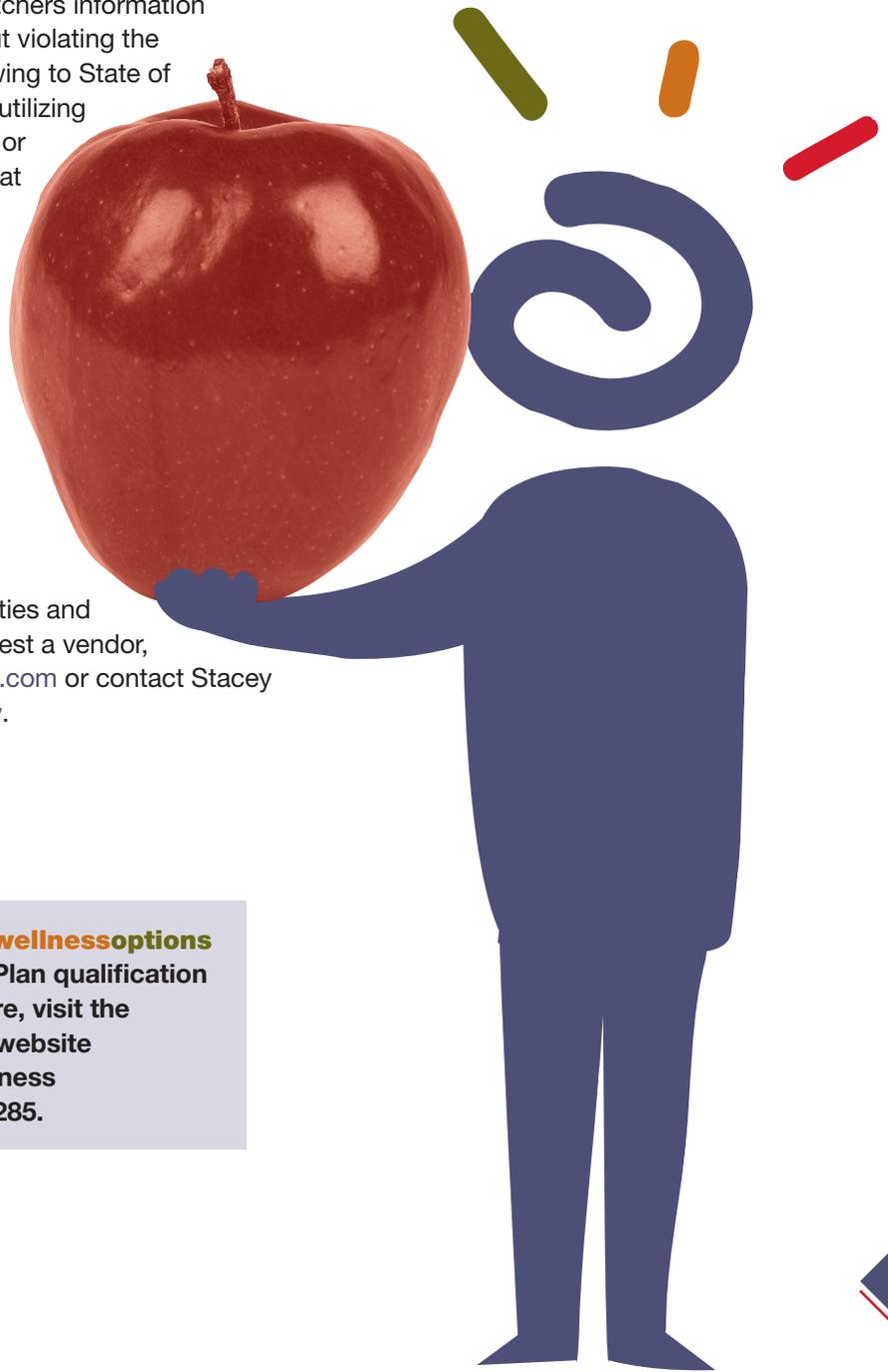
Your personal health information will not be held against you.

For **wellnessoptions** website log-in support, call
1-866-956-4285
option 1.



