

Your Pharmacy Benefits

	Wellness Health Plan	Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
RETAIL - 30 DAY SUPPLY			
Tier 1	\$5 copay	\$5 copay	20% after deductible
Tier 2	\$30 copay	\$30 copay	20% after deductible
Tier 3	\$50 copay	\$50 copay	20% after deductible
MAIL ORDER - 90 DAY SUPPLY (OR RETAIL)			
Tier 1	\$10 copay	\$10 copay	20% after deductible
Tier 2	\$60 copay	\$60 copay	20% after deductible
Tier 3	\$100 copay	\$100 copay	20% after deductible
Pharmacy Out-of-Pocket Maximum	\$2,000 - individual \$4,000 - family	\$2,000 - individual \$4,000 - family	Included in the medical out-of-pocket maximum

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 - 90 DAY SUPPLY (OR RETAIL)	
Tier 1	
Tier 2	2 Times the 30-day supply
Tier 3	

Pay the Difference

If a generic equivalent is available, and you choose brand, you will pay the difference in cost between the generic cost and brand cost, in addition to the appropriate copay. Penalty does not apply if physician does not allow substitution.

Wellness and Regular Health Plans Pharmacy Out-Of-Pocket Maximums

The pharmacy out-of-pocket maximum limits are in addition to the medical out-of-pocket maximums on page 28-29. Once the out-of-pocket maximum has been met for pharmacy co-pays, all prescriptions covered under the plan will be paid 100% by the plan.

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 - 90 DAY SUPPLY (OR RETAIL)	
Tier 1	
Tier 2	2 Times the 30-day supply
Tier 3	

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 <http://das.nebraska.gov/benefits.html>.
- 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.

QUICK REFERENCE GUIDE 2016-17 Health Benefits



Medical, Dental & Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2016 through June 30, 2017 are shown below.

The State contributes 79% of the total cost of your health care benefits for full-time employees.

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: 30-40 hours
Part-Time: 20-29 hours

		Wellness Health Plan		Regular Health Plan		Consumer Focused Health Plan	
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only (Single Coverage)	Your Cost:	\$116.10	\$190.34	\$139.24	\$228.28	\$79.30	\$130.02
	State Cost:	\$436.78	\$362.54	\$523.84	\$434.80	\$298.36	\$247.64
	Total:	\$552.88	\$552.88	\$663.08	\$663.08	\$377.66	\$377.66
Employee + Spouse (Two-Party Coverage)	Your Cost:	\$307.68	\$504.44	\$369.00	\$604.98	\$210.16	\$344.56
	State Cost:	\$1,157.46	\$960.70	\$1,388.16	\$1,152.18	\$790.64	\$656.24
	Total:	\$1,465.14	\$1,465.14	\$1,757.16	\$1,757.16	\$1,000.80	\$1,000.80
Employee + Dependent Children (Four-Party Coverage)	Your Cost:	\$238.02	\$390.22	\$285.46	\$468.02	\$162.58	\$266.56
	State Cost:	\$895.38	\$743.18	\$1,073.86	\$891.30	\$611.64	\$507.66
	Total:	\$1,133.40	\$1,133.40	\$1,359.32	\$1,359.32	\$774.22	\$774.22
Employee + Spouse + Dependent Children (Family Coverage)	Your Cost:	\$412.18	\$675.76	\$494.32	\$810.46	\$281.54	\$461.60
	State Cost:	\$1,550.54	\$1,286.96	\$1,859.62	\$1,543.48	\$1,059.16	\$879.10
	Total:	\$1,962.72	\$1,962.72	\$2,353.94	\$2,353.94	\$1,340.70	\$1,340.70

Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	\$23.12	\$27.00
Employee + Spouse (Two-Party Coverage)	\$46.28	\$54.04
Employee + Dependent Children (Four-Party Coverage)	\$66.68	\$77.92
Employee + Spouse + Dependent Children (Family Coverage)	\$72.44	\$84.60

Monthly Vision Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	\$5.30	\$8.20
Employee + Spouse (Two-Party Coverage)	\$8.50	\$13.16
Employee + Dependent Children (Four-Party Coverage)	\$8.68	\$13.40
Employee + Spouse + Dependent Children (Family Coverage)	\$13.96	\$21.64

