

# QUICK REFERENCE GUIDE 2019-20 HEALTH BENEFITS



## Monthly Dental Plan Premiums

	Basic Option	Premium Option
<b>COBRA/Retiree Employee Only</b> (Single Coverage)	\$24.32	\$28.40
<b>COBRA/Retiree Employee + Spouse</b> (Two-Party Coverage)	\$48.67	\$56.83
<b>COBRA/Retiree Employee + Dependent Children</b> (Four-Party Coverage)	\$70.09	\$81.93
<b>COBRA/Retiree Employee + Spouse + Dependent Children</b> (Family Coverage)	\$76.13	\$88.94

## Monthly Vision Plan Premiums

	Basic Option	Premium Option
<b>COBRA/Retiree Employee Only</b> (Single Coverage)	\$5.45	\$8.47
<b>COBRA/Retiree Employee + Spouse</b> (Two-Party Coverage)	\$8.75	\$13.55
<b>COBRA/Retiree Employee + Dependent Children</b> (Four-Party Coverage)	\$8.94	\$13.79
<b>COBRA/Retiree Employee + Spouse + Dependent Children</b> (Family Coverage)	\$14.38	\$22.28

## COBRA and Retiree Medical, Dental, and Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2019, through June 30, 2020, are shown below.

### Monthly Medical Plan Premiums

		Wellness Health Plan		Regular Health Plan	Consumer Focused Health Plan
		With Wellness Incentive	Without Wellness Incentive		
<b>Retiree/COBRA Employee Only</b> (Single Coverage)	<b>Retiree:</b>	\$622.18	\$751.48	\$751.48	\$425.00
	<b>COBRA:</b>	\$634.62	\$766.51	\$766.51	\$433.50
<b>Retiree/COBRA Employee + Spouse</b> (Two-Party Coverage)	<b>Retiree:</b>	\$1,648.78	\$1,991.42	\$1,991.42	\$1,126.24
	<b>COBRA:</b>	\$1,681.76	\$2,031.25	\$2,031.25	\$1,148.76
<b>Retiree/COBRA Employee + Dependent Children</b> (Four Party Coverage)	<b>Retiree:</b>	\$1,275.46	\$1,540.54	\$1,540.54	\$871.26
	<b>COBRA:</b>	\$1,300.97	\$1,571.35	\$1,571.35	\$888.69
<b>Retiree/COBRA Employee + Spouse + Dependent Children</b> (Family)	<b>Retiree:</b>	\$2,208.72	\$2,667.76	\$2,667.76	\$1,508.74
	<b>COBRA:</b>	\$2,252.89	\$2,721.12	\$2,721.12	\$1,538.91

## Your Pharmacy Benefits

	WellNebraska Plan		Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
	With Wellness Incentive	Without Wellness Incentive		
<b>RETAIL - 30 DAY SUPPLY</b>				
<b>Tier 1</b>	\$5 copay	\$5 copay	\$5 copay	20% after deductible
<b>Tier 2</b>	\$30 copay	\$40 copay	\$40 copay	20% after deductible
<b>Tier 3</b>	\$50 copay	\$60 copay	\$60 copay	20% after deductible
<b>MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY</b>				
<b>Tier 1</b>	\$10 copay	\$10 copay	\$10 copay	20% after deductible
<b>Tier 2</b>	\$60 copay	\$80 copay	\$80 copay	20% after deductible
<b>Tier 3</b>	\$100 copay	\$120 copay	\$120 copay	20% after deductible
<b>Pharmacy Out-of-Pocket Maximum</b>	\$2,000 - individual \$4,000 - family	\$2,250 - individual \$4,500 - family	\$2,250 - individual \$4,500 - family	Included in the medical out-of-pocket maximum

<b>WellNebraska Health Plan ONLY (with Wellness Incentive)</b>	
<b>DIABETIC, HYPERTENSION, AND HIGH CHOLESTEROL PRESCRIPTIONS</b>	
<b>RETAIL - 30 DAY SUPPLY</b>	
<b>Tier 1</b>	No copay
<b>Tier 2</b>	\$15 copay
<b>Tier 3</b>	\$30 copay
<b>MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY</b>	
<b>Tier 1</b>	
<b>Tier 2</b>	2 Times the 30-day supply
<b>Tier 3</b>	

<b>Consumer Focused Health Plan ONLY</b>	
<b>UHC PREVENTIVE DRUG LIST (FORMULARY)</b>	
For list, go to Wellness & Benefits Resources page at <a href="http://das.nebraska.gov/benefits">das.nebraska.gov/benefits</a>	
<b>RETAIL - 30 DAY SUPPLY</b>	
<b>Tier 1</b>	No copay
<b>Tier 2</b>	\$25 copay
<b>Tier 3</b>	\$50 copay
<b>MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY</b>	
<b>Tier 1</b>	
<b>Tier 2</b>	2 Times the 30-day supply
<b>Tier 3</b>	

### Direct Primary Care Monthly Premiums and Membership Fees

		High Deductible Health Plan		Membership Fees
		Select	Standard	
<b>Retiree/COBRA Employee Only</b> (Single Coverage)	<b>Retiree:</b>	\$301.14	\$259.90	\$89.00
	<b>COBRA:</b>	\$307.16	\$265.10	\$90.78
<b>Retiree/COBRA Employee + Spouse</b> (Two-Party Coverage)	<b>Retiree:</b>	\$855.86	\$746.56	\$178.00
	<b>COBRA:</b>	\$872.98	\$761.49	\$181.56
<b>Retiree/COBRA Employee + Dependent Children</b> (Four Party Coverage)	<b>Retiree:</b>	\$649.80	\$565.24	\$150.00
	<b>COBRA:</b>	\$662.80	\$576.54	\$153.00
<b>Retiree/COBRA Employee + Spouse + Dependent Children</b> (Family Coverage)	<b>Retiree:</b>	\$1,085.98	\$939.56	\$299.00
	<b>COBRA:</b>	\$1,107.70	\$958.35	\$304.98

# Your Health Insurance Benefits

	WellNebraska Health Plan			
	With Wellness Incentive		Without Wellness Incentive*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Plan Year Deductible (must be satisfied before coinsurance is paid)</b>	\$800 individual \$1,600 family	\$1,600 individual \$3,200 family	\$1,400 individual \$2,600 family	\$2,800 individual \$5,200 family
<b>Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, &amp; medical co-pays)</b>	\$2,700 individual \$5,400 family	\$5,400 individual \$10,800 family	\$4,000 individual \$8,000 family	\$8,000 individual \$16,000 family
<b>Annual Pharmacy Out-of-Pocket Maximum</b>	\$2,000 individual \$4,000 family		\$2,250 individual \$4,500 family	
<b>PHYSICIAN OFFICE VISITS</b>				
<b>Primary Care Physician Office visit</b>	\$35 copay	30% after deductible	\$45 copay	40% after deductible
<b>Specialty Office visit</b>	\$50 copay		\$55 copay	
<b>Virtual Visits</b>	Plan pays 100%		Plan pays 100%	
<b>Allergy testing / serum</b>	Plan pays 100%		20% after deductible	
<b>Allergy shots</b>	Plan pays 100%			
<b>Lab and Pathology Services</b>	Paid at 100% up to \$500; then 20% after deductible			
<b>Radiology and Chemotherapy/Radiation Therapy</b>	20% after deductible			
<b>Routine Vision Exam plus Refraction</b>	Not covered	Not covered	Not covered	
<b>PREVENTIVE EXAMS</b>				
<b>Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening.</b>	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.
<b>See Summary Plan Document on Employee Wellness &amp; Benefits website for a comprehensive list of your preventive care services.</b>				
<b>EMERGENCY CARE</b>				
<b>Ambulance</b>	Plan pays 100%		20%; deductible waived	
<b>Urgent care center</b>	\$50 copay	30% after deductible	\$55 copay	40% after deductible
<b>Hospital emergency room</b>	20% after deductible		20% after deductible	
<b>HOSPITAL SERVICES</b>				
<b>Inpatient and outpatient hospital services</b>	20% after deductible	30% after deductible	20% after deductible	40% after deductible
<b>Approved skilled nursing facility</b>				
<b>Home health care, Hospice care</b>				
<b>BEHAVIORAL HEALTH SERVICES</b>				
<b>Inpatient</b>	20% after deductible	30% after deductible	20% after deductible	40% after deductible
<b>Outpatient</b>	\$35 copay		\$45 copay	
<b>OTHER SERVICES</b>				
<b>Chiropractic Office visit (Limit 30 sessions per year)</b>	\$50 copay	30% after deductible	20% after deductible	40% after deductible
<b>Therapy - Occupational, Physical, Speech (Limit 20 sessions each per year)</b>	\$35 copay			
<b>Hearing aids &amp; exam (Limit \$3,500 every 3 years)</b>	20% after deductible			
<b>Durable Medical Equipment (including continuous glucose monitors)</b>				

\*See further description of WellNebraska Health Plan without incentives on page 16.

	Regular Health Plan		Consumer Focused Health Plan (HSA Eligible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	<b>Plan Year Deductible (must be satisfied before coinsurance is paid)</b>	\$1,400 individual \$2,600 family	\$2,800 individual \$5,200 family	\$2,700 individual \$5,200 family
<b>Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, &amp; medical co-pays)</b>	\$4,000 individual \$8,000 family	\$8,000 individual \$16,000 family	\$4,100 individual \$8,200 family	\$8,200 individual \$16,400 family
<b>Annual Pharmacy Out-of-Pocket Maximum</b>	\$2,250 individual \$4,500 family		Included in the medical out-of-pocket maximum	
<b>PHYSICIAN OFFICE VISITS</b>				
<b>Primary Care Physician Office visit</b>	\$45 copay	40% after deductible	20% after deductible	40% after deductible
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<b>Allergy testing / serum</b>	20% after deductible			
<b>Allergy shots</b>				
<b>Lab and Pathology Services</b>				
<b>Radiology and Chemotherapy/Radiation Therapy</b>				
<b>Routine Vision Exam plus Refraction</b>	Not covered		Not covered	
<b>PREVENTIVE EXAMS</b>				
<b>Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening.</b>	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.
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<b>Ambulance</b>	20%; deductible waived		20% after deductible	
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<b>Hospital emergency room</b>	20% after deductible		20% after deductible	
<b>HOSPITAL SERVICES</b>				
<b>Inpatient and outpatient hospital services</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<b>Approved skilled nursing facility</b>				
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<b>Chiropractic Office visit (Limit 30 sessions per year)</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
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<b>Hearing aids &amp; exam (Limit \$3,500 every 3 years)</b>				
<b>Durable Medical Equipment (including continuous glucose monitors)</b>				

**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 at [das.nebraska.gov/benefits](http://das.nebraska.gov/benefits) for exact benefits, exclusions and limitations.