ADDITIONAL HEALTH RESOURCES

- **Health Education presentations** – The **wellnessoptions** program now offers a variety of Health Education presentations (over 25 healthy lifestyle topics) that can be presented at your worksite. For further information or to schedule a presentation, contact Barbara Munro, Wellness Specialist at 402-471-4110 or barbara.munro@nebraska.gov.
- **Employee Assistance Program** – Provides short-term counseling to help with life's challenges. EAP also provides lunchtime educational sessions available face to face or via webinar every other month. To schedule a confidential appointment or to obtain a schedule of educational sessions – all at no cost.
- **Weight Watchers** – Weight Watchers is a part of WeSave as an approved State of Nebraska vendor. As a result, Weight Watchers information can now be posted and promoted without violating the State Solicitation Policy to offer the following to State of Nebraska employees and spouses. Now utilizing Monthly Pass, At work meetings (with 20 or more qualified members), can be offered at your worksite. Please see website www.wellnessoptions.nebraska.gov for more information, and click on Health Resources (left hand column on Home Health page).
- **WeSave Employee Discount Program** – Provides national, online, and local discounts for State Employees. All State Employees are eligible to participate and encouraged to suggest local vendors to participate in the program. This includes national and local health and fitness facilities and vendors. For more information or to suggest a vendor, please visit the website at: www.wesave.com or contact Stacey Dvorak at stacey.dvorak@nebraska.gov.



For more information on all **wellnessoptions** programs, Wellness Health Plan qualification requirements and more, visit the **wellnessoptions** website or call HealthFitness at 1-866-956-4285.

DENTAL BENEFITS

Regular, professional dental care is not only essential to good health, but it can also prevent serious and costly medical and/or dental problems. That's why the dental benefit plan encourages you and your family to see a dentist regularly. The plan places special emphasis on preventive care, but also covers many other dental services you may need.

Whether or not you elect health coverage, you can choose dental coverage for yourself and your eligible dependents. The dental plan is a preferred provider organization (PPO) with a network of participating providers. You have the option of selecting dental care in- or out-of-network each time you receive dental care, but the plan pays the greatest benefit for care received from a provider in the Ameritas network.

Dental Rewards

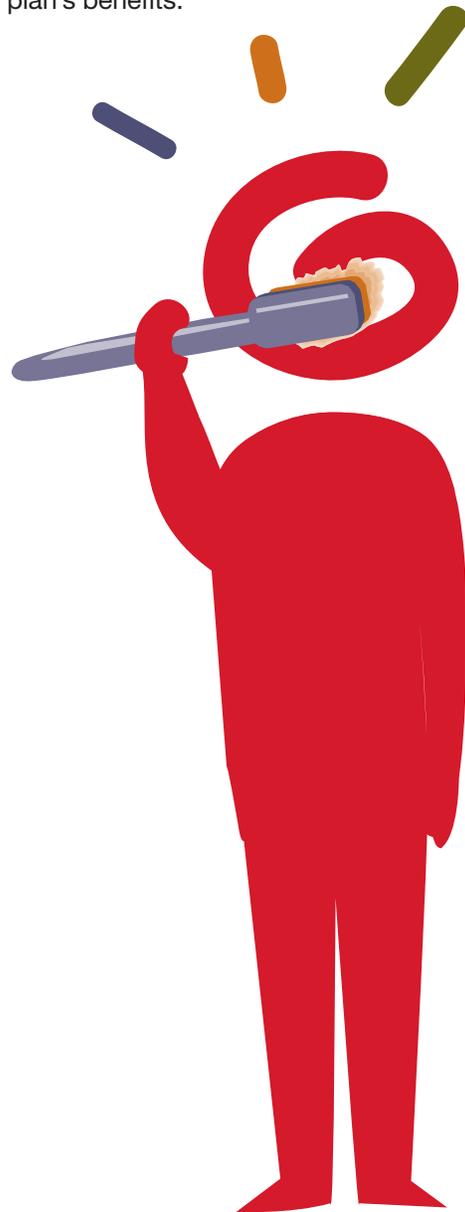
Dental Rewards is a valuable program that encourages good dental habits through regular dental check-ups. If you file at least one dental claim during the plan year (July 1, 2013 – June 30, 2014) and total benefits paid are less than \$500, you will qualify for a reward of \$250.00 (\$350.00 if using a PPO dentist) increase in your annual maximum the following plan year (beginning July 1, 2014). This continues until you reach a total reward of \$1,000. The Dental Reward amount earned is reduced by any amount used in any plan year.

NOTE: Orthodontia and TMJ procedures are excluded from Dental Rewards as they have their own maximum benefit.

Please be aware that Dental Rewards is a program sponsored by Ameritas and not the State of Nebraska. If in future plan years the State contracts with a different dental provider, these carryover benefits will not carryover.

