QUICK REFERENCE GUIDE
2024-25 Health Benefits

COBRA and Retiree Medical, Dental, and Vision Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2024, through June 30, 2025, are shown below.

Monthly Medical Plan Premiums

		Wellness Health Plan		Regular Health Plan	Consumer Focused Health Plan
		With Wellness Incentive	Without Wellness Incentive		
Retiree/COBRA Employee Only (Single Coverage)	**Retiree:**	$717.36	$866.46	$866.46	$490.02
	COBRA:	$731.71	$883.79	$883.79	$499.82
Retiree/COBRA Employee + Spouse (Two-Party Coverage)	**Retiree:**	$1,901.02	$2,296.08	$2,296.08	$1,298.54
	COBRA:	$1,939.04	$2,342.00	$2,342.00	$1,324.51
Retiree/COBRA Employee + Dependent Children (Four Party Coverage)	**Retiree:**	$1,470.60	$1,776.24	$1,776.24	$1,004.56
	COBRA:	$1,500.01	$1,811.76	$1,811.76	$1,024.65
Retiree/COBRA Employee + Spouse + Dependent Children (Family)	**Retiree:**	$2,546.62	$3,075.90	$3,075.90	$1,739.56
	COBRA:	$2,597.55	$3,137.42	$3,137.42	$1,774.35

Monthly Dental Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	$26.44	$30.95
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	$52.96	$61.95
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	$76.38	$89.31
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	$83.21	$96.96

Monthly Vision Plan Premiums

	Basic Option	Premium Option
COBRA/Retiree Employee Only (Single Coverage)	$5.37	$8.34
COBRA/Retiree Employee + Spouse (Two-Party Coverage)	$8.61	$13.34
COBRA/Retiree Employee + Dependent Children (Four-Party Coverage)	$8.79	$13.59
COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage)	$14.14	$21.93

Your Health Insurance Benefits

	WellNebraska Health Plan			
	With Wellness Incentive		Without Wellness Incentive	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	$800 individual $1,600 family	$1,600 individual $3,200 family	$1,400 individual $2,600 family	$2,800 individual $5,200 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	$2,700 individual $5,400 family	$5,400 individual $10,800 family	$4,000 individual $8,000 family	$8,000 individual $16,000 family
Annual Pharmacy Out-of-Pocket Maximum	$2,000 individual $4,000 family		$2,250 individual $4,500 family	
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit	$25 copay	30% after deductible	$35 copay	40% after deductible
Specialty Office visit	$40 copay		$45 copay	
24/7 Virtual Visits	Plan pays 100%	Not covered	Plan pays 100%	Not covered
Allergy testing / serum	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
Allergy shots	Plan pays 100%			
Lab and Pathology Services	Paid at 100% up to $500; then 20% after deductible			
Radiology and Chemotherapy/Radiation Therapy	20% after deductible			
Routine Vision Exam plus Refraction	Not covered		Not covered	
PREVENTIVE EXAMS				
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. **See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.**	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.
EMERGENCY CARE				
Ambulance	Plan pays 100%		20%; deductible waived	
Urgent care center	$40 copay	30% after deductible	$45 copay	40% after deductible
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient and outpatient hospital services **Approved skilled nursing facility** **Home health care, Hospice care**	20% after deductible	30% after deductible	20% after deductible	40% after deductible
BEHAVIORAL HEALTH SERVICES				
Inpatient	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient	$25 copay		$35 copay	
OTHER SERVICES				
Chiropractic Office visit (Limit 30 sessions per year)	$40 copay	30% after deductible	20% after deductible	40% after deductible
Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)	$25 copay			
Hearing aids & exam (Limit $3,500 every 3 years)	20% after deductible			
Durable Medical Equipment (including continuous glucose monitors)				
MATERNITY SERVICES				
Outpatient maternity services (medically necessary)	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
Inpatient maternity related hospital charges (medically necessary)	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
Inpatient well baby nursery (eligible charges)	Plan pays 100%	30% - deductible doesn't apply	20% - deductible doesn't apply	40% deductible doesn't apply

	Regular Health Plan		Consumer Focused Health Plan (HSA Eligible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	$1,400 individual $2,600 family	$2,800 individual $5,200 family	$3,200 individual $5,200 family	$5,200 individual $10,400 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	$4,000 individual $8,000 family	$8,000 individual $16,000 family	$4,100 individual $8,200 family	$8,200 individual $16,400 family
Annual Pharmacy Out-of-Pocket Maximum	$2,250 individual $4,500 family		Included in the medical out-of-pocket maximum	
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit	$35 copay	40% after deductible	20% after deductible	40% after deductible
Specialty Office visit	$45 copay			
24/7 Virtual Visits	Plan pays 100%	Not covered		Not covered
Allergy testing / serum	20% after deductible	40% after deductible		40% after deductible
Allergy shots				
Lab and Pathology Services				
Radiology and Chemotherapy/Radiation Therapy				
Routine Vision Exam plus Refraction	Not covered		Not covered	
PREVENTIVE EXAMS				
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. **See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.**	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.
EMERGENCY CARE				
Ambulance	20%; deductible waived		20% after deductible	
Urgent care center	$45 copay	40% after deductible	20% after deductible	40% after deductible
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient and outpatient hospital services **Approved skilled nursing facility** **Home health care, Hospice care**	20% after deductible	40% after deductible	20% after deductible	40% after deductible
BEHAVIORAL HEALTH SERVICES				
Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient	$35 copay			
OTHER SERVICES				
Chiropractic Office visit (Limit 30 sessions per year)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)				
Hearing aids & exam (Limit $3,500 every 3 years)				
Durable Medical Equipment (including continuous glucose monitors)				

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/personnel/wellness/index.html** for exact benefits, exclusions and limitations.

Your Pharmacy Benefits

	WellNebraska Plan		Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
	With Wellness Incentive	Without Wellness Incentive		
RETAIL - 30 DAY SUPPLY				
Tier 1	$5 copay	$5 copay	$5 copay	20% after deductible
Tier 2	$30 copay	$40 copay	$40 copay	20% after deductible
Tier 3	$50 copay	$60 copay	$60 copay	20% after deductible
MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY				
Tier 1	$10 copay	$10 copay	$10 copay	20% after deductible
Tier 2	$60 copay	$80 copay	$80 copay	20% after deductible
Tier 3	$100 copay	$120 copay	$120 copay	20% after deductible
Pharmacy Out-of-Pocket Maximum	$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

WellNebraska Health Plan ONLY (with Wellness Incentive)

UHC PREVENTIVE DRUG LIST (FORMULARY)
For list, go to Wellness & Benefits Resources page at **das.nebraska.gov/personnel/wellness/index.html**

RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	$15 copay
Tier 3	$30 copay
MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY	
Tier 1	2 Times the 30-day supply
Tier 2	
Tier 3	

All Other Plans

UHC PREVENTIVE DRUG LIST (FORMULARY)
For list, go to Wellness & Benefits Resources page at **das.nebraska.gov/personnel/wellness/index.html**

RETAIL - 30 DAY SUPPLY	
Tier 1	No copay
Tier 2	$25 copay
Tier 3	$50 copay
MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY	
Tier 1	2 Times the 30-day supply
Tier 2	
Tier 3	