

Guide to Your
**2014-2015 State
Wellness & Benefits Programs**
COBRA & Retirees

Welcome

Dear State Employee,

Welcome to the State of Nebraska's 2014-15 Options Guide. Please use this as a resource to review the many benefit options available to you and to select those that best meet the needs of you and your family.

This guide is meant to assist new hires, newly benefit-eligible employees and current employees going through the Open Enrollment process in making health benefit decisions. Specific information is provided about eligibility and enrollment requirements and deadlines. It is important that you pay attention to all time frames and meet the deadlines referenced throughout this guide. They are strict, including those associated with qualifying for the State's Wellness Health Plan.

The State offers a Wellness Health Plan along with a wellness program. As in the past, there is a three-step process for current employees to complete in order to be eligible for the Wellness Health Plan. Make sure to take notice that Step 1 enrollment requirements have changed and the timing of Steps 2 and 3 are new.

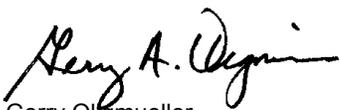
I hope you have taken the opportunity to spend time on the new and improved wellNEssoptions website, www.wellnessoptions.nebraska.gov. It is easy to navigate and provides several different resources to help you 'make the moves that matter.' No matter what health plan you choose, incorporating wellness activities such as walking, drinking water, and eating more fruits and vegetables into your daily routine is an investment in your future. These wellness efforts not only help you live healthier and longer, but also help you and the State save money on health care.

Over the last several years the expenses associated with health care have significantly increased resulting in higher premiums for many public and private sector employees across the country. The State of Nebraska has been able to manage much of these increases through plan designs, adopting a culture of wellness, utilizing tools provided by our health care administrator and other efforts. We will continue to do so; however, the pace at which changes can be made to offset premium increases may not always be able to keep up with rising health care costs, utilization and other factors. Each year we look for new and innovative measures to help employees and the State control costs.

This year, for the first time, we are pleased to be able to offer the Consumer Focused Health Plan and the opportunity for employees to open a Health Savings Account (HSA). This new health plan has many exciting features and those features, along with the HSA, are discussed in more detail later in this guide. We believe many employees will find this new option appealing as they look for new ways to manage health care costs and meet their individual needs.

Health insurance is important. Please take the time to read and understand this Options Guide as you make decisions that impact you and your family. If you have questions, do not hesitate to call an Employee Wellness & Benefits Specialist at 402-471-4443 or 877-721-2228.

Best Wishes for a Healthy 2014-15,



Gerry Olfmueller
Acting Director
Department of Administrative Services

Contact Information:

Employee Wellness & Benefits
1526 K Street, Suite 110
Lincoln, NE 68508

402-471-4443
877-721-2228

as.employeebenefits@nebraska.gov

OFFICE HOURS:
Monday - Friday
8:00 a.m. to 5:00 p.m.

Table of Contents & Contact Information

Open Enrollment	5	Employee Wellness & Benefits 402-471-4443 - Lincoln 877-721-2228 - outside Lincoln as.employeebenefits@nebraska.gov link.nebraska.gov
Changes for 2014-15 Benefits	6	
Open Enrollment - COBRA	7	
Open Enrollment - Retirees	8	
About Your Benefits	9	

Wellness & Benefits Programs

Contact Information:

wellNEssoptions	11	HealthFitness 866-956-4285 www.wellnessoptions.nebraska.gov
Medical	15	UnitedHealthcare 877-263-0911 www.myUHC.com
Health Savings Account	21	Optum Bank 866-234-8913 www.optumbank.com
Pharmacy	23	OptumRx 877-263-0911 www.myUHC.com
Vision	29	EyeMed Vision Care 877-861-3459 www.eyemedvisioncare.com
Dental	30	Ameritas 800-487-5553 www.ameritasgroup.com
Employee Assistance Program (EAP)	32	Deer Oaks EAP 866-792-3616 www.deeroaks.com Login/Password: SON
Legal Notifications	33	Employee Wellness & Benefits 402-471-4443 - Lincoln link.nebraska.gov 877-721-2228 - outside Lincoln

IMPORTANT INFORMATION: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official documents. If there are any inconsistencies between this summary and the official plan documents, the plan document will prevail. Please refer to the summary plan documents found on Employee Wellness & Benefits website under link.nebraska.gov for exact benefits, exclusions and limitations.

Open Enrollment - COBRA Participants & Retirees

BEGINS: Tuesday, May 13, 2014 at 7:00 a.m. CST

ENDS: Tuesday, May 27, 2014 at 5:00 p.m. CST

TAKE ACTION!
Your coverage for health, dental and vision will end on June 30, 2014, unless you take action during Open Enrollment.

Open Enrollment To-Do List

- ✓ Read this Options Guide
- ✓ Complete Open Enrollment Form for Retirees/COBRA
- Return Form to Employee Wellness & Benefits
DUE BY Tuesday, May 27, 2014. Must be received by 5:00 p.m. or postmarked by May 27, 2014.

Questions?

Both COBRA and the State's Early Retiree Program are administered by Employee Wellness & Benefits. If you have questions, please contact Employee Wellness & Benefits at 402-471-4443 in Lincoln or at 877-721-2228 outside of Lincoln.

Qualifying for 2014-15 Wellness Health Plan

To enroll in the Wellness Health Plan, you and your spouse (if enrolled) will need to complete the three (3) required steps:

- Step 1** Must have completed wellness program by March 28, 2014.
- Step 2** Complete a biometric health screening between April 1 – May 31, 2014.
- Step 3** Complete the online health assessment between April 1 – May 31, 2014.

Looking ahead!

Qualifying for 2015-16 Wellness Health Plan

You and your spouse (if enrolled) will need to complete the three (3) required steps to enroll in the Wellness Health Plan during Open Enrollment for plan year 2015-16 beginning July 1, 2015:

- Step 1** Complete a biometric health screening between April 1 – May 31, 2014.
- Step 2** Complete the online health assessment between April 1 – May 31, 2014.
- Step 3** Enroll in your choice of wellness programs by November 20, 2014. **Complete your wellness program by March 31, 2015.**

Changes for the 2014-15 Plan Year

All Health Plans

- New premiums.
- In compliance with the Affordable Care Act, medical copays are applied to annual out-of-pocket maximum. Pharmacy copays are NOT included in this change.
- "Annual Out-of-Pocket Maximum" includes Deductible, Coinsurance, and Medical copays.
- Added coverage for hearing aids and hearing exam with a \$1,500 limit, every three years.
- Added coverage for surgical stockings under durable medical equipment.
- Added office copay for outpatient behavioral health.

NEW Plan – Consumer Focused Health Plan (Health Savings Account eligible)

- Preventive Pharmacy Drug Listing offering \$0 copay on Tier 1.
- Participants may contribute to HSA, if eligible.

NEW – Health Savings Account (HSA)

- Must be enrolled in NEW Consumer Focused Health Plan.
See page 23 of this Options Guide for more details.

Wellness Health Plan

- In-network deductible is \$600 individual and \$1,200 family.
- Out-of-network deductible is \$800 individual and \$1,600 family.
- In-network maximum coinsurance and medical copays are \$1,700 individual and \$3,400 family.
- Out-of-network maximum coinsurance and medical copays are \$3,700 individual and \$5,300 family.
- In-network annual out-of-pocket maximum is \$2,300 individual and \$4,600 family.
- Out-of-network annual out-of-pocket maximum is \$4,500 individual and \$6,900 family.
- Outpatient behavioral health services change from deductible and coinsurance to \$25 copay.

Choice Health Plan

- **Plan not offered for 2014-15.**

Regular Health Plan

- In-network maximum coinsurance and medical copays are \$2,800 individual and \$5,600 family.
- Out-of-network maximum coinsurance and medical copays are \$5,000 individual and \$10,000 family.
- In-network annual out-of-pocket maximum is \$3,600 individual and \$7,200 family.

- Out-of-network annual out-of-pocket maximum is \$6,200 individual and \$12,400 family.
- Outpatient behavioral health services will change from deductible and coinsurance to \$30 copay.
- Out-of-network coinsurance paid by participant will be 40%.
- Routine vision exam for children under age 5 no longer covered.

High Deductible Health Plan (HDHP)

- Plan will no longer be offered after **June 30, 2015**.
- In-network deductible is \$1,500 individual and \$3,000 family.
- Out-of-network deductible is \$3,000 individual and \$6,000 family.
- In-network maximum coinsurance and medical copays are \$3,000 individual and \$6,000 family.
- Out-of-network maximum coinsurance and medical copays are \$6,000 individual and \$12,000 family.
- In-network annual out-of-pocket maximum is \$4,500 individual and \$9,000 family.
- Out-of-network annual out-of-pocket maximum is \$9,000 individual and \$18,000 family.
- Outpatient behavioral health services change from deductible and coinsurance to \$30 copay.
- Routine vision exam for children under age 5 no longer covered.

wellNESSoptions Wellness Program

- New logo and improved website starting April 1, 2014.
- All new hires and newly eligible Wellness Health Plan participants must complete online health assessment within 30 days after coverage begins to stay on Wellness Health Plan.
- EMPOWERED Lifestyle Coaching – Meet 8 goals per year to qualify for Wellness Health Plan.
- EMPOWERED Condition Management Coaching – Meet 8 goals per year to qualify for Wellness Health Plan.
- Walk This Way – Walk 900,000 steps to qualify for the Wellness Health Plan.
- Cardio Log – Record 60 qualifying workouts on your HealthFitness account.

Dental Plan

- New premiums for Basic and Premium Plans.
- Premium plan - New out-of-network coinsurance design for Preventive and Basic services.

Open Enrollment - COBRA Participants

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and their qualified beneficiaries the opportunity to continue certain health benefits on the State of Nebraska's Employee Wellness & Benefits program when a "qualifying event" results in the loss of eligibility. Through COBRA, you are able to continue coverage for your health, dental, vision, employee assistance program (EAP), and health care flexible spending account (FSA) you are actively enrolled in on your last day of employment. You can only continue the health care FSA plan on COBRA during the plan year of your COBRA qualifying event.

The choices you make during Open Enrollment take effect on July 1, 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 – See page 10 of this Options guide.

All COBRA participants must re-enroll in health, dental, and vision insurance during Open Enrollment to have coverage for the new plan year. During Open Enrollment you may not add benefit plans (health, dental, vision) not currently in effect.



Have Questions?

Contact Employee
Wellness & Benefits at
402-471-4443
877-721-2228
as.employeebenefits@
nebraska.gov

COBRA Open Enrollment To-Do List

- | | |
|----------|--|
| ✓ Health | Elect or waive a plan - Wellness*, Regular, HDHP, Consumer Focused Health Plan |
| ✓ Dental | Elect or waive a plan - Basic or Premium Option |
| ✓ Vision | Elect or waive a plan – Basic or Premium Option |
| ✓ EAP | Elect or waive |

*2014-15 Wellness Health Plan Qualifications

- Must have completed wellness program by March 28, 2014.
- Complete your biometric health screening and online health assessment between April 1 – May 31, 2014.

Your COBRA coverage continues until:

- The end of the month in which you voluntarily end your COBRA coverage.
- You have reached the maximum length of COBRA as communicated in your original COBRA letter.
- Your monthly premium payments are not paid on a timely basis.
- You become entitled to Medicare benefits after electing COBRA coverage.
- You become covered under another group health plan after electing COBRA coverage.

It is imperative that you notify Employee Wellness & Benefits if there is a change in your marital status and or your dependent child is no longer eligible for coverage under our plan.

Open Enrollment – Early Retiree Program

This program was created for State employees who meet the qualifications to retire. The program allows a retiree, at your own expense, the option to continue to participate in the State's health, dental, vision, and EAP coverage you are actively enrolled in on your last day of employment. If you are enrolled in the health care FSA, you may continue only through the remainder of the current plan year.

The choices you make during Open Enrollment begin on July 1, 2014 and remain in effect until June 30, 2015 or until you no longer qualify for the Early Retiree Program. You can make limited changes at other times during the year only as a result of a qualifying event as defined by the IRS – See page 10 of this Options Guide.

All retirees must re-enroll in health, dental, and vision insurance during Open Enrollment to have coverage for the new plan year.

During Open Enrollment you may not add dependents or benefit plans (health, dental, vision) not currently in effect.

Retiree Open Enrollment To-Do List

- ✓ **Health** Elect or waive a plan - Wellness*, Regular, HDHP, Consumer Focused Health Plan
- ✓ **Dental** Elect or waive a plan - Basic or Premium Option
- ✓ **Vision** Elect or waive a plan – Basic or Premium Option
- ✓ **EAP** Elect or waive coverage

If you drop a dependent during Open Enrollment, you can only re-add the dependent if you have a qualifying life event.

If you drop coverage (health, dental, or vision), you cannot re-add the coverage at a later date.

*2014-15 Wellness Health Plan Qualifications

- Must have completed wellness program by March 28, 2014.
- Complete your biometric health screening and online health assessment between April 1 – May 31, 2014.

When does Retiree coverage end?

- Coverage may be continued up to the first of the month in which the employee reaches age 65.
- If your family member turns age 65 before you, your dependent is ineligible to continue coverage through the retiree program.

Medicare

If you become entitled to Medicare Part A or Part B prior to age of 65, you can stay on the retiree program until the first of the month of your 65th birthday. However, you will need to notify Employee Wellness & Benefits of your entitlement date so coordination of benefits with the health insurance company will take place without any interruption to your medical service payments.

Disability Retirement

If you are under age 55, you may retire as a result of disability. You will need to contact the Nebraska Public Employees Retirement System (NPERS) to apply for retirement. You will first elect COBRA and, upon approval, NPERS will notify Employee Wellness & Benefits. Your coverage will be converted to the Early Retiree Program and you may continue up to the first of the month of your 65th birthday.



Have Questions?

Contact Employee Wellness & Benefits at 402-471-4443
877-721-2228
as.employeebenefits@nebraska.gov

About Your Benefits

Employee Wellness & Benefits is responsible for the administration of the benefit and wellness programs described within this Options Guide, COBRA and Early Retiree Program.

Understanding your benefit options and making the right decisions are important steps for you and your family. Please review the content carefully and refer to our website found at link.nebraska.gov, Wellness & Benefits Resources, for additional information.

If you require additional assistance, please contact Employee Wellness & Benefits at 402-471-4443 or 877-721-2228 or email as.employeebenefits@nebraska.gov.

~ Your Wellness & Benefits Team

Benefit Plan Eligibility & Enrollment



Contact Employee Wellness & Benefits

Employee Wellness & Benefits is available to assist you with your benefit questions.

Office hours:	Monday - Friday 8:00 a.m. to 5:00 p.m.
Phone:	402-471-4443 or 877-721-2228
Email:	as.employeebenefits@nebraska.gov
Location:	Administrative Services 1526 K Street, Suite 110 Lincoln, NE 68508
Website:	link.nebraska.gov go to Wellness & Benefits Resources

Dependent Eligibility:

- **Legal Spouse**, as a result of a marriage that is valid and recognized by State of Nebraska law.*
- **Children** up to age 26, including:
 - Natural child
 - Step child, if enrolled in Family coverage
 - Legally adopted child
 - Child placed with you for adoption
 - Child, or grandchild, for whom you have legal custody, legal guardianship or court ordered custody
- **Child over 26**, if disabled and dependent upon you for support
 - Child must be disabled prior to age 26
 - Child must be covered on the State health plan upon attaining age 26

*Only marriage between a man and a woman shall be valid or recognized in Nebraska, per Article I-29 of the Nebraska State Constitution.

Dependent (Spouse & Children) Eligibility Verification Process

The State contracts with UnitedHealthcare and Aon Hewitt to verify eligibility of all new dependents added to the State's health insurance plans. This process is necessary to ensure only eligible dependents are enrolled in State plans.

You will receive a request by U.S. Mail from Aon Hewitt to submit requested documentation to Aon Hewitt in order to verify that all newly added dependents meet the definition of an eligible dependent.

Failure to respond and provide the requested documentation by the stated deadline will result in loss of coverage for your dependent(s) and may result in disciplinary action up to and including termination of employment.

Making Changes to Your Elections

Qualifying Life Events

You have 30 days, including the qualifying event date, to notify Employee Wellness & Benefits of a qualifying event. Documentation of the status change must be provided before the change will be approved.

If adding coverage, the effective date of the change is the first day of the month following the qualifying event unless noted below. If you are removing coverage, coverage will continue until the last day of the month and premiums will be collected accordingly. No refunds or retroactive terminations will be allowed.

Qualifying life events include:

- Change in legal marital status, including marriage, death of spouse, divorce or legal separation.
- Change in participant's number of dependents including birth, adoption of a child, or death.
 - For birth or adoption, effective date of the change is the child's date of birth or adoption.
- Dependent child reaches age 26.
- Spouse's change in employment status results in a gain or loss of coverage.
- Employee's change in employment status resulting in gain or loss of benefit eligibility, including an unpaid leave of absence.
- Employee's change in employment status resulting in an increase or decrease of 10 hours or more per week. A status change of less than 10 hours does not qualify.
- A change corresponding with a spouse's open enrollment period at his or her place of employment.
- Newly eligible for Medicare coverage.
- Gain or loss of coverage under a State Medicaid or CHIP program (you have 60 days to notify State).

Newborn Child

Under State Statute 44-710.19, all newborns receive 31 days of automatic coverage and the state does not collect premiums for the newborn for the first 31 days. For coverage to continue after the first 31 days, you must contact Employee Wellness & Benefits within 30 calendar days of the child's birth. **If a request is not submitted within 30 days of the child's birth, coverage ends at the end of the 31 days and the child cannot be added to your health plan until the next Open Enrollment period.**

To be in compliance with HIPAA, all adopted children, regardless of age, must be enrolled using the same process as described above for newborns and coverage becomes effective on the date of placement.

Legal Divorce

In the State of Nebraska, your divorce is considered final six months after the decree is rendered. Any requests to change your coverage due to the divorce will be effective on the first day of the month following the six-month waiting period.

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 and a certificate of creditable coverage. Your ex-spouse is not eligible to continue 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 HR representative.

Rehires

If you leave employment with the State of Nebraska, and return to a benefit-eligible position within 30 days, you will be required to enroll in the same benefit plans and tiers you had on your last day of employment. The waiting period is waived and coverage will begin first day of the month following your rehire date.

If you are rehired after 30 days, you will follow the same guidelines as a new hire. You will have to re-elect your benefit plans and coverage will begin the first day of the month following the 30 day waiting period before enrolling in coverage.

Rehires are NOT eligible to participate in the State's Flexible Spending Accounts (Medical or Dependent Care) until Open Enrollment for the following Plan Year (July 1).

For more information, contact your agency HR representative.

Wellness

Benefits are provided by HealthFitness™

The State of Nebraska wellness program, **wellNEssoptions**, launched in 2009 and has become integral in our efforts to:

1. Create a healthier workforce by encouraging healthy behaviors and the use of preventive care benefits.
2. Control health care costs.

Confidentiality is a Top Priority

Privacy of personal information is our top priority. HealthFitness™ maintains the confidentiality of all personal health information in accordance with federal regulations. This means your personal health information, which is obtained by HealthFitness™, will not be released to the State of Nebraska, except in aggregate form.

Eligibility & Participation

All employees and spouses enrolled in a State of Nebraska health plan can participate in **wellNEssoptions**.

To Get Started

Approximately 10 days after your health plan coverage begins, you and your spouse (if enrolled) will receive a welcome letter from HealthFitness with information about the **wellNEssoptions** program and how to register on www.wellnessoptions.nebraska.gov. On the **wellNEssoptions** website, you can register for your biometric health screening (April-May), complete your online health assessment, and enroll in a wellness program designed to help you achieve and maintain a healthy lifestyle.



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

Wellness Incentives

Employees and spouses who complete three simple steps each year are eligible to enroll in the Wellness Health Plan.

Wellness Health Plan Advantages

- Plan with lowest deductible and annual out-of-pocket maximums
- All blood work (including preventive) is covered up to \$500
- No age restrictions for preventive screenings
- Thyroid testing
- Bone density testing (no age restriction)
- 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
- Diabetic prescriptions at a reduced copay
- Hemoglobin A1C testing twice per year
- Routine prostate cancer screening
- Vision exam with a copay

Follow Your Progress Online

Track the completion of your progress at www.wellnessoptions.nebraska.gov. After you register and set up your personal settings, you can review your progress on your Rewards tab located in your [wellNESSoptions](#) website account.

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 answers or biometric screening results. This 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. 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 health plan is committed to helping you achieve your best health. Incentives for participating in the [wellNESSoptions](#) program are available to all employees. If you think you may be unable to meet a requirement under the [wellNESSoptions](#) program, you may qualify in a different manner. Please contact a Wellness Specialist at 402-471-4110 or 402-471-4703 and we will work with you and with your doctor to find a wellness program that is right for you in light of your health status.

2014-15 Wellness Health Plan Premium Savings

Plan Name	Single	Two-Party	Four-Party	Family
Regular Health Plan	\$1,394.64	\$3,695.76	\$2,858.88	\$4,950.72
Wellness Health Plan	\$1,162.80	\$3,081.60	\$2,383.92	\$4,128.24
You Save:	\$231.84	\$614.16	\$474.96	\$822.48



**Make
the Moves
that Matter**
...for a long and healthy life

2015-16 Wellness Plan Qualifications

The following confidential programs are available to all those enrolled in any of the State of Nebraska health plans. However, to qualify for enrollment into the Wellness Health Plan, BOTH the enrolled employee AND covered spouse (if applicable) must complete all 3 STEPS on an annual basis.

- Step 1 Complete an Annual Biometric Health Screening**
Three confidential options available April 1 – May 31, 2014.
- Step 2 Complete the Annual Online health assessment**
The confidential online questionnaire must be completed between April 1 – May 31, 2014.
- Step 3 Enroll and Complete a Wellness Program**
Enroll and begin your choice of at least one of the following confidential wellness programs between April 1 – November 20, 2014. Complete program by March 31, 2015.

Wellness Programs

Personalized Lifestyle Program

- Self-directed digital coaching program
- Complete the enrollment consultation, 30-day and 90-day check-in surveys

Cardio Tracker

- Maintain or improve your health by being physically active
- Log 60 workouts of at least 30 minutes per day; one credit given per day

Walk This Way®

- Boost your activity level by wearing a pedometer and tracking your steps
- Log a minimum of 900,000 steps online

EMPOWERED Coaching™: Lifestyle Management

- Work with a Wellness program coach to support and guide you in making lifestyle changes
- Complete 8 or more goals with your coach

EMPOWERED Coaching™: Condition Management

- Manage a chronic health condition with help from a health coach
- Complete 8 or more goals with your coach

Wellness Program Results

Congratulations Wellness Program Participants!

Over 7,600 employees and spouses participated in **wellNEssoptions** health screenings and health risk assessments offered during April and May 2013. Employees and spouses who participated in wellness for the past four years saw their number of health risks reduce from an average of 1.70 to 1.53 (see chart below).

Below are other indicators that show how our health and wellness programs are improving the lives of State of Nebraska employees through preventive check-ups, screenings, and increased activity levels:

- 154 participants quit using tobacco
- 74% now exercise 3+ days per week
- 80% now consume 3+ fruits and vegetables a day
- Over 200,000 cardio log activities submitted
- Participants walked over 6 billion steps
- High Blood Pressure - 783 cases diagnosed
- High Cholesterol - 964 cases diagnosed
- Colorectal screenings detected 626 cases of benign polyps
- Cervical screenings detected 117 cases of pre-cancerous lesions
- Breast exams detected 9 cases of early stage cancer

A Culture of Health & Wellness

As a result of our wellness program efforts and outcomes, the State of Nebraska is among the leaders across the country in wellness. The State's **wellNEssoptions** program has received several prestigious national awards including the 2010 and 2012 Gold Well Workplace by the Wellness Council of America, the Innovations Award from The Council of State Governments, and the coveted 2012 C. Everett Koop National Health Award.

Wellness Champions

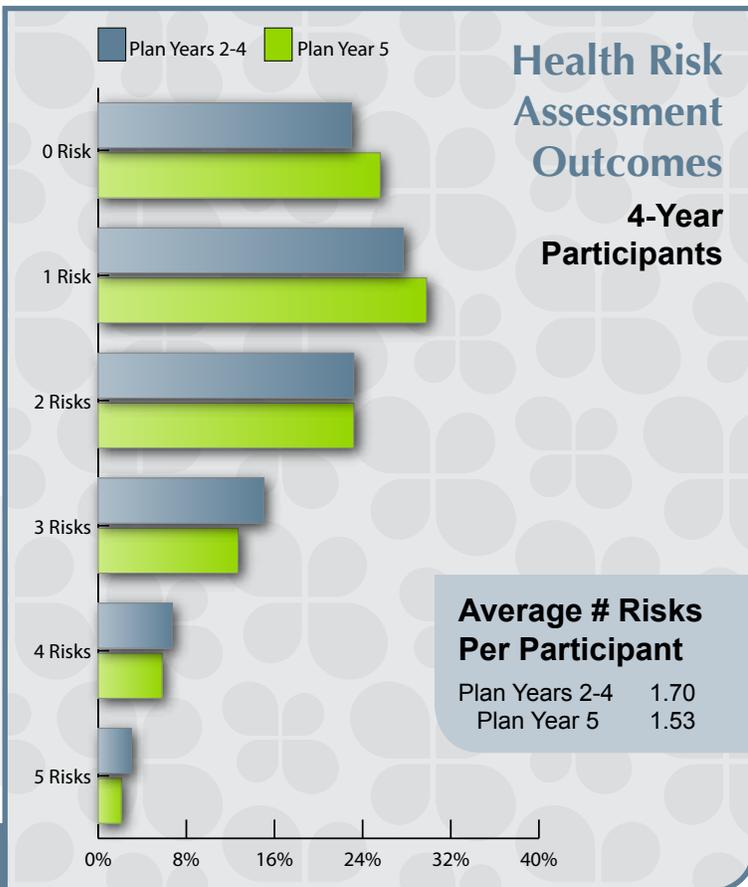
Employee Wellness & Benefits partners with Wellness Champions from several agencies across the state to provide feedback and help with promoting and supporting a culture of wellness. There are over 140 volunteers who serve as State of Nebraska Wellness Champions! Wellness Champions encourage their co-workers to adopt healthy behaviors in order to positively impact their quality of life. They are also instrumental in providing input on 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 within your work area, speak with a Wellness & Benefits Specialist on the Employee Wellness & Benefits team.

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.

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 Awards Banquet. The Wall of Fame recipients, State of Nebraska Agency Wellness Champions, and Agency Directors (for those agencies with objective measures of health improvements, high wellness program participation percentage and participation growth) are recognized each year at the banquet.



Health Insurance

Benefits are administered by UnitedHealthcare (UHC)

The State of Nebraska offers you a comprehensive health insurance program which includes both medical and pharmacy benefits. Health insurance premiums include both medical and pharmacy benefits.

You have four great plans to choose from. All four health plan options are administered by UnitedHealthcare and includes both in-network and out-of-network coverage. If you change plans, UHC will send you a new insurance ID Card.

- Wellness Health Plan
- **NEW for 2014-15** Consumer Focused Health Plan (with Health Savings Account Eligibility)
- Regular Plan
- High Deductible Health Plan (HDHP) – **Ending June 30, 2015**

Qualifying for the 2014-15 Wellness Health Plan

To enroll in the Wellness Health Plan, you and your spouse (if enrolled in State Health Plan) will need to complete the 3 required steps:

- Step 1** Completed wellness program by March 28, 2014.
- Step 2** Complete a biometric health screening between April 1 - May 31, 2014.
- Step 3** Complete the online health assessment between April 1 - May 31, 2014.

Qualifying for the 2015-16 Wellness Health Plan

See Wellness for more details

You and your spouse (if enrolled on a State health plan) must complete the following steps to enroll in the Wellness Health Plan during Open Enrollment for plan year 2015-16 beginning July 1, 2015:

- Step 1** Complete a biometric health screening between April 1 – May 31, 2014.
- Step 2** Complete the online health assessment between April 1 – May 31, 2014.
- Step 3** Enroll in your choice of four wellness programs by November 20, 2014. Complete your wellness program by March 31, 2015.

Navigating your Health Insurance

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.

Find a Doctor or Hospital

UnitedHealthcare is continuously evaluating, contracting and managing providers in their network to ensure it meets the needs of the State of Nebraska. To locate a provider:

- Visit link.nebraska.gov; link to Employee Wellness & Benefits Resources.
- Or go to www.myuhc.com. For all State health plans, choose the UnitedHealthcare Choice Plus network.

Difference between a Primary and a Specialty Physician

PRIMARY PHYSICIAN: A 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.

Understanding health care costs before you see the doctor is easy, just remember the 4Ps

- Procedure** – Learn and compare treatment options
- Provider** – Select a provider
- Price** – Estimate and compare costs between providers
- Place** – Locate network providers in your area

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 save you and the State money. Provider directories are located at <http://nebraska.welcometouhc.com/physicians-facilities>.

Call UHC before your procedure

Contact UnitedHealthcare to confirm treatment has been authorized any time your doctor recommends you for follow-up treatment including inpatient and outpatient hospitalizations, advanced radiology, such as MRI's and CAT scans, and rehabilitation services, such as physical therapy. Please see Summary Plan Document for details.

Understanding Insurance Terminology

Deductible	The amount you must pay before the plan begins to pay for services provided.
Coinsurance	The percentage of cost you pay for services provided after the deductible is met.
Copays	A flat dollar amount you pay each time a service is provided.
Annual Out-of-Pocket Maximum	The most you pay for covered services provided in a calendar year. This includes your deductible, coinsurance, and medical plan copays.
Open Enrollment	A period of time you can make changes to your health, dental, vision, and FSA. The State of Nebraska offers Open Enrollment in May and changes become effective on July 1.
FSA	Flexible Spending Account is an account you can contribute pre-tax dollars to and use for paying your health care (medical, dental, vision, or pharmacy) or dependent care (day care) expenses. Since your contributions are pre-tax, you save money by not paying taxes on these contributions. Employees cannot contribute to a FSA and Health Savings Account (HSA) in the same plan year.
HSA	Health Savings Account is a bank account that you own. You can use it to save money, federal income tax free, to pay for qualified medical expenses. You use the money to pay for qualified medical expenses including medical, pharmacy, dental, or vision expenses. You must be enrolled in a qualified high deductible plan like the State's Consumer Focused Health Plan to make contributions to an HSA. This money goes with you after employment and can even be used to pay for healthcare expenses during retirement.
PPO	Preferred Provider Organization is a medical plan that allows for a higher level of coverage for eligible services when seeing providers who contract with the network. If you use providers outside of the network, you will pay higher out of pocket costs, be responsible for amounts that may exceed the contracted amount and, in most cases, file your own claims.
Premiums	The money deducted from your paycheck for the benefits coverage you elected.
Qualified Medical Expense	The Internal Revenue Service (IRS) decides which expenses can be paid and reimbursed from an HSA and FSA. See IRS Publication 502 at irs.gov for a complete listing.
Coordination of Benefits (COB)	When an individual is covered by more than one group health plan, health plans coordinate the benefits payable to ensure that the medical provider is not paid more than the allowable medical expenses. Under COB, the primary plan pays its normal plan benefits. The secondary plan pays the difference between allowable expense and amount paid by primary plan, provided this difference does not exceed the normal plan benefits.

For active employees, the State's health plan is always primary. For retirees and dependents, UHC will send out COB notices once a year to dependents who file a claim on the State's health plan.

Go to www.uhcpreventivecare.com for a list of preventive care approved procedures for your age & gender.

What is Preventive Care?

Preventive care focuses on evaluating your current health status when you are symptom free. Preventive care allows you to obtain early diagnosis and treatment, to help avoid more serious health problems. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through a preventive exam and routine health screenings, your doctor can determine your current health status and detect early warning signs of more serious problems.

Your preventive care services may include immunizations, physical exams, lab work and x-rays. During your preventive visit your doctor will determine what tests or health screenings are right for you based on your age, gender, overall health status, and current health condition.

Preventive or Diagnostic?

Certain services can be done for preventive or diagnostic reasons. If you are going in for preventive services, make sure your doctor's office codes them correctly as 'routine.'

Preventive Care is when the patient:

- Does not have symptoms or any abnormal studies indicating an abnormality.
- Has had a screening done within the recommended age and gender guidelines with the results being considered normal.
- Has had a diagnostic service with normal results, after which the physician recommends future preventive care screenings using the appropriate age and gender guidelines.
- Has a preventive service done that results in a diagnostic service being done at the same time and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), subject to benefit plan provisions.

Diagnostic Care is when:

- Abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services.
- Abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline recommendations would require.
- Services are ordered due to current symptom(s) that require further diagnosis.

Your Money – Your Health

You have control over how much you spend for healthcare. Here are some suggestions:

1. When you compare plans, look at both premiums and out-of-pockets costs.
2. Shop around and compare prices and quality of doctors, facilities, and pharmacies.
3. Choose generic prescriptions instead of brand name drugs.
4. Write down your questions to ask when you go to the doctor. It's easy to feel overwhelmed and forget.
5. Schedule your annual preventive exams for medical, dental, and vision.
6. Set aside money for unplanned healthcare expenses. The new Health Savings Account is a great solution for this!
7. Only use the emergency room for a very serious or life threatening conditions. Consider an urgent care center or convenience care clinic if you cannot see a doctor.
8. Enter 877-543-4295 into your cell phone contact listing - it's the myNurseLine phone number and it's FREE for anyone insured under a State of Nebraska health plan.
9. Set up your www.myuhc.com account and start shopping for more ways to save money on your health!



Questions?

Visit link.nebraska.gov and link to Wellness & Benefits Resources.

Call UnitedHealthcare Customer Care at 877-263-0911

FREE
myNurseLine

877-543-4295

24 hours a day, 7 days a week

TTY: 711



myNurseLine

Receive immediate answers from nurses, backed by medical professionals who are here to help you.

- Chat with a registered nurse
- Understand your symptoms
- Explore treatment options to help you make the right decision
- Decide if you should see a doctor, go to the ER, or try self-care
- Understand your medications

Choosing the Right Health Setting

When you or a loved one is hurt, you want the best care. And when possible, you want to consider seeking that care through your primary care doctor. Your doctor knows you and your health history and has access to your medical records. If your primary care doctor is unavailable and care is not urgent or an emergency, you may want to consider other health care alternatives.

Convenience Care Clinics	Urgent Care Centers	Emergency Rooms
<p>Convenience care clinics are often located in malls or retail stores offering fast walk-in services, for minor health conditions such as*:</p> <ul style="list-style-type: none"> • Common infections (e.g.: strep throat) • Minor skin conditions (e.g.: poison ivy) • Flu shots • Pregnancy tests • Minor cuts • Earaches 	<p>Urgent care centers offer treatment for urgent, but non-life threatening injuries or illnesses, and are available on a walk-in basis to treat conditions such as*:</p> <ul style="list-style-type: none"> • Sprains • Strains • Minor broken bones (e.g., finger) • Minor infections • Small cuts that may need a few stitches • Minor burns 	<p>The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention such as*:</p> <ul style="list-style-type: none"> • Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Difficulty breathing • Major broken bones <p>Do not ignore an emergency. If a situation seems life threatening, take action. Call 911 or your local emergency number right away.</p>

* This is a sample list of services and may not be all-inclusive.

** Cost information represents averages only based on internal claims data and is not tied to a specific condition or treatment. Your out-of-pocket costs will vary based on plan design. Not all treatment facilities are covered equally under all plan designs. Always refer to your specific Plan Documents for your coverage details. Some treatments may require preauthorization or a referral from your Primary care physician. The information provided through these programs is for educational purposes only as a part of your health plan and is not a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Your personal health information is kept private in accordance with your plan's privacy policy. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Be an Informed Health Care Consumer

The cost of medical care can vary widely. Your costs depend on where and how you receive care. Knowing the facts may help you manage your health care and your health care dollars.

If you are not sure where to go, call the number on the back of your UnitedHealthcare health plan ID Card to speak with a customer care professional. Here are the average costs for medical services in the various settings**(see page 18):

- **Emergency room visit = \$1200 - \$1500**
- **Urgent care center = \$150 - \$200**
- **Physician office visit = \$100 - \$150**
- **Convenience care clinic visit = \$50 - \$100**

Your Online Resources

www.myuhc.com

Once you have elected a State of Nebraska health plan, it's time to go to www.myuhc.com and register to take advantage of the many resources available to you and your covered family members.

- Print an additional ID card
- Find a network doctor or pharmacy in your area
- Find answers to frequently asked questions
- Learn about your pharmacy benefit
- Learn about your plan details
- View Explanation of Benefits (EOBs)
- Track your out-of-pocket costs
- Look up health information
- Compare the cost of procedures among several providers
- Order refills for your mail order prescriptions
- Learn what's covered as preventive care for your age

myHealthcare Cost Estimator

Login to www.myuhc.com or Health4Me and estimate your health care costs before you see the doctor.

- Shows you the estimated costs for a treatment or procedure
- Displays how that cost is impacted by your deductible, co-insurance and out-of-pocket maximum
- Gives you an estimate of what you'll be responsible to pay
- Provides you with usable information for planning and budgeting

Go Mobile – download Health4Me™

UHC strives to make it easy to get help, wherever you are. The confidential app features work best when you register at www.myuhc.com prior to using the app. It includes:

- Search for physicians or facilities
- View and share ID card information
- View claims
- Check status of deductible and out-of-pocket spending
- View benefit plan details
- Contact an experienced registered nurse 24/7

Why is UnitedHealthcare calling you or sending you mail?

UHC may contact you by phone or mail for a variety of reasons. Here are a few:

- A Care Coordinator may call to help you with follow-up care instructions, medication, and durable medical equipment.
- Disease management staff may offer connections to needed care and resources for your health condition.
- Health Pregnancy nurses may call to offer educational services and resources.
- The mail order pharmacy may contact you about your prescription orders.
- The subrogation division may request additional information about accident-related claims.
- The claims team may request information about other coverage for your dependents.

Failure to respond may affect claims processing or your opportunity to save money on future health care costs. Therefore, it is important for you to pick up the phone or open the mail and respond to their requests and support efforts.

The screenshot shows the 'myHealthcare Cost Estimator' interface. At the top, it says 'UnitedHealthcare' and 'myHealthcare Cost Estimator'. Below that, it displays 'MRI Scan Without Dye - Knee'. The 'Your Quick Estimate' section shows: 'Estimated duration of your treatment: 1 Day', 'Your estimated total cost (in-network): \$454', 'Estimated amount you'll pay: \$184', and 'Your estimated out-of-pocket cost: \$270'. There is also a section on the right titled 'Add your preferred physicians and facilities to this estimate to see even more accurate results.' with a 'Personalize Your Estimate' button.

NEW Consumer Focused Health Plan

Consumer Focused Health Plan administered by UnitedHealthcare (UHC)
HSA Provided by Optum Bank

The State of Nebraska is committed to providing our employees, retirees and their families with access to comprehensive and competitive health benefits. We want to make sure the plans we offer continue to give you the flexibility to manage your specific medical needs, improve your overall health — and help control your costs.

That's why we're introducing the **Consumer Focused Health Plan** – a new type of medical plan that helps keep you healthy, protects you from high costs when you're sick and lets you save for the future by opening a Health Savings Account (HSA).

Why choose the Consumer Focused Health Plan and HSA?

Lower premiums

With the Consumer Focused Health Plan, you pay a lower premium, which leaves you with more money in your bank account each month. You can use these savings to make deposits into your HSA.

Annual deductible

When you receive medical care or need a prescription, you pay out of pocket for those expenses until you reach your deductible. For 2014-15, the deductible is \$2,500 per individual and \$5,000 max per family. After you reach the deductible, you pay 20% coinsurance until you reach your annual out-of-pocket maximum.

Preventive Drug Listing

The Consumer Focused Health Plan offers you low copays for a specific list of preventive maintenance medication. Only medication on this list has copays with no deductible or coinsurance. The types of drugs include high blood pressure, high cholesterol, diabetic, asthma, multiple sclerosis, and osteoporosis. Not all drugs in these therapeutic classes are included on this list.

Health Savings Account

You have the option of opening a Health Savings Account through a pre-tax payroll deduction to help pay for out-of-pocket costs (deductibles and copays) or save for the future.

In addition, the Consumer Focused Health Plan:

- **Covers the same types of medical expenses as our other medical plans.** Once you pay the deductible, you're only responsible for 20% of your expenses – the plan will cover the other 80%. The amount you pay applies to your out-of-pocket maximum.
- **Lets you keep your current doctor.** If you have a preferred doctor, you can continue to use that doctor or choose a doctor that is in the network to save more on the cost of care.

- **Protects you if you get sick.** If you happen to need significant medical care, you're protected by an out-of-pocket maximum. It limits the amount of money you pay before the plan covers 100% of your claims. For 2014-15, the most you'll pay in a year is \$4,000 for individual coverage and \$8,000 for family coverage.
- **Helps you save!** You have the option of opening a Health Savings Account if you are eligible. You can make tax-free contributions to your HSA through an automatic payroll deduction – and save for the future. The money in your HSA is always yours to keep, even if you leave your job with the State of Nebraska.



Preventive Care

Under the Consumer Focused Health Plan, you don't pay anything for eligible preventive care – it's covered at 100% with no deductible, as long as you use a network doctor.

NEW Health Savings Account (HSA)

With the introduction of the Consumer Focused Health Plan, the State of Nebraska is offering eligible employees the opportunity to open a Health Savings Account, managed by Optum Bank. An HSA is a personal bank account that you own, and it allows you to save money out of each paycheck on a pre-tax basis.

You can use the money you save in your HSA to pay for qualified medical, dental and vision expenses, such as doctor visits, prescriptions and hospital visits, or you can save the money for a future need – even retirement. The way you use your HSA will depend on your health care needs and your savings goals. Spend or save. The choice is yours.



Can You Open an HSA?

Because you don't pay taxes on HSA contributions, the interest or earnings on investments, you have to meet certain requirements to open an HSA:

- You are covered under the Consumer Focused Health Plan
- You are not covered by any other health plan, such as a spouse's non-HSA plan, or FSA Healthcare plan
- You are not enrolled in Medicare or TRICARE
- You have not received Veterans Administration (VA) benefits within the past three months
- You are not claimed as a dependent on another person's tax return

Benefits of an HSA

- **You own the HSA.** Any money you deposit into your HSA is yours to keep, even if you change medical plans or leave your job.
- **There is no "use it or lose it" rule.** Your HSA balance carries over from year to year, letting you save for future health care expenses that may occur well into retirement.
- **You can grow your money.** The money you contribute to your HSA grows with interest, and once your balance reaches a certain level, you can choose to invest some of your savings in mutual funds to help your money grow further and work harder for you.
- **You get triple tax savings.** The money you contribute to your HSA is tax-free. You don't pay taxes on your contributions or the interest your account earns, as long as you use them for eligible medical expenses.

Like all good things, there's a limit on the amount that you can contribute to your HSA. Currently, the IRS limits the amount you can save during the benefit plan year depending whether or not you carry dependent coverage. You'll need to make sure your contributions don't put you over the annual maximum.

The 2014 maximum limits are:

- \$3,300 for individual coverage
- \$6,550 for family coverage
- If you're age 55 or older, you can contribute an additional \$1,000 to your HSA during the plan year

How does the HSA work?

If you enroll in the Consumer Focused Health Plan, you are eligible to contribute to a HSA. Many financial institutions offer HSA accounts, including Optum Bank, an affiliate of UnitedHealthcare.

At Optum Bank, there is a monthly bank fee of \$1.00 for average monthly balances under \$500.00. There is no fee for monthly average balances of \$500.00 or greater.

With the money you save in your HSA, you can:

- Use your Optum Bank HSA Debit MasterCard® to pay for qualified health care expenses at your pharmacy, doctor's office or other health care provider.
- Reimburse yourself for qualified health care expenses from your HSA.
- Pay bills online at no charge, or pay with checks linked to your HSA, if you choose to purchase them.
- Save for future healthcare expenses.

How is it different from a FSA Healthcare account?

- It's a bank account owned by you. It goes with you even if you change jobs or health plans.
- Like a bank account, you can only use the money you have deposited in the account.
- Higher annual contributions limits.
- Your account balance earns interest.
- You can invest your balance in mutual funds once it reaches the investment threshold.
- Anyone can deposit money in your account.
- You can use it now, or save it for the future.

What are qualified expenses?

Some examples are listed below. For a complete listing, see IRS Publication 502 at irs.gov.

- Acupuncture
- Ambulance
- Artificial limbs
- Diabetic supplies
- Breast pumps
- Chiropractor
- Contact lenses and solution
- Crutches
- Dental treatments
- Doctor's office visits and procedures
- Prescriptions
- Eyeglasses and vision exams
- Fertility treatment
- Deductibles and copayments
- Premiums for COBRA, long-term care insurance, tax-deductible health insurance
- Hearing aids
- Laboratory fees
- Laser eye surgery
- Physical therapy
- Psychiatric care
- Speech therapy
- Stop-smoking programs
- Walker
- Wheelchair



To Learn More...

Visit www.optumbank.com or call 866-234-8913 Monday - Friday 7:00 a.m. - 7:00 p.m. Central Time

What expenses are not covered?

- Expenses reimbursed from another source
- Cosmetic surgery
- Diaper service
- Electrolysis or hair removal
- Health club dues
- Household help
- Maternity clothes
- Nutritional supplements
- OTC medicines
- Toothbrush, toothpaste
- Swimming lessons
- Teeth whitening

Pharmacy Benefits

Benefits are administered by OptumRx (affiliate of UnitedHealthcare)

When you enroll in a State of Nebraska health plan, you will also be enrolled in the State of Nebraska pharmacy program. UnitedHealthcare (UHC) will send you an identification card which will be used for both medical and pharmacy claims. You will want to carry your UHC card with you at all times. Additional cards can be ordered through www.myuhc.com or by calling UHC at 877-263-0911.

The pharmacy program offers flexibility and choice in finding the right medication for you. Medications are placed on different “tiers” based on their overall value.

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

To learn more about the tiers, covered drugs, and list of network pharmacies, go to the Prescription Plan page at Employee Wellness & Benefits Resources, www.link.nebraska.gov.

Get registered at www.myuhc.com

Upon enrolling in a State of Nebraska health plan, you will receive a welcome kit from UnitedHealthcare. Go online at www.myuhc.com and register. Once you register, click on “Manage My Prescriptions” and you will be able to:

1. View the most current prescription drug list (also referred to as a formulary).
2. Locate a network pharmacy.
3. Compare drug prices and lower cost options.
4. Find your cost before you go to the pharmacy.
5. Refill and track your mail order prescriptions.
6. View medication limits including quantity limits, prior authorization, and step therapy.
7. View drugs not covered under your plan.

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.



Are YOU getting the most out of your Pharmacy Benefit?

- Register at www.myuhc.com
- Choose drugs on Tier 1, when available
- Use mail order
- Choose Generic instead of brand name medications

Mail Order – Save money & time!

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 saves you money. You are not able to get a 180-day prescription from your local pharmacy.

To start using mail order:

1. Tell your physician you would like to start mail service

Once you and your physician are confident you will continue taking a medication on an ongoing basis, have your physician write a prescription for a 180-day supply, plus up to one refill. Prescriptions with more than one refill will not be processed as it will exceed a one year maximum supply as required by law.

2. Contact OptumRx™ at 800-562-6223, 24 hours a day, seven days a week and have your prescription label available when you call.

You can mail the order form - include with the original prescription(s). Write the member ID and date of birth on each prescription and mail with completed order form. Please fill out one order form per member. You can download an order form from link.nebraska.gov - link to Employee Wellness & Benefit Resources.

Your Pharmacy Benefits

	Wellness Health Plan	Regular Health Plan	High Deductible Health Plan (HDHP) (Ending 6/30/15)	Consumer Focused Health Plan (HSA Eligible)
RETAIL - 30 DAY SUPPLY				
Tier 1	\$5 copay	\$10 copay	\$10 copay	20% after deductible
Tier 2	\$25 copay	\$25 copay	\$30 copay	20% after deductible
Tier 3	\$40 copay	\$40 copay	\$50 copay	20% after deductible
MAIL ORDER - 180 DAY SUPPLY				
Tier 1	\$20 copay	\$35 copay	\$35 copay	20% after deductible
Tier 2	\$100 copay	\$100 copay	\$120 copay	20% after deductible
Tier 3	\$150 copay	\$150 copay	\$175 copay	20% after deductible

Wellness Health Plan ONLY	
DIABETIC, HYPERTENSION AND HIGH CHOLESTEROL PRESCRIPTIONS	
RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	\$15 copay
Tier 3	\$30 copay
MAIL ORDER (180 DAY SUPPLY)	
Tier 1	No copay
Tier 2	\$75 copay
Tier 3	\$120 copay

Consumer Focused Health Plan ONLY	
UHC PREVENTIVE DRUG LIST (FORMULARY)	
Go to link.nebraska.gov ; Wellness & Benefits Resources page for list	
RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	\$25 copay
Tier 3	\$50 copay
MAIL ORDER (180 DAY SUPPLY)	
Tier 1	No copay
Tier 2	\$100 copay
Tier 3	\$200 copay

Wellness, Regular, and HDHP Plans

For each covered prescription, you pay the copay listed for each 30-day or 180-day supply. These copays do not go towards your maximum out-of-pocket limit on your health plan.

Consumer Focused Health Plan

1. If your medication is on the UHC Preventive Drug List, you pay the copay. Your copay will apply towards your annual out-of-pocket maximum. After your limit is met, the plan pays 100% of your costs. Go to Employee Wellness & Benefits Resources found at link.nebraska.gov to view the UHC Preventive Drug List.
2. For all other covered prescriptions, the full cost of the prescription is applied towards your deductible. Once you meet your deductible, then you pay 20% coinsurance until your annual out-of-pocket limit is met. Then all costs are paid 100% by the plan.

Wellness Health Plan participants ONLY

Enroll in the Empowered Lifestyle coaching program and choose 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.

Diabetic Supplies

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. If you have any questions, call customer service at 877-263-0911.

Specialty Pharmacy Program

Benefits are administered by OptumRx (affiliate of United Healthcare)

Certain prescriptions on our prescription drug listing require that you use the OptumRx™ Specialty Pharmacy to refill your prescriptions. Specialty pharmacies have experience in storing, handling, and distributing these unique medications and typically provide a higher level of customized care for specialty medications than traditional retail pharmacies. Specialty pharmacists and nurses also have additional clinical expertise surrounding these medications and complex diseases.

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?

Your first fill:

When you are first prescribed a specialty medication, you can receive a 30-day supply from your local pharmacy. Your pharmacist will let you know when you are prescribed a specialty medication. Also, you will also receive a welcome packet from OptumRx with instructions on how to refill your medication.

Follow-up refills:

Contact the OptumRx Specialty Pharmacy at 866-218-5445 and speak with a Patient Care Coordinator to help set up your account, order refills, and answer questions about your prescription.

Your Health Insurance Benefits

Plan Year Deductible (must be satisfied before coinsurance is paid)
Maximum Coinsurance & Medical Co-Pays paid by participant
Annual Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)
PHYSICIAN OFFICE VISITS
Primary Care Physician Office visit
Specialty Office visit
Allergy testing / serum
Allergy shots
Maternity Services (beyond initial visit)
Pathology Services
Surgery, Radiology & Pathology (office)
Chemotherapy/Radiation Therapy
Routine Vision Exam plus Refraction
PREVENTIVE EXAMS
Flu Shots
Annual exams (includes foot exams for diabetics)
Immunizations - Child & Adult
Pneumococcal immunizations
Well baby exams
Diabetes vision screening
Mammogram
Pap smear
Colonoscopy
Prostate cancer screening
EMERGENCY CARE
Ambulance
Urgent care center
Hospital emergency room
HOSPITAL SERVICES
Inpatient hospital
Ambulatory Surgical Center
Approved skilled nursing facility
Outpatient hospital services (diagnostic lab., radiology)
Durable medical equipment
Home health care, Hospice care
BEHAVIORAL HEALTH SERVICES
Inpatient
Outpatient
OTHER SERVICES
Chiropractic Office visit (Limit 60 sessions per year)
Therapy - Occupational, Physical, Speech (Limit 60 sessions per year)
Hearing aids & exam (Limit \$1,500 every 3 years)

Wellness Health Plan	
In-Network	Out-of-Network
\$600 individual \$1,200 family	\$800 individual \$1,600 family
\$1,700 individual \$3,400 family	\$3,700 individual \$5,300 family
\$2,300 individual \$4,600 family	\$4,500 individual \$6,900 family
\$25 copay	30% after deductible
\$35 copay	
Plan pays 100%	
Plan pays 100%	
Plan pays 100%	
Paid at 100% up to \$500; then 20% after deductible	Not covered
20% after deductible	
20% after deductible	
\$35 copay	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.
Plan pays 100%	30% after deductible
	Plan pays 100%
\$35 copay	30% after deductible
	20% after deductible
20% after deductible	30% after deductible
20% after deductible	30% after deductible
\$25 copay	
\$35 copay	30% after deductible
\$25 copay	
20% after deductible	30% after deductible

Regular Health Plan		High Deductible Health Plan (HDHP) (Ending 6/30/15)		Consumer Focused Health Plan (HSA Eligible)	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$800 individual \$1,600 family	\$1,200 individual \$2,400 family	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family
\$2,800 individual \$5,600 family	\$5,000 individual \$10,000 family	\$3,000 individual \$6,000 family	\$6,000 individual \$12,000 family	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family
\$3,600 individual \$7,200 family	\$6,200 individual \$12,400 family	\$4,500 individual \$9,000 family	\$9,000 individual \$18,000 family	\$4,000 individual \$8,000 family	\$8,000 individual \$16,000 family
\$30 copay	40% after deductible	\$30 copay	40% after deductible	20% after deductible	40% after deductible
\$40 copay		\$40 copay			
20% after deductible		30% after deductible			
Not covered		Not covered		Not covered	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of 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 of National Health Care Reform guidelines, they are not covered.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of 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 of National Health Care Reform guidelines, they are not covered.	Covered at 40% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside of National Health Care Reform guidelines, they are not covered.
Not covered		Not covered		Not covered	
20%; deductible waived		30%; deductible waived		20% after deductible	
20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after deductible	40% after deductible
20% after deductible		30% after deductible		20% after deductible	
20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after deductible	40% after deductible
20% after deductible	40% after deductible	30% after deductible	30% after deductible	20% after deductible	40% after deductible
\$30 copay		\$30 copay			
20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after deductible	40% after deductible
20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after Deductible	40% after Deductible

Medical, Dental & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2014 through June 30, 2015 are shown below.

Monthly Medical Premiums

		Wellness Health Plan	Regular Health Plan	HDHP	Consumer Focused Health Plan
Retiree/COBRA Employee Only (Single Coverage)	Retiree:	\$461.46	\$553.42	\$340.54	\$328.44
	COBRA:	\$470.69	\$564.49	\$347.35	\$335.01
Retiree/COBRA Employee + Spouse (Two-Party Coverage)	Retiree:	\$1,222.86	\$1,466.56	\$902.44	\$870.42
	COBRA:	\$1,247.32	\$1,495.89	\$920.49	\$887.83
Retiree/COBRA Employee + Dependent Children (Four Party Coverage)	Retiree:	\$945.98	\$1,134.52	\$698.10	\$673.34
	COBRA:	\$964.90	\$1,157.21	\$712.06	\$686.81
Retiree/COBRA Employee + Spouse + Dependent Children (Family Coverage)	Retiree:	\$1,638.18	\$1,964.64	\$1,208.94	\$1,166.02
	COBRA:	\$1,670.94	\$2,003.93	\$1,233.12	\$1,189.34

Monthly Dental Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	\$22.89	\$26.72
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	\$45.82	\$53.49
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	\$66.01	\$77.11
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	\$71.73	\$83.76

Monthly Vision Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	\$5.26	\$8.14
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	\$8.45	\$13.04
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	\$8.61	\$13.30
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	\$13.85	\$21.42

Monthly Employee Assistance Program (EAP) Premium

	Premium
COBRA/Retiree Employee (Covers All Members of the Household)	\$0.94

Vision Benefits

Benefits are provided by EyeMed Vision Care

The State of Nebraska offers the choice of two vision insurance plans to eligible full-time and part-time employees through EyeMed Vision Care. You may elect to cover yourself and eligible dependents. All premiums are paid through pre-tax, payroll deductions. If you are a new plan participant, EyeMed will mail you an insurance ID card upon enrollment. For more details about the vision benefits offered through EyeMed, including in-network and out-of-network benefits, go to the Wellness & Benefits Resources page located at www.link.nebraska.gov.

State of Nebraska employees who elect the vision insurance plan have access to the EyeMed ACCESS network of providers. Through this network, you will find both private practitioners and national optical retailers. To find a provider, you can:

- Go to www.eyemedvisioncare.com
- Call EyeMed at 877-861-3459

Monthly Vision Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	\$5.26	\$8.14
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	\$8.45	\$13.04
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	\$8.61	\$13.30
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	\$13.85	\$21.42

EyeMed Vision Care Summary of In-Network Coverage

	Basic Option	Premium Option
Exam	\$10 copay	\$10 copay
Frames	80% over \$105	80% over \$120
Lenses		
<ul style="list-style-type: none"> • Single, Bifocal, Trifocal, Standard Progressive • Premium Progressive 	\$10 copay \$75 copay plus (80% of charge less \$120)	\$10 copay \$75 copay plus (80% of charge less \$120)
Contact Lenses		
<ul style="list-style-type: none"> • Conventional • Disposable 	85% over \$105 100% over \$105	85% over \$130 100% over \$130
Frequency		
<ul style="list-style-type: none"> • Exam • Frames • Prescription Lenses • Contact Lenses 	Every 12 months Every 24 months Every 24 months Every 24 months	Every 12 months Every 12 months Every 12 months Every 12 months

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.

Dental Benefits

Benefits are provided by Ameritas

The State of Nebraska offers dental insurance to all full-time and part-time employees. All of the premiums are paid by the employee and collected through pre-tax payroll deductions. For new plan participants, dental ID cards will be mailed to your home.

Our dental program promotes routine dental care as part of our wellness culture for you and your family. 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 program offered by Ameritas and encourages good dental habits through regular dental check-ups. It is available to all family members who participate on the dental plan. If you file at least one dental claim during the plan year and total benefits paid are less than \$500, your annual maximum for the following year will be increased by \$250 (\$350 if using a PPO dentist). This continues until you reach a total reward of \$1,000. The Dental Rewards amount is available to use in future years in addition to your annual maximum. It can only be reduced if you have claims totaling more than \$1,000 or if you fail to submit at least one claim during any given year.



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

Penalty for Late Entrants

A late entrant is any participant on the plan who does not elect coverage during your initial 30 days of eligibility, or, any participant who re-enrolls in the dental plan after dropping coverage. It applies to both you and your dependents.

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.

Find an Approved Provider

At www.ameritasgroup.com or call 800-487-5553.

Ameritas Dental Plan Benefits

Plan Feature	Basic Option		Premium Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Basic & Major Procedures Only	\$50 per individual \$150 per family			
Type 1 - Preventive	Plan covers 100%	Plan covers 50%	Plan covers 100%	Plan covers 50-60-70%**
Type 2 - Basic	Plan covers 80%	Plan covers 50%	Plan covers 80%	Plan covers 50-60-70%**
Type 3 - Major	Plan covers 50%	Plan covers 25%	Plan covers 50%	Plan covers 30%
Calendar Year Maximum	\$1,000	\$1,000	\$1,500	\$1,000
Dental Rewards®	Included	Included	Included	Included
ORTHODONTICS & TMJ				
Coinsurance (No Deductible)	Plan covers 50% (To age 19)	Plan covers 25% (To age 19)	Plan covers 50% (Adults & Children)	Plan covers 30% (Adults & Children)
Lifetime Maximum (per person)	\$2,000	\$2,000	\$2,000	\$2,000
Dental Rewards®	Excluded	Excluded	Excluded	Excluded

Type 1 - Preventive Procedures

Exam & cleanings (2 per year), x-rays sealants

Type 2 - Basic Procedures

Fillings, root canals, gum disease treatment, extractions

Type 3 - Major Procedures

Initial and replacement crowns, dentures, bridges

**Premium Plan ONLY

**Premium Plan ONLY - Type 1 and 2 procedures for out of network providers will be reimbursed on an incentive basis that progressively increases each plan year. New plan members begin at 50% coinsurance. As long as plan members visit the dentist and have at least one covered procedure performed each plan year, they advance one coinsurance level the following plan year until they reach 70%. If a plan member fails to have at least one dental procedure performed during any benefit year, he or she will revert back to the beginning coinsurance level to begin advancing through the levels.

NOTE: Members who are enrolled in the Premium Plan effective July 1, 2014 will automatically start at the highest coinsurance level of 70%. These members must have at least one covered dental procedure performed during each plan year to remain at 70%.

Monthly Dental Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	\$22.89	\$26.72
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	\$45.82	\$53.49
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	\$66.01	\$77.11
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	\$71.73	\$83.76

Employee Assistance Program (EAP)

Benefits are offered through Deer Oaks Employee Assistance Program



Contact Us

Helpline: (866) 792-3616

Website: www.deeroaks.com

Login/Password: SON

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for employees and their household members by the State of Nebraska. The EAP is designed to help you and your family manage life's challenges.

Through this program, you and your family members may access a wide variety of counseling, referral, and consultation services to help you deal with personal and work-related issues that may be affecting your job performance or personal well-being. Whether you seek mental health counseling, work and life consultation services, legal and financial resources, assistance with locating child and elder care facilities, or you have uncertainty about retirement, Deer Oaks is there to assist with these, and other requests, 24 hours per day, 7 days per week.

Monthly Employee Assistance Program (EAP) Premium

	Premium
COBRA/Retiree Employee (Covers All Members of the Household)	\$0.94

Deer Oaks offers a multidisciplinary team of professional counselors and work/life consultants trained to assist with such issues as:

- Work/Life Balance
- Depression/Anxiety
- Substance Abuse
- Preparing for Retirement
- Emotional & Psychological Issues
- Life Changes & Transitions
- Stress & Time Management
- Legal & Financial Difficulties
- Family & Marital Problems
- Child/Elder/Adult Care Issues
- Healthy Lifestyles
- Loss & Grief

These services are completely confidential and may be easily accessed 24/7 by calling the toll-free Helpline listed above. You may also visit us online at www.deeroaks.com to browse articles, interactive assessments, audio and video files, and to participate in monthly webinars and live chat sessions.



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

Legal Notifications

Summary Plan Documents

Plan documents are accessible through the Employee Wellness & Benefits Resources page located at www.link.nebraska.gov.

Women's Health and Cancer Rights Act of 1998 (WHRCA)

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Your State sponsored health coverage plans comply with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the plan administrator at 402-471-4443.

Mental Health Parity Act

The Mental Health Parity and Addiction Equity Act of 2008 prohibit 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.

Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or

group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Employee Wellness & Benefits at 402-471-4443 or 877-721-2228.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 866-444-EBSA (3272).

Cont'd on page 42

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2014. You should contact your State for further information on eligibility –

ALABAMA – Medicaid
Web: <http://www.medicaid.alabama.gov>
Phone: 855-692-5447

ALASKA – Medicaid
Web: <http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone Outside Anchorage: 888-318-8890
Phone Anchorage: 907-269-6529

ARIZONA – CHIP
Web: <http://www.azahcccs.gov/applicants>
Phone Outside Maricopa Co.: 877-764-5437
Phone Maricopa County: 602-417-5437

COLORADO – Medicaid
Medicaid Web: <http://www.colorado.gov/>
Medicaid Phone (In state): 800-866-3513
Medicaid Phone Out of state: 800-221-3943

FLORIDA – Medicaid
Web: <https://www.flmedicaidtprerecovery.com/>
Phone: 877-357-3268

GEORGIA – Medicaid
Web: <http://dch.georgia.gov/>
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 800-869-1150

IDAHO – Medicaid
Medicaid Web: <http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx>
Medicaid Phone: 800-926-2588

INDIANA – Medicaid
Web: <http://www.in.gov/fssa>
Phone: 800-889-9949

IOWA – Medicaid
Web: www.dhs.state.ia.us/hipp/
Phone: 888-346-9562

KANSAS – Medicaid
Web: <http://www.kdheks.gov/hcf/>
Phone: 800-792-4884

KENTUCKY – Medicaid
Web: <http://chfs.ky.gov/dms/default.htm>
Phone: 800-635-2570

LOUISIANA – Medicaid
Web: <http://www.lahipp.dhh.louisiana.gov>
Phone: 888-695-2447

MAINE – Medicaid
Web: <http://www.maine.gov/dhhs/of/public-assistance/index.html>
Phone: 800-977-6740
TTY: 800-977-6741

MASSACHUSETTS – Medicaid & CHIP
Web: <http://www.mass.gov/MassHealth>
Phone: 800-462-1120

MINNESOTA – Medicaid
Web: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone: 800-657-3629

MISSOURI – Medicaid
Web: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid
Web: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
Phone: 800-694-3084

NEBRASKA – Medicaid
Web: www.ACCESSNebraska.ne.gov
Phone: 800-383-4278

NEVADA – Medicaid
Medicaid Web: <http://dwss.nv.gov/>
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Web: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>
Phone: 603-271-5218

NEW JERSEY – Medicaid & CHIP
Medicaid Web: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Web: <http://www.njfamilycare.org/index.html>
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Web: http://www.nyhealth.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Web: <http://www.ncdhs.gov/dma>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Web: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 800-755-2604

OKLAHOMA – Medicaid and CHIP
Web: <http://www.insureoklahoma.org>
Phone: 888-365-3742

OREGON – Medicaid
Web: <http://www.oregonhealthykids.gov>
<http://www.hijossaludablesoregon.gov>
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Web: <http://www.dpw.state.pa.us/hipp>
Phone: 800-692-7462

RHODE ISLAND – Medicaid
Web: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Web: <http://www.scdhhs.gov>
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid
Web: <https://www.gethipptexas.com/>
Phone: 800-440-0493

UTAH – Medicaid & CHIP
Web: <http://health.utah.gov/upp>
Phone: 866-435-7414

VERMONT – Medicaid
Web: <http://www.greenmountaincare.org/>
Phone: 800-250-8427

VIRGINIA – Medicaid & CHIP
Medicaid Web: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
Medicaid Phone: 800-432-5924
CHIP Web: <http://www.famis.org/>
CHIP Phone: 866-873-2647

WASHINGTON – Medicaid
Web: <http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx>
Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Web: www.dhhr.wv.gov/bms/
Phone: 877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Web: <http://www.badgercareplus.org/pubs/p-10095.htm>
Phone: 800-362-3002

WYOMING – Medicaid
Web: <http://health.wyo.gov/healthcarefin/equalitycare>
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

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

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

IMPORTANT NOTICE FROM STATE OF NEBRASKA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with State of Nebraska and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. State of Nebraska has determined that the prescription drug coverage offered by the State of Nebraska is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current State of Nebraska coverage will be affected. If you do decide to join a Medicare drug plan and drop your current State of Nebraska coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with State of Nebraska and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through State of Nebraska changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

Date: April 14, 2014
Name of Entity/Sender: State of Nebraska
Contact--Position/Office: DAS Employee Wellness & Benefits
Address: 1526 K Street, Suite 110, Lincoln, NE 68508
Phone Number: 402-471-4443

NOTICE OF PRIVACY PRACTICES OF CERTAIN GROUP HEALTH PLANS SPONSORED BY STATE OF NEBRASKA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Each Group Health Plan in which you participate is required by federal law to maintain the privacy of your personal health information. Each Plan is also required to give you a Notice which describes its privacy practices, its legal duties and your rights concerning such information. This is the required joint Notice for all group health plans sponsored by State of Nebraska, collectively referred to in this Notice as (the "Plan Sponsor"):

USES AND DISCLOSURES OF YOUR INFORMATION

The Plan is permitted or required to use or disclose your health information without your authorization (permission) to carry out certain services and activities. Health information includes medical information involving your diagnosis or treatment, insurance information, and health care claims and payment information. Many of those services or activities are performed through contracts with outside persons or organizations, such as auditing, actuarial services, administrative services, legal services, etc. It may be necessary for the Plan to provide certain of your health information to these outside persons or organizations who assist the Plan with these functions or activities. The Plan requires these persons and entities to appropriately safeguard the privacy of your information.

The following are the types of uses and disclosures the Plan may make of your health information without your authorization. Where State or federal law restricts one of the described uses or disclosures, the Plan will follow the requirements of such State or federal law. The following are general descriptions only. They do not cover every example of a disclosure within a category.

Treatment. The Plan will make disclosures of your health information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request certain of your health information that the Plan maintains in order to make decisions about your care. We will disclose your medical information to your physician and other practitioners, providers and health care facilities for their use in treating you.

Payment. The Plan will use and disclose your health information as necessary for payment purposes. For example, the Plan may use and disclose your health information to pay claims from doctors, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to determine whether services are medically necessary or to pre-authorize or certify services as covered under your plan of benefits. We may also disclose medical information about you to other health care providers and health plans for their payment purposes. For example, if you have other health coverage, the Plan may disclose your health information to other health care programs or insurance carriers in order to coordinate payment of benefits. The Group Health Plans jointly following this Notice will share your health information for purposes of payment.

Health Care Operations. The Plan will use and disclose your health information as necessary for the Plan's Health Care Operations. For example, the Plan may use and disclose your medical information to conduct quality improvement activities, engage in care coordination or to purchase reinsurance coverage. The Plan may also disclose your health information to another Covered Entity for purposes of that entity's Health Care Operations. For example, another health plan or health care provider may request your health information for purposes of conducting quality assurance and improvement activities, or accreditation, certification, licensing or credentialing activities. The Group Health Plans jointly following this Notice will share your health information for purposes of joint Health Care Operations of the Plan.

Plan Sponsor. The Plan may disclose your health information to the Plan Sponsor to permit the Plan Sponsor to perform plan administration functions on behalf of the Plan. The Plan may disclose "Summary Health Information" to the Plan Sponsor for obtaining bids or for the purpose of amending or terminating the Plan. "Summary Health Information" includes claim history, claim expenses and types of claims by individuals without including any personally identifying information. The Plan may also disclose to the Plan Sponsor information on whether you are participating in the Plan. If the Plan discloses any other health information to the Plan Sponsor without your authorization, the Plan documents will restrict how the information is used and prevent it from being used to make employment decisions about you. The Plan documents restrict the uses and disclosures that the Plan Sponsor may make of your health information, and require the Plan Sponsor to certify that the information provided will be maintained in a confidential manner and not used for employment-related decisions or for other employee benefit determinations without your authorization or in any other manner not permitted by law or the Plan documents.

Information Received Prior to Enrollment. The Plan may receive from you and your health care providers health information prior to your enrollment in the Plan. The Plan will not use or further disclose this health information for any purpose, except as required by law, unless you enroll in the Plan. After enrollment, uses and disclosures are governed by the terms of the Notice then in effect.

Friends and Family. The Plan may disclose health information to family members or friends who are involved in your care or payment for your care to facilitate that person's involvement in caring for you or paying for your care. If you are present, the Plan will give you the opportunity to object before it makes such disclosures. If you are unavailable, incapacitated or are in an emergency situation, the Plan may disclose limited information to these persons if the Plan determines disclosure is in your best interest.

Disaster Relief. The Plan may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.

Deceased Individuals. The Plan may disclose the health information of a deceased individual to a coroner, medical examiner or funeral director to carry out their duties as allowed by law.

Organ Donation. If you are an organ donor, or recipient, the Plan may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Research. The Plan may use or disclose your medical information for research purposes in accordance with certain safeguards.

Law Enforcement. The Plan may disclose your health information to law enforcement authorities for law enforcement purposes, such as reporting wounds of violence and physical injuries or other similar disclosures allowed by the law; in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; if you are the victim of a crime, but only if your agreement is obtained or, under certain limited circumstances, if the Plan is unable to obtain your agreement; about a death which is believed to be the result of criminal conduct; and in emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. The Plan must comply with federal and state laws in making such disclosures.

Public Health Activities. The Plan may disclose medical information about you for public health activities. These activities may include disclosures to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability; to appropriate authorities authorized to receive reports of child abuse and neglect; to the Food and Drug Administration (FDA) or a person subject to the jurisdiction of the FDA for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect and Domestic Violence. The Plan may notify the appropriate government authority if it believes you have been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law, the Plan will only make this disclosure if you agree or, if unable to obtain your agreement, under other limited circumstances when authorized by law.

To Avert a Serious Threat To Health or Safety. Under certain circumstances the Plan may use or disclose Protected Health Information if, in good faith, the use or disclosure is necessary to prevent or lessen the threat and is to a person reasonably able to prevent or lessen the threat (including the subject of the threat) or, under limited circumstances, is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Military and National Security. The Plan may release your health information if you are a member of the armed forces as required by military command authorities. It may also release medical information about foreign military personnel to the appropriate foreign military authority. The Plan may also release your health information to federal authorities, if necessary, for national security or intelligence activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your Protected Health Information to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you, (2) your health and safety and the health and safety of others, or (3) the health and security of the correctional institution.

Legal Proceedings. If you are involved in a lawsuit or a dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

Workers' Compensation. The Plan may disclose your health information to comply with workers' compensation laws or other similar programs providing benefits for work-related injuries.

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

Required by Law. The Plan will disclose health information about you when required to do so by federal or state law, including disclosures to the U.S. Department of Health and Human Services upon request for purposes of determining the Plan's compliance with federal law.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. We will make reasonable efforts to limit these incidental uses and disclosures.

Other Uses and Disclosures. Other uses and disclosures of your medical information not covered above will be made only with your written authorization. If you authorize us to use and disclose your information, you may revoke that authorization at any time. Such revocation will not affect any action we have taken prior to the revocation in reliance on your authorization.

INDIVIDUAL RIGHTS

Access to Your Health Information. You have the right to copy and/or inspect the health information that the Plan maintains on your behalf, with limited exceptions. All requests for access must be made in writing and signed by you or your representative. If you request copies, the Plan may charge you a reasonable, cost-based fee for each page, plus an additional amount for postage if you request a mailed copy. If you prefer, the Plan may agree to prepare a summary or an explanation of your health information and may charge a fee to prepare such summary.

Amendment to Your Health Information. You have the right to request in writing that the health information the Plan maintains about you be amended or corrected. The Plan is not obligated to make all requested amendments but will give each request careful consideration. For example, if the Plan did not create the information, your request will be denied. If the Plan denies your request, you will be provided with a written explanation and an explanation of your rights. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment.

Accounting for Disclosures of Your Health Information. You have the right to receive an accounting of certain disclosures made by the Plan of your personal health information after April 14, 2004. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you may be charged a fee for each subsequent accounting you request within the same 12-month period.

Request for Voluntary Restrictions on Use and Disclosure. You have the right to request that the Plan voluntarily place additional restrictions on its use or disclosure of your health information for treatment, payment, Health Care Operations or to persons you identify. The Plan is not required to agree to these additional restrictions, but if it does, it will abide by the agreement (except in an emergency). To be effective, any agreement by the Plan must be in writing signed by a person authorized to make such an agreement on the Plan's behalf. The Plan retains the right to terminate any agreed to restriction upon notification to you of such termination. The termination will only be effective for health information received after providing notice to you.

Confidential Communications. You have the right to request that the Plan communicate with you about your health information by alternative means or at an alternative location. You must make your request in writing to the address listed at the end of this Notice. The Plan is required to accommodate reasonable requests if you inform the Plan that disclosure of all or part of your information could place you in danger, specify the alternative means or location and continue to permit the Plan to collect premiums and pay claims under your health plan, including issuance of explanation of benefits to the subscriber of Plan in which you participate.

Complaints. If you have concerns about any of the Plan's privacy practices or believe that your privacy rights may have violated. You may also submit a written complaint to the U.S. Department of Health and Human Services. The Plan supports your right to protect the privacy of your health information. Neither the Plan nor the Plan Sponsor will retaliate in any way if you chose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Exercising Your Rights. The Plan contracts with outside administrators (the "Administrator") to actually administer and operate the Plan. Under the terms of the arrangement, it is the Administrator, not the Plan, which creates, maintains and uses most or all of the medical information about you. To exercise the individual rights described in this Notice, or to file a complaint, contact:

Medical & Prescription Drug Benefits

UnitedHealthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815
866-633-2446

Dental Benefits

UNIFI Privacy Office
Attn: HIPAA Privacy
P.O. Box 81889
Lincoln, NE 68510
800-487-5553

Vision Benefits

Eyemed
Privacy Office
Luxottica Retail
4000 Luxottica Place
Mason, OH 45040
513-765-4321

FSA Benefits

ASI Flex
Attn: HIPAA Privacy
201 W Broadway, Suite 4-C
Columbia, MO 65203
800-659-3035

ABOUT THIS NOTICE

The Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all of your personal health information that it maintains, including that which it created or received while the prior Notice was in effect. If the Plan makes a material change to its privacy practices, it will revise its Notice and provide you with a copy of the revised Notice.

If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact the Privacy Officer at the address listed below to obtain a written copy of this Notice.

CONTACT INFORMATION

PRIVACY OFFICER: For questions about this Notice, contact the Plan's Privacy Officer at:

Wellness & Benefits Administrator
Attn: HIPAA Privacy Officer
1526 K Street, Suite 110
Lincoln, NE 68508
402-471-4443

EFFECTIVE DATE OF NOTICE: April 1, 2014.