Enrollment for Late Entrants

If you and/or your dependents do not enroll within 30 days from being eligible for insurance (this includes enrolling as a new hire, or being eligible due to a mid year qualified event) or elect to become insured again after dropping out of the dental plan, you and/or your dependents will be considered "late entrants." As an example, if an employee is hired on April 15, 2013 and elects the dental coverage, this would become effective on June 1, 2013. However, if the employee does not elect to enroll in the dental coverage as a new hire and, elects to enroll in the dental coverage during any subsequent open enrollment period they would be considered a late entrant and have the late entrant penalty (waiting period) for the first 12 months. As late entrants, your benefits will be limited to only preventive procedures for the first 12 months that you are covered. After 12 months, you will have access to all of the plan's benefits.



Your Dental Benefits

Basic Plan

AMERITAS DENTAL PLAN BENEFITS		
Plan Feature	PPO In-Network Dentist	Non-PPO Out-of-Network Dentist
Deductible for both Basic and Major Procedures (waived for preventive care, orthodontia and TMJ)	\$50 per individual \$150 per family	\$50 per individual \$150 per family
Maximum Benefit	\$1,000	\$1,000
Orthodontia & TMJ lifetime maximum (per person)	\$2,000	\$2,000
Preventive Procedures (exams, cleanings – 2 per year, x-rays, sealants)	Plan covers 100%	Plan covers 50%
Basic Procedures (fillings, root canals, gum disease treatment, extractions)	Plan covers 80%	Plan covers 50%
Major Procedures (initial and replacement crowns, dentures, bridges)	Plan covers 50%	Plan covers 25%
Orthodontia (to age 19) & TMJ Procedures	Plan covers 50%	Plan covers 25%

	Employee Only (Single Coverage)	Employee + Spouse (Two Party Coverage)	Employee + Dependent Children (Four Party Coverage)	Employee + Spouse + Dependent Children (Family Coverage)
Ameritas Dental	\$21.16	\$42.36	\$61.04	\$66.32

Premium Plan

Plan Feature	PPO In-Network Dentist	Non-PPO Out-of-Network Dentist
Deductible for both Basic and Major Procedures (waived for preventive care, orthodontia and TMJ)	\$50 per individual \$150 per family	\$50 per individual \$150 per family
Maximum Benefit	\$1,500	\$1,500
Orthodontia & TMJ lifetime maximum (per person)	\$2,000	\$2,000
Preventive Procedures (exams, cleanings – 2 per year, x-rays, sealants)	Plan covers 100%	Plan covers 80%
Basic Procedures (fillings, root canals, gum disease treatment, extractions)	Plan covers 80%	Plan covers 80%
Major Procedures (initial and replacement crowns, dentures, bridges)	Plan covers 50%	Plan covers 50%
Orthodontia (FOR ADULTS AND CHILDREN) & TMJ Procedures	Plan covers 50%	Plan covers 50%

	Employee Only (Single Coverage)	Employee + Spouse (Two Party Coverage)	Employee + Dependent Children (Four Party Coverage)	Employee + Spouse + Dependent Children (Family Coverage)
Ameritas Dental	\$23.68	\$47.40	\$68.32	\$74.24

VISION CARE BENEFITS

Proper vision care is an essential part of good health. Routine eye exams can help determine the need for prescription glasses, but can also help detect symptoms of serious conditions such as glaucoma, cataracts and diabetes.

When you use the services of providers who participate in the EyeMed Vision Care network, you generally pay a small copay and the plan pays the rest. Here's how it works:

- Choose an EyeMed Vision Care participating provider at link.ne.gov and connect to Wellness and Benefits Resources, then:
 - Click on "Active Employees" then
 - Click on "Vision Plan" then
 - Click on "Find a Provider" or call **1-877-861-3459**
- Make an appointment and tell the provider you are an EyeMed Vision Care member

- Two personalized ID cards will be issued with the subscriber's name for the new enrollees only; eligible dependents can use one of the cards for identification purposes. You will need to verify with your provider that they accept your plan when scheduling an appointment. Included with your ID cards will be a listing of the EyeMed Vision Care providers near you. Present your ID card at the time of service
- Choose from thousands of convenient locations including private practitioners and leading optical retailers, such as LensCrafters, Pearle Vision, Sears Optical, Target Optical and JC Penney Optical

You have a choice of two affordable eye care plans — the Basic Option and the Premium Option. Here's how they compare:

VISION PLAN BENEFITS		
Coverage	Basic Option	Premium Option
EXAM covered in full (after \$10 copay)	every 12 months	every 12 months
PRESCRIPTION GLASSES		
LENSES covered in full (after \$10 copay) — Includes single vision, lined bifocal, lined trifocal lenses, and polycarbonate lenses for dependent children	every 24 months	every 12 months
OR		
CONTACT LENS allowance applied toward the cost of contacts.	\$105 every 24 months	\$130 every 12 months
FRAMES — Includes a frame of your choice	every 24 months \$105 allowance, 20% off balance over \$105	every 12 months \$120 allowance, 20% off balance over \$120

	Employee Only (Single Coverage)	Employee + Spouse (Two Party Coverage)	Employee + Dependent Children (Four Party Coverage)	Employee + Spouse + Dependent Children (Family Coverage)
Basic Option	\$5.16	\$8.28	\$8.44	\$13.58
Premium Option	\$7.98	\$12.78	\$13.04	\$21.00

LEGAL DISCLAIMER: Member will receive a 20% discount on items not covered by the plan at network Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Allowances are one-time use benefits; no remaining balance. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. The plan design is offered with the EyeMed Access panel of providers. Limitations and exclusions apply. Insured plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri except in New York. Fidelity Security Life Policy Number VC-19/VC-20 form number M-9083.

FLEXIBLE SPENDING ACCOUNTS (FSA)

(Elections are for the plan year: July 1, 2013 through June 30, 2014)

Flexible Spending Accounts (FSAs) offer you a way to save money on your health care and/or dependent care expenses. The money you deposit into the spending accounts is deducted from your paycheck in equal amounts throughout the year before Federal and State income and FICA taxes are withheld, and most people save at least 25% on each dollar that is set aside through the FSA program. The State of Nebraska offers you two flexible spending accounts: the Health Care FSA and the Dependent Care FSA. You must enroll each year to participate in the flexible spending accounts.

Important Facts about the Flexible Spending Accounts

- You can participate in either the Health Care FSA, the Dependent Care FSA or both programs.
- Use your health care account to pay for eligible expenses incurred from July 1, 2013 through June 30, 2014. You have until October 31, 2014 to file a claim for reimbursement.
- Under the Health Care FSA, you have a 2½ month grace period for incurring eligible expenses. That means you can be reimbursed for any expenses you incur through September 15, 2014, to access any remaining dollars from the 2013-2014 plan year.
- Use your dependent day care account to pay for eligible day care expenses incurred between July 1, 2013 through June 30, 2014. There is no carry-over (grace period) for dependent care claims.
- Estimate your expenses carefully — any money left in your account after all claims have been paid will be forfeited.
- Money cannot be transferred from the Health Care FSA to the Dependent Care FSA and vice versa.
- Effective January 1, 2011, you will be required to submit a prescription in order to get a tax break for any over-the-counter medications you purchase.
- You cannot set aside more than \$2,500 into your Health Care FSA each plan year.

Go Green!

You will also have the option to sign up for account notices to be sent through email and/or text messaging, and can also sign up to receive all reimbursements via direct deposit. If you are already enrolled to receive your FSA reimbursements through direct deposit, you do not have to complete any paperwork to continue using this convenient feature. Your direct deposit account information will stay the same year to year unless you request otherwise. If you are new to the FSA program, you will receive a check in the mail unless you sign up to receive reimbursements by direct deposit to a checking or savings account.

A direct deposit form will be included with your welcome packet. You can also find this form online at link.ne.gov and connect to Wellness and Benefits Resources then:

- Click on “Active Employees” then
- Click on “Flexible Spending Accounts.”

Health Care FSA

The Health Care FSA reimburses you for eligible out-of-pocket health care expenses not covered by any health, dental or vision care plan you may have. You can set aside up to \$2,500 per employee for the plan year (July 1, 2013 through June 30, 2014) in your Health Care FSA. The money you elect to contribute to the Health Care FSA is deposited into an account for you.

A new FSA vendor may be chosen subsequent to the distribution of this Options Guide. Please go to link.ne.gov under the Wellness and Benefits then:

- **Click on “Active Employees” then**
- **Click on “Flexible Spending Accounts” for updates.**

Eligible Health Care Expenses

Eligible expenses under the Health Care FSA include:

- Deductibles, copays and coinsurance for health care, prescription drugs, dental and vision care expenses
- LASIK eye surgery
- Over-the-counter-medications such as cough syrup, aspirin and allergy medications (if medically documented) with a doctor's prescription

Ineligible Health Care Expenses

The following expenses are not reimbursable under the Health Care FSA:

- Insurance premiums
- Cosmetic procedures (i.e., face lifts, teeth whitening, veneers)
- Clip-on or nonprescription sunglasses
- Toiletries
- Long-term care expenses
- Drugs, herbs or vitamins for general health and not used to treat a medical condition

Health Care FSA elections may not exceed \$2,500 per enrollee.

SAVE MONEY WITH AN FSA

Here's how you can save money when you use an FSA. As you can see, an employee who earns \$30,000 annually and uses the plan to cover \$1,500 in eligible expenses would save \$415 by using the FSA plan.

Let's assume...	With FSA	Without FSA
Annual Base Pay	\$30,000	\$30,000
Total Annual Contribution	\$1,500	\$0
Taxable Income	\$28,500	\$30,000
Federal Income Tax (20%)	\$5,700	\$6,000
Social Security (FICA) Tax (7.65%)	\$2,180	\$2,295
Total Tax	\$7,880	\$8,295
After-tax Eligible FSA Expenses	\$0	\$1,500
Take Home Pay	\$20,620	\$20,205
Annual Tax Savings	\$415	\$0

Dependent Care FSA

The Dependent Care FSA allows you to use tax free money to pay for eligible day care and before and after-school expenses for a child under age 13 or a disabled adult who lives with you at least eight hours a day and depends on you for support.

The maximum per pay period amount allowed for dependent day care expenses is: \$416.66 for employees paid on a monthly basis and, \$208.33 for employees paid a biweekly basis. This applies to elections made during the open enrollment period, new hires throughout the plan year and, any changes made because of a midyear qualified status change.

You are reimbursed up to the amount you have contributed at the time your claim is submitted. Amounts requested above your account balance will automatically be reimbursed as subsequent contributions from your paycheck become available.

Eligible Dependent Care Expenses

The following services are reimbursable under the Dependent Care FSA:

- Costs for care inside your home, but not for care provided by your spouse or dependent child under age 19
- Nonresidential dependent nursing or custodial care in your home for your elderly or disabled dependent who is unable to care for him or herself and lives with you at least eight hours a day
- Preschool provided in conjunction with day care at the same facility
- General purpose day camps

Ineligible Dependent Care Expenses

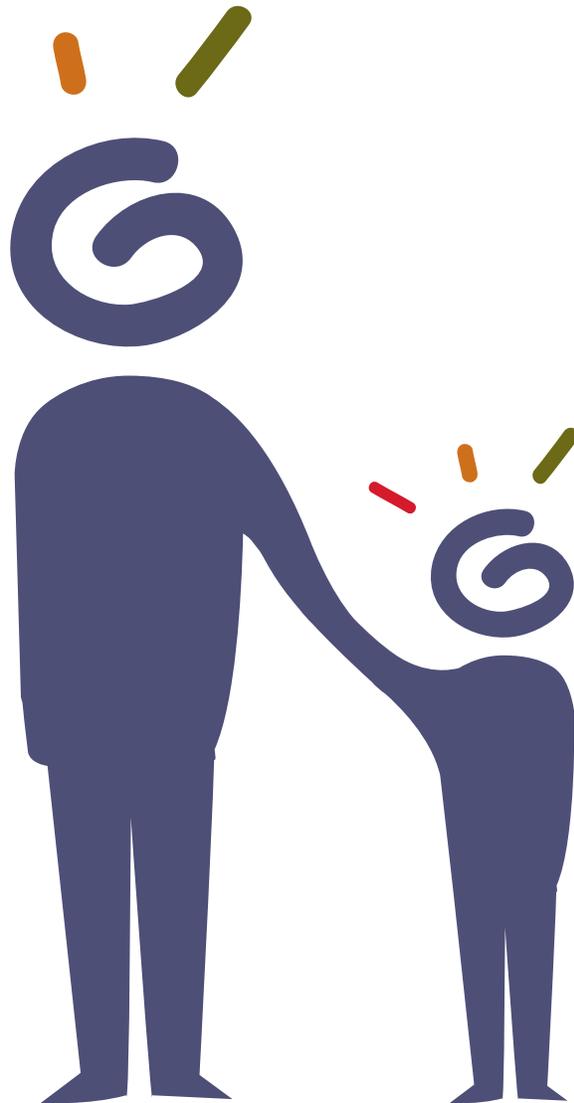
The following expenses cannot be reimbursed from your Dependent Care FSA:

- Care provided by someone you claim as a dependent on your federal income tax return
- Amounts you claim as a tax credit on your federal income tax return for the calendar year
- Overnight camp
- Transportation to and from your dependent care provider

Dependent Care FSA vs. Dependent Care Tax Credit

The money you contribute to the Dependent Care FSA reduces the amount of dependent care expenses you can claim on your federal income tax. You may want to talk with a tax professional to determine if the Dependent Care FSA or the federal tax credit provides you with the greatest savings.

Flexible Spending Accounts (FSA) (Elections are for the plan year: July 1, 2013 through June 30, 2014)



LONG-TERM DISABILITY BENEFITS

Long-Term Disability (LTD) provides a tax-free monthly income benefit if you become disabled and are unable to work due to illness or injury. This benefit provides financial protection when you need it most. After a careful and thorough review, a significant change has been made to the plans. As of July 1, 2013, LTD plans will offer a single benefit percentage rather than two benefit percentage options. The LTD benefit will be 60%, and this percentage will be in effect as of July 1, 2013. Should you need to use the LTD coverage, this benefit rate would remain the same throughout the life of your claim. As in previous years, you have the option to choose the length of the elimination period. The elimination period is the amount of time you must be continuously disabled prior to the benefits being payable. There are four choices for the elimination period; 2, 3, 6 or 9 months. LTD plans typically offer a single, fixed-benefit percentage and this change brings your plan more in line with the industry. In addition, this change will simplify your decision making process. Once you decide to enroll in the plan, your only decision will be to choose the length of the elimination period.

Employees currently enrolled in the LTD benefit will be required to choose an elimination period during Open Enrollment. For those currently enrolled in an LTD plan who do not make a choice during Open Enrollment, coverage will be waived. Those selecting a plan during Open Enrollment will not be required to submit evidence of insurability.

Employees not currently enrolled in an LTD plan also will have the one-time opportunity during this Open Enrollment period to select LTD coverage effective July 1, 2013, without supplying evidence of insurability.

Newly eligible employees who elect LTD coverage within their first 30 days of employment are not required to submit evidence of insurability. However, if coverage is not elected within the first 30 days of employment and the employee wishes to add coverage at a later date, coverage will not be in effect until the employee has provided evidence of insurability and been approved by the LTD carrier.

A new LTD vendor may be chosen subsequent to the distribution of this Options Guide. Please go to link.ne.gov under the Wellness and Benefits then:

- Click on "Active Employees" then
- Click on "Long-Term Disability" for updates.



Supplemental life and long-term disability plan rates are based on your age and salary as of July 1 of each year.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

AD&D insurance pays benefits if you die or suffer certain serious injuries as a result of an accident. AD&D insurance provides coverage on your life while you are employed by the State. The loss must occur within 90 days of the date of the accident, and you must be covered under the plan on the date of the accident. You pay the full cost of AD&D coverage at a rate of \$0.10 per month.

AD&D benefits are based on a *Principal Sum*, which is \$5,200.

The AD&D benefit is paid based upon the type of loss you suffer. The benefit for loss of life will be paid to your beneficiary and all other benefits will be paid to you.



Beneficiary Update: Open Enrollment is a good time to review your beneficiary elections for the life and AD&D insurance plans. Your beneficiary is the person or persons who will receive benefits if you die. Any amount for which a beneficiary is not named will be paid to your estate. If you elect coverage for your spouse or dependent children, you are automatically the beneficiary.

LIFE INSURANCE BENEFITS

Life insurance provides important financial protection for your family in the event of your death. Whether single or raising a family, you should examine your lifestyle and consider what level of protection is appropriate based on your financial and family obligations.

The State of Nebraska provides you with basic life insurance coverage at no cost to you. You decide if you want additional life coverage for yourself, your spouse and your dependents. Benefits are provided by Aetna.

Basic Life Insurance

The State provides eligible full-time employees with a basic life insurance benefit of \$20,000 at no cost and to eligible part-time employees for a minimal monthly charge.

During Open Enrollment Only

If you are currently enrolled in supplemental life insurance coverage, YOU MAY INCREASE YOUR COVERAGE LEVEL BY ONE INCREMENT WITHOUT PROVIDING EVIDENCE OF INSURABILITY.

Supplemental Employee Life Insurance

You may elect to purchase additional life insurance coverage for yourself. You pay the entire cost for supplemental life insurance. You may purchase one supplemental life plan for yourself in amounts .5, one, one and a half, two, three, four or five times your annual salary.

Amounts will be rounded to the next highest \$1,000. Newly hired employees may elect any supplemental coverage amount within the first 30 days of employment without having to provide evidence of insurability.

MONTHLY RATES FOR SUPPLEMENT LIFE COVERAGE BASED UPON YOUR AGE:

Age	Rate/\$1,000	Age	Rate/\$1,000
Under 25	\$0.024	55-59	\$0.381
25-29	\$0.024	60-64	\$0.729
30-34	\$0.032	65-69	\$1.191
35-39	\$0.049	70-74	\$1.620
40-44	\$0.073	75-79	\$3.677
45-49	\$0.105	80 and over	\$7.444
50-54	\$0.178		

Optional Dependent Life

You may also purchase optional life insurance for your spouse and dependent children. If both husband and wife are employed by the State, only one may cover the children on the State's dependent life coverage. They cannot elect dependent life coverage on each other. There are two dependent life options to choose from; a high and a low option; click on the Aetna link found online at link.ne.gov and connect to Wellness and Benefits Resources then:

- Click on "Active Employees" then
- Click on "Life Insurance."

OPTION 1 (LOW OPTION)

For your spouse \$5,000

For your dependent(s) to age 26 \$5,000

Monthly rates

Per family \$1.54

Dependent age 70 or older \$4.10

OPTION 2 (HIGH OPTION)

For your spouse \$10,000

For your dependent(s) to age 26 \$10,000

Monthly rates

Per family \$3.00

Dependent age 70 or older \$8.22



Supplemental life and long-term disability plan rates are based on your age and salary as of July 1 of each year.

Evidence of Insurability (EOI) is a statement or proof of a person's physical condition. Any increase to your supplemental life coverage that is more than a one increment increase during this Open Enrollment period will require EOI. Rates for coverage can be found online at link.ne.gov and connect to Wellness and Benefits Resources.



COUNSELING SERVICES - YOUR EAP

The Employee Assistance Program (EAP), offers free, confidential counseling and referral services to help you and your family deal with issues that may be affecting your job performance or personal well-being. Counselors are trained to help with such issues as:

- marital or relationship concerns
- family or parent challenges
- stress
- substance abuse
- grief / depression

Not all State agencies have elected to provide EAP coverage for their employees. Please contact your agency Human Resource office to determine whether your agency is participating in the EAP.

When you contact the EAP, you'll speak with a specialist who can help identify the issue, determine the most suitable type of assistance and work with you on a course of action. The EAP is available 24 hours a day, seven days a week. All consultations and counseling are completely confidential.

Why is Asking for Help So Difficult?

You may be afraid of looking weak, needy or incompetent; however, stalling can let a situation grow from a problem into a crisis. Asking for assistance during a personal or professional challenge shows good judgment. The EAP provider is available to support you through difficult situations.

A new EAP vendor may be chosen subsequent to the distribution of this Options Guide. Please go to [link.ne.gov](#) under the Wellness and Benefits then:

- Click on "Active Employees" then
- Click on "Employee Assistance Program" for updates.

CONTINUING YOUR COVERAGE - COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the State of Nebraska's benefit plans ends, you and/or your eligible dependents may be eligible to continue your health, dental, vision, EAP and health flex benefits at your own expense for a temporary period of time. To be eligible, a qualifying event causing the loss of coverage must take place. The date that event occurs determines your eligibility status. Your existing coverage is always carried to the end of the month in which the qualifying event occurs as long as the entire monthly premium has been paid.

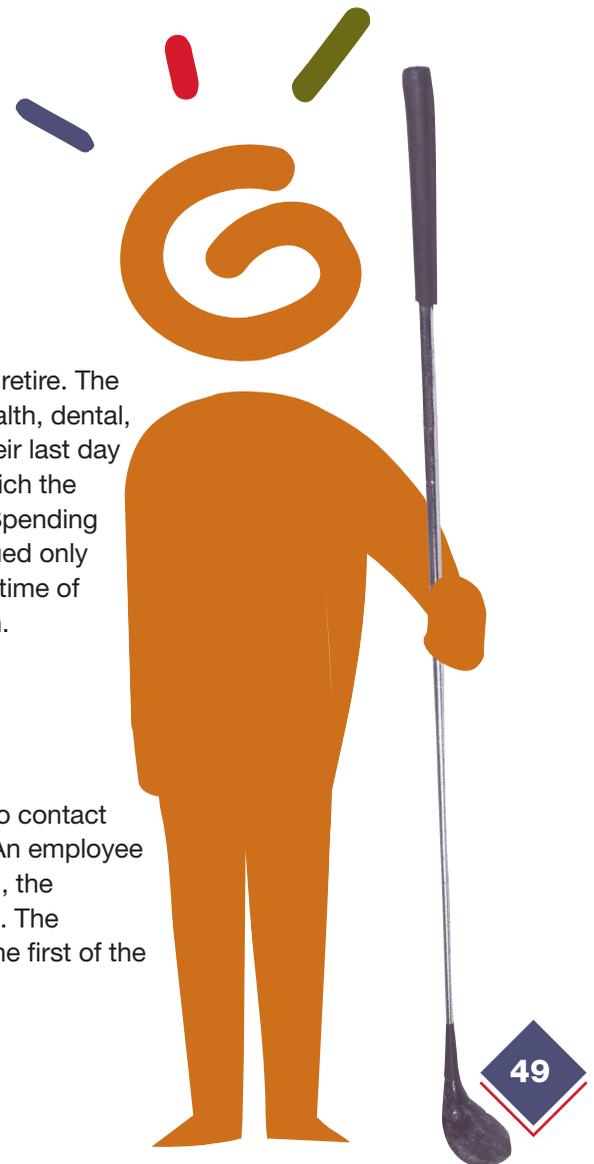
A qualifying event may be an employee's termination, a divorce or a dependent child is no longer eligible. For a complete list of qualifying events, who may continue coverage and the maximum period of continuation, please refer to your summary plan description (SPD) or contact State Employee Wellness and Benefits at **402-471-4443** in Lincoln or at **877-721-2228** outside of Lincoln.

RETIREES EARLY RETIREES PROGRAM

This program was created for State employees who meet the qualifications to retire. The program allows a retiree, at his or her own expense, the option to continue health, dental, vision and EAP coverage if he or she was actively enrolled in the benefit on their last day of employment. Coverage may be continued up to the first of the month in which the employee reaches age 65. If the employee is enrolled in the Medical Flexible Spending Account program on the last day of employment, participation may be continued only through the remainder of the current plan year. Retirees age 65 or older at the time of Retirement and their spouse will be offered 18 months of COBRA continuation.

Disability Retirement

An employee under age 55 may retire as a result of a disability. You will need to contact the Nebraska Public Employees Retirement System on how to apply for this. An employee who chooses this option must first elect COBRA and once he/she is approved, the Retirement System will notify the State Employee Wellness and Benefits office. The individual's coverage will be converted to the Early Retiree Health plan up to the first of the month in which the employee reaches age 65.



TIME TO ENROLL

Open Enrollment



BEGINS:

**Tuesday, May 14, 2013
at 7:00 a.m. C.D.T.**



ENDS:

**Tuesday, May 28, 2013
at 5:00 p.m. C.D.T.**

**All enrollment elections
will be done online
through the
Employee Work Center
at link.ne.gov**

Before you enroll, consider this checklist of items:

- ✓ Read this guide
- ✓ Keep in mind that the elections you make are in effect from July 1, 2013 through June 30, 2014
- ✓ Become familiar with your benefit options
- ✓ Talk to your family and share benefit decisions
- ✓ Gather the Social Security numbers of all of your enrolled dependents
- ✓ Get questions answered through vendor telephone numbers and websites (see back cover)
- ✓ View Open Enrollment informational meeting located on the Wellness and Benefits website

**System requirements to access
the Employee Work Center:**

- ✓ Adobe Flash Player of at least 10.1.53
- ✓ Internet Explorer version 7.0 or later
- ✓ Firefox 3.5



Contact Information

Here are resources to contact if you have questions about your coverage options.

FOR MORE INFORMATION ABOUT...	CALL ...	OR GO TO...
Health Plans UnitedHealthcare	1-877-263-0911	link.ne.gov and connect to Wellness and Benefits Resources
Prescription Drug Plan and Specialty Pharmacy OptumRx™	1-877-263-0911	
Dental Plan Ameritas	1-800-487-5553	
Vision Plan EyeMed Vision Care	1-877-861-3459	
EAP	See link.ne.gov	
Flexible Spending Accounts	See link.ne.gov	
Life and AD&D Insurance Plans Aetna	1-800-523-5065 (Claims Questions)	
Long-Term Disability	See link.ne.gov	
Wellness Provider HealthFitness	1-866-956-4285	
Nebraska State Employee Wellness and Benefits	402-471-4443 (in Lincoln) 1-877-721-2228 (outside Lincoln)	

