

# QUICK REFERENCE GUIDE

## 2025-26 Health Benefits

### Medical & Dental Premiums



#### Monthly Medical Plan Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2025, through June 30, 2026, are shown below. The state contributes 79% of the total cost of your health care benefits for full-time public servants. Premiums are deducted from your paycheck pre-tax, meaning you do not pay taxes on them as they are deducted from your pay before taxes are withheld.

**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 public servant 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 public servants who are paid bi-weekly, your deduction will be half of the total shown here and deductions are only taken 24 times per year.

		WellNebraska Health Plan				Regular Health Plan		Consumer Focused Health Plan	
		With Wellness Incentive		Without Wellness Incentive		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
		FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
<b>Employee Only</b> (Single Coverage)	<b>Your Cost:</b>	<b>\$167.22</b>	<b>\$273.92</b>	<b>\$196.50</b>	<b>\$321.90</b>	<b>\$196.50</b>	<b>\$321.90</b>	<b>\$111.14</b>	<b>\$182.04</b>
	State Cost:	\$629.06	\$522.36	\$739.28	\$613.88	\$739.28	\$613.88	\$418.08	\$347.18
	Total:	\$796.28	\$796.28	\$935.78	\$935.78	\$935.78	\$935.78	\$529.22	\$529.22
<b>Employee + Spouse</b> (Two-Party Coverage)	<b>Your Cost:</b>	<b>\$443.12</b>	<b>\$725.88</b>	<b>\$520.74</b>	<b>\$853.04</b>	<b>\$520.74</b>	<b>\$853.04</b>	<b>\$294.50</b>	<b>\$482.42</b>
	State Cost:	\$1,667.02	\$1,384.26	\$1,959.04	\$1,626.74	\$1,959.04	\$1,626.74	\$1,107.92	\$920.00
	Total:	\$2,110.14	\$2,110.14	\$2,479.78	\$2,479.78	\$2,479.78	\$2,479.78	\$1,402.42	\$1,402.42
<b>Employee + Dependent Children</b> (Four-Party Coverage)	<b>Your Cost:</b>	<b>\$342.80</b>	<b>\$561.54</b>	<b>\$402.84</b>	<b>\$659.90</b>	<b>\$402.84</b>	<b>\$659.90</b>	<b>\$227.82</b>	<b>\$373.20</b>
	State Cost:	\$1,289.58	\$1,070.84	\$1,515.50	\$1,258.44	\$1,515.50	\$1,258.44	\$857.10	\$711.72
	Total:	\$1,632.38	\$1,632.38	\$1,918.34	\$1,918.34	\$1,918.34	\$1,918.34	\$1,084.92	\$1,084.92
<b>Employee + Spouse + Dependent Children</b> (Family Coverage)	<b>Your Cost:</b>	<b>\$593.62</b>	<b>\$972.40</b>	<b>\$697.62</b>	<b>\$1,142.76</b>	<b>\$697.62</b>	<b>\$1,142.76</b>	<b>\$394.52</b>	<b>\$646.28</b>
	State Cost:	\$2,233.14	\$1,854.36	\$2,624.36	\$2,179.22	\$2,624.36	\$2,179.22	\$1,484.20	\$1,232.44
	Total:	\$2,826.76	\$2,826.76	\$2,826.76	\$2,826.76	\$3,321.98	\$3,321.98	\$1,878.72	\$1,878.72



#### Monthly Dental Plan Premiums

	Basic Option	Premium Option
<b>Employee Only</b> (Single Coverage)	\$26.70	\$31.26
<b>Employee + Spouse</b> (Two-Party Coverage)	\$53.48	\$62.58
<b>Employee + Dependent Children</b> (Four-Party Coverage)	\$77.14	\$90.20
<b>Employee + Spouse + Dependent Children</b> (Family Coverage)	\$84.04	\$97.92

