City of Grand Island

Tuesday, August 11, 2015

Council Session

Item I-3

#2015-218 - Consideration of Approving Health and Dental Benefits

Staff Contact: Aaron Schmid, Human Resources Director

Council Agenda Memo

From: Aaron Schmid, Human Resources Director

Meeting: August 11, 2015

Subject: Approval of Health and Dental Benefits

Presenter(s): Aaron Schmid, Human Resources Director

Background

The City of Grand Island provides health and dental benefits to its employees. The City has a partially self-funded plan, meaning that claims are actually paid for by the premium dollars generated through the plan to a specified limit. The City utilizes a third party, Blue Cross Blue Shield of Nebraska, to administer and pay claims and provide stop loss coverage.

The City's current "specific deductible" or stop loss is $150,000 per participant. This means that the first $150,000 of claims for a plan participant is paid for by the premium dollars generated and then the reinsurance carrier picks up the claims that exceed the deductible. The City's dental plan is self-funded and the principle is the same as for health insurance in that the premiums generated pay the claims incurred.

Discussion

As the new fiscal and plan years are set to begin on October 1, it is customary to bring the health insurance renewal forward as well as funding requirements. The City budgeted $8.817 million for fiscal year 2015/2016 for health and dental insurance expenses. The budgeted amount covers items such as payment of claims, administrative fees, and HSA contributions.

The addition of the Qualified High Deductible Plan (QHDP) continues to have a favorable impact on claims. Approximately 25% of eligible employees are enrolled in the QHDP. Although we have experienced a small number of large claims, overall the rest of our claims experience was positive.

The proposed QHDP has a $3,000/$5,500 in network deductible. The traditional PPO plan has a $500/$1,000 in-network deductible. Participants who go out of network will experience deductibles that are twice the in network amount. That has been part of the City's plan design for many years. City employees pay 16% of the PPO plan premium and 12% of the QHDP premium. As the initial 2 years of experience with the QDHP has

been so positive, I am proposing the HSA contribution stay the same at $1,250 for single coverage and $2,500 for family coverage to be paid to plan participant's Health Savings Account (HSA). This contribution will take place in January 2015. The intention is to further incentivize employees to move to the high deductible plan and continue to control rising costs with increased consumerism.

I am also proposing that we continue to calculate HSA contributions for new employees based on their starting date. The contribution adjustment would be calculated quarterly. As an example, an employee who becomes eligible for single coverage in April would receive a contribution for three quarters of the remaining year. After the start of each quarter of the calendar year, the amount would be reduced by 25%.

Dental insurance was separated from the health plan in 2013/20414 and is a voluntary benefit. Employees can determine whether or not they want to elect this benefit and at what level. The employee pays 30% of the premium for the dental benefit. This is comparable in the market for dental to be a separate benefit.

Delta Dental is the provider of the dental insurance. The service to our plan participants has been excellent. The administrative fees for dental services are $3.85 per employee per month to be paid by the City. The City entered into a three year contract with Delta Dental of Nebraska in 2013/2014.

The contract with Blue Cross and Blue Shield of Nebraska (BCBSNE) specifies administrative fees of $30.00 per employee per month. Individual stop loss coverage will cost $114.98 per employee per month and the aggregate stop loss coverage will cost $5.64 per employee per month. The contract with Strong Financial will cost $1,654 per month. COBRA administration will be handled by Discovery Benefits, Inc. (DBI). The cost for COBRA administration will be $0.70 per employee per month for the term of the contract. The fees associated with the wellness screenings will be $67.45 per participant for the duration of the contract.

Alternatives

It appears that the Council has the following alternatives concerning the issue at hand. The Council may:

1. Move to approve
2. Refer the issue to a Committee
3. Postpone the issue to future date
4. Take no action on the issue

Recommendation

City Administration recommends that the Council approve health plan renewal and the recommended contributions to the employee's HSA.

Sample Motion

Move to approve the health plan renewal and the recommended contribution levels to the employee's HSA.

Purchasing Division of Legal Department
INTEROFFICE MEMORANDUM

CITY OF GRAND ISLAND

Stacy Nonhof, Purchasing Agent

Working Together for a Better Tomorrow, Today

REQUEST FOR PROPOSAL
FOR
MEDICAL/Rx HEALTH INSURANCE PLAN

RFP DUE DATE: **May 14, 2015 at 4:00 p.m.**

DEPARTMENT: **Human Resources**

PUBLICATION DATE: **April 13, 2015**

NO. POTENTIAL BIDDERS: **11**

SUMMARY OF PROPOSALS RECEIVED

National Stop Loss
Bedford, MA

United Health Group0
Rocky Hill, CT

Aetna Life Insurance Company
Hartford, CT

Blue Cross Blue Shield
Omaha, NE

Regional Care, Inc.
Scottsbluff, NE

MedTrak Services
Overland Park, KS

CoreSource
Overland Park, KS

Cigna 312
Overland Park, KS

cc: Aaron Schmid, Human Resources Director
Marlan Ferguson, City Administrator
Stacy Nonhof, Purchasing Agent
Tami Herald, HR Rick Manager
William Clingman, Interim Finance Director

P1814

Client Profile

Group Name:	**City of Grand Island**
Effective Date:	**10/1/2015**

The Client Profile document sets forth group demographic information and specific plan terms, requirements and benefit design elements. The Client Profile is part of the Benefit Plan Document, which includes the Administrative Services Agreement (ASA), Summary Plan Description (SPD), and is incorporated therein by this reference.

Account Team

Group Information		
Group Name:	City of Grand Island	
Effective Date:	10/1/2015	

Sales Executive:	Brad Utoft
Sales Executive Number:	32
Account Executive:	Lisa Shoup
Account Executive Number:	22
Account Service Representative:	Mike Perry
Account Service Representative Number:	BZ
Underwriter:	Sherry Young
Broker Name:	Cal Strong
BCBSNE Assigned Broker Number:	01721
Brokerage Name:	Strong Financial Services
BCBSNE Assigned Brokerage Number:	25191

Group Information

Group Information

Group Name:	City of Grand Island
Effective Date:	10/1/2015

New Group, Renewal, Revision, Termination:	Renewal
Renewal Month:	October
ERISA Plan Year Month:	October
Group's Original Effective Date:	10/1/12

Applicant Information

Applicant/Employer Legal Name:	City of Grand Island
Short Name (35 character limit):	
Market Affiliation Code (MAC) Number:	1525
Group Number(s):	305208

****For Roll Numbers, Break Out Codes and Rate Pool Codes, see attached Roll Listing.****

Physical Address:

100 East 1st St.	Street Address
Grand Island	City
NE	State
68801	Zip Code
No	Use as billing address?

P.O. Box Address:

PO Box 1968	PO Box
Grand Island	City
NE	State
68802	Zip Code
Yes	Use as billing address?

Billing Address if different than above:

	Address
	City
	State
	Zip Code

Group Prefix:	YED
Employer (Tax) Identification Number (EIN):	47-6006205
North American Industry Classification System (NAICS) Number:	921100
Funding Type:	ASO
Grandfathered Status:	Non-Grandfathered
Religious Employer Exemption (Please include form 89-109 (01-01-14):	No
Is group subject to Employee Retirement Income Security Act (ERISA)?	No

Name(s) of Subsidiaries or Affiliated organizations to be included: (must be majority-owned - 51% or greater)

N/A

Authorized Plan Contacts

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules provide that the Group Health Plan ("GHP") is a separate legal entity from the Employer/Plan Sponsor. In compliance with HIPAA Privacy Rules, it is necessary to designate Authorized Plan Contacts for the GHP.

The GHP Primary Contact serves as BCBSNE's primary contact for the GHP, and may also designate additional Authorized Plan Contacts for the GHP. The GHP Primary Contact shall notify BCBSNE of any additions or deletions to the following list, by noting changes/additions below.

We will automatically include your GHP's Agent of Record as one of your Authorized Plan Contacts. If you choose not to have the GHP's Agent of Record authorized to receive this information, please check here: ☐

The following individuals may be given access to GHP information received from BCBSNE in accordance with the requirements set forth within HIPAA Privacy Rules.

Head of Firm:

Reason for Change:	N/A
Name:	Aaron Schmid
Title:	Human Resources Director
Phone Number:	308-385-5444 Ext 199
Fax Number:	N/A
Email Address:	aarons@grand-island.com
Access to Blues Enroll?	No
Access to Protected Health Information (PHI):	Full Access
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Group Leader/Group Health Plan Primary Contact:

Reason for Change:	N/A
Name:	Tami Herald
Title:	Human Resources
Phone Number:	308-385-5444 Ext 192
Fax Number:	
Email Address:	TamiH@Grand-Island.com
Access to Blues Enroll?	
Access to Protected Health Information (PHI):	Full Access
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Billing Contact:

Reason for Change:	N/A
Name:	Tami Herald
Title:	Human Resources
Phone Number:	308-385-5444 Ext 192
Fax Number:	
Email Address:	TamiH@Grand-Island.com
Access to Blues Enroll?	
Access to Protected Health Information (PHI):	Full Access
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Eligibility/Enrollment Contact:

Reason for Change:	N/A
Name:	Tami Herald
Title:	Human Resources
Phone Number:	308-385-5444 Ext 192
Fax Number:	
Email Address:	TamiH@Grand-Island.com
Access to Blues Enroll?	
Access to Protected Health Information (PHI):	Full Access
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Changes to Authorized Plan Contacts (Include additions, deletions and updates only).

Additional Plan Contact:

Reason for Change:	
Name:	
Title:	
Phone Number:	
Fax Number:	
Email Address:	
Access to Blues Enroll?	
Access to Protected Health Information (PHI):	
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Additional Plan Contact:

Reason for Change:	
Name:	
Title:	
Phone Number:	
Fax Number:	
Email Address:	
Access to Blues Enroll?	
Access to Protected Health Information (PHI):	
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Additional Plan Contact:

Reason for Change:	
Name:	
Title:	
Phone Number:	
Fax Number:	
Email Address:	
Access to Blues Enroll?	
Access to Protected Health Information (PHI):	
If limited access, please only allow PHI access for the following Group/Roll numbers:	

Comments:	

Current List of Authorized Plan Contacts:

Name:	Calvin Strong
Title:	Broker
Should this person still be authorized?	Yes

Name:	Strong Financial Services
Title:	Brokerage
Should this person still be authorized?	Yes

Name:	
Title:	
Should this person still be authorized?	

Name:	
Title:	
Should this person still be authorized?	

General Information

Group Information		
Group Name:	City of Grand Island	
Effective Date:	10/1/2015	

Products to be administered by BCBSNE			
Traditional Two-Tier PPO Health:	Yes ☑ No ☐	Number of Options:	1
Two-Tier CDHP Health (HSA Eligible):	Yes ☑ No ☐	Number of Options:	1
Three-Tier PPO Health:	Yes ☐ No ☑	Number of Options:	
Three-Tier CDHP Health (HSA Eligible):	Yes ☐ No ☑	Number of Options:	
Dental Coverage:	Yes ☐ No ☑	Number of Options:	
RX Nebraska Prescription Drug Program (Prime) If no, please attach Rx sheet:	Yes ☑ No ☐	Number of Options:	2
Group Medicare Supplement (Retirees Only):	Yes ☐ No ☑	Number of Options:	
Reinsurance/Stop Loss:	Yes ☑ No ☐		

Attached Documents (Documents should be uploaded with the Client Profile)

Please list any documents that will be uploaded with this client profile below:

N/A

Ancillary Products

Davis Vision, USAble, Clearstone, and EveryMove are independent companies and do not provide BCBSNE products and services. Those companies are solely responsible for the services they provide.

Other Programs and Services Offered to Self-funded Employer Groups

Medicare Part D - Administered and underwritten by Clearstone?	Yes ☐ No ☑
Vision Plan - Administered and underwritten by Davis Vision?	Yes ☐ No ☑
Life/AD&D - Administered and underwritten by USAble?	Yes ☐ No ☑

Blue Health Partners (If any of the below are marked, please attach applicable form(s).)

Option A (Diabetes, Cardiac, Heart Failure, COPD, Asthma):	Yes ☐ No ☑
Option B (Diabetes, Cardiac, Heart Failure, COPD):	Yes ☐ No ☑
Option C (Diabetes, Cardiac, Heart Failure):	Yes ☐ No ☑
Other:	

BlueHealth Advantage

Standard option is included. Additional health education can be purchased separately.

EveryMove:	Yes ☐ No ☑
BlueHealth Advantage Premium:	Yes ☑ No ☐
Other:	Group has biometric screening options.

GeoBlue

Group Ex-Patriot (Working abroad 6 months or more):	Yes ☐ No ☑
Group Travelers (Business travel less than 6 months):	Yes ☐ No ☑
Other:	

Non-BCBSNE Products that the Group Contracts for Independently

Traditional Two-Tier PPO Health:	Yes ☐ No ☑	Number of Options:	
Vendor Name:			
Two-Tier CDHP Health (HSA-Eligible):	Yes ☐ No ☑	Number of Options:	
Vendor Name:			
Three-Tier PPO Health:	Yes ☐ No ☑	Number of Options:	
Vendor Name:			
Three-Tier CDHP Health (HSA-Eligible):	Yes ☐ No ☑	Number of Options:	
Vendor Name:			
Dental Coverage:	Yes ☑ No ☐	Number of Options:	1
Vendor Name:	Delta Dental		
Group Medicare Supplement (Retirees Only):	Yes ☐ No ☑	Number of Options:	
Vendor Name:			
Reinsurance/Stop Loss:	Yes ☐ No ☑		
Vendor Name:			
Pharmacy Benefit Manager:	Yes ☐ No ☑		
Vendor Name:			

HRA/HSA/FSA Vendors

Does the Group offer a Health Savings Account (HSA)?	Yes ☑ No ☐
Vendor Name:	ConnectiCare
Does the Group have a direct relationship with the vendor?	Yes ☑ No ☐
If through BCBSNE, select vendor number and attach completed HSA Employer Setup Form:	

Does the Group offer a Health Reimbursement Account (HRA)?	Yes ☐ No ☑
Vendor Name:	
Does the Group have a direct relationship with the vendor?	Yes ