

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.

The State contributes 79% of the total cost of your health care benefits for full-time employees. The medical premiums reflect rates for full-time employees. If you work less than 40 hours a week, consult your HR representative for part-time rates.

Premiums are deducted from your paycheck pre-tax. That means the premiums are deducted from your pay before taxes are withheld and thus, you do not pay taxes on these premiums.

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

NOTE: For employees who are paid bi-weekly, your deduction will be half of the total shown here and deductions are only taken 24 times per year.

Monthly Medical Plan Premiums - Full-Time Employees

		Wellness Health Plan	Regular Health Plan	HDHP	Consumer Focused Health Plan
Employee Only (Single Coverage)	Your Cost:	\$96.90	\$116.22	\$71.50	\$68.98
	State Cost:	\$364.56	\$437.20	\$269.04	\$259.46
	Total:	\$461.46	\$553.42	\$340.54	\$328.44
Employee + Spouse (Two-Party Coverage)	Your Cost:	\$256.80	\$307.98	\$189.50	\$182.78
	State Cost:	\$966.06	\$1,158.58	\$712.94	\$687.64
	Total:	\$1,222.86	\$1,466.56	\$902.44	\$870.42
Employee + Dependent Children (Four-Party Coverage)	Your Cost:	\$198.66	\$238.24	\$146.60	\$141.40
	State Cost:	\$747.32	\$896.28	\$551.50	\$531.94
	Total:	\$945.98	\$1,134.52	\$698.10	\$673.34
Employee + Spouse + Dependent Children (Family Coverage)	Your Cost:	\$344.02	\$412.56	\$253.88	\$244.86
	State Cost:	\$1,294.16	\$1,552.08	\$955.06	\$921.16
	Total:	\$1,638.18	\$1,964.64	\$1,208.94	\$1,166.02

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	\$22.44	\$26.20
Employee + Spouse (Two-Party Coverage)	\$44.92	\$52.44
Employee + Dependent Children (Four-Party Coverage)	\$64.72	\$75.60
Employee + Spouse + Dependent Children (Family Coverage)	\$70.32	\$82.12

Monthly Vision Plan Premiums

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

QUICK REFERENCE GUIDE 2014-15 Health Benefits



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 www.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

- 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 www.link.nebraska.gov to view the UHC Preventive Drug List.
- 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. That 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.

Your Health Insurance Benefits

	Wellness Health Plan		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	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	\$600 individual \$1,200 family	\$800 individual \$1,600 family	\$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
Maximum Coinsurance & Medical Co-Pays paid by participant	\$1,700 individual \$3,400 family	\$3,700 individual \$5,300 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
Annual Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	\$2,300 individual \$4,600 family	\$4,500 individual \$6,900 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
PHYSICIAN OFFICE VISITS								
Primary Care Physician Office visit	\$25 copay	30% after deductible	\$30 copay	40% after deductible	\$30 copay	40% after deductible	20% after deductible	40% after deductible
Specialty Office visit	\$35 copay		\$40 copay		\$40 copay			
Allergy testing / serum	Plan pays 100%		20% after deductible		30% after deductible			
Allergy shots	Plan pays 100%							
Maternity Services (beyond initial visit)	Plan pays 100%							
Pathology Services	Paid at 100% up to \$500; then 20% after deductible							
Surgery, Radiology & Pathology (office)	20% after deductible							
Chemotherapy/Radiation Therapy	20% after deductible							
Routine Vision Exam plus Refraction	\$35 copay	Not covered						
PREVENTIVE EXAMS								
Flu Shots	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% 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.	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.
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	Plan pays 100%	30% after deductible						
EMERGENCY CARE								
Ambulance	Plan pays 100%		20%; deductible waived		30%; deductible waived		20% after deductible	
Urgent care center	\$35 copay	30% after deductible	20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital emergency room	20% after deductible		20% after deductible		30% after deductible		20% after deductible	
HOSPITAL SERVICES								
Inpatient hospital	20% after deductible	30% after deductible	20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after deductible	40% after deductible
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	20% after deductible	30% after deductible	20% after deductible	40% after deductible	30% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient	\$25 copay		\$30 copay		\$30 copay			
OTHER SERVICES								
Chiropractic Office visit (Limit 60 sessions per year)	\$35 copay	30% after deductible	20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after deductible	40% after deductible
Therapy - Occupational, Physical, Speech (Limit 60 sessions per year)	\$25 copay							
Hearing aids & exam (Limit \$1,500 every 3 years)	20% after deductible	30% after deductible	20% after deductible	40% after deductible	30% after deductible	40% after deductible	20% after Deductible	40% after Deductible