# 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</b> (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
<b>Annual Medical Out-of-Pocket Maximum</b> (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
<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>	\$25 copay	30% after deductible	\$35 copay	40% after deductible
<b>Specialty Office visit</b>	\$40 copay		\$45 copay	
<b>24/7 Virtual Visits</b>	Plan pays 100%	Not covered	Plan pays 100%	Not covered
<b>Allergy testing / serum</b>	Plan pays 100%	30% after deductible	20% after deductible	40% 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	
<b>PREVENTIVE EXAMS</b>				
<b>Services include flu shots, immunizations, preventive exams, well-baby exams, routine prenatal 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>	\$40 copay	30% after deductible	\$45 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>	\$25 copay		\$35 copay	
<b>OTHER SERVICES</b>				
<b>Chiropractic Office visit (Limit 30 sessions per year)</b>	\$40 copay	30% after deductible	20% after deductible	40% after deductible
<b>Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)</b>	\$25 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>				
<b>MATERNITY SERVICES</b>				
<b>Outpatient maternity services (medically necessary)</b>	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
<b>Inpatient maternity related hospital charges (medically necessary)</b>	Plan pays 100%	30% after deductible	20% after deductible	40% after deductible
<b>Inpatient well baby nursery (eligible charges)</b>	Plan pays 100%	30% - deductible doesn't apply	20% - deductible doesn't apply	40% deductible doesn't apply

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. Refer to the summary plan documents found on Employee Wellness & Benefits website at [das.nebraska.gov/personnel/wellness/index.html](http://das.nebraska.gov/personnel/wellness/index.html) for exact benefits, exclusions and limitations.

	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	\$3,300 individual \$5,200 family	\$5,200 individual \$10,400 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	\$4,300 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>	\$35 copay	40% after deductible	20% after deductible	40% after deductible
<b>Specialty Office visit</b>	\$45 copay	Not covered		Not covered
<b>24/7 Virtual Visits</b>	Plan pays 100%			
<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>  <b>See Summary Plan Document on Employee Wellness &amp; Benefits website for a comprehensive list of your preventive care services.</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.
<b>EMERGENCY CARE</b>				
<b>Ambulance</b>	20%; deductible waived		20% after deductible	
<b>Urgent care center</b>	\$45 copay	40% after deductible	20% after deductible	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	40% 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	40% after deductible	20% after deductible	40% after deductible
<b>Outpatient</b>	\$35 copay			
<b>OTHER SERVICES</b>				
<b>Chiropractic Office visit (Limit 30 sessions per year)</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<b>Therapy - Occupational, Physical, Speech (Limit 30 sessions each per year)</b>				
<b>Hearing aids &amp; exam (Limit \$3,500 every 3 years)</b>				
<b>Durable Medical Equipment (including</b>				
<b>MATERNITY SERVICES</b>				
<b>Outpatient maternity services (medically necessary)</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<b>Inpatient maternity related hospital charges (medically necessary)</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<b>Inpatient well baby nursery (eligible charges)</b>	20%-deductible doesn't apply	40% - deductible doesn't apply	20% - deductible doesn't apply	40% deductible doesn't apply

# Your Pharmacy Benefits

	WellNebraska Plan With Wellness Incentive      Without Wellness Incentive		Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
<b>RETAIL - 30 DAY SUPPLY</b>				
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
<b>MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY</b>				
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
<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>UHC PREVENTIVE DRUG LIST (FORMULARY)</b> For list, go to Wellness & Benefits Resources page at <a href="http://das.nebraska.gov/personnel/wellness/index.html">das.nebraska.gov/personnel/wellness/index.html</a> .	
<b>RETAIL - 30 DAY SUPPLY</b>	
Tier 1	No copay
Tier 2	\$15 copay
Tier 3	\$30 copay
<b>MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY</b>	
Tier 1	
Tier 2	2 Times the 30-day supply
Tier 3	

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

## Virtual Visits

(24/7 Virtual Visits, Virtual Preventive Care, and Virtual Specialists)

With your UHC account you now have access to Virtual care in ways like never before. Not only can you do your standard Virtual visits for those non-emergency medical conditions that can spring up, you now can establish a Virtual Primary care provider for your day to day care. Or take it one step further with out Virtual Specialist.

Virtual Care Benefits	WellNebraska Health Plan (with incentive)	Regular Health Plan/ WellNebraska Plan (without incentive)	Consumer Focused Health Plan
24/7 Virtual Visits	\$0 copay Plan pays 100%	\$0 copay Plan pays 100%	20% after deductible
Virtual Primary Care and Virtual Specialists	\$25 copay for Primary care \$40 copay for Specialist	\$35 copay for Primary care \$45 copay for Specialist	20% after deductible

## FREE NurseLine

877-263-0911

24 hours a day, 7 days a week

TTY: 711

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

- Speak with a registered nurse
- Understand your symptoms and treatment options
- Ask medication questions
- Decide if you should use virtual visits, see a doctor, go to the ER, or try self-care
- Find a doctor, hospital, or specialist
- Make an appointment with your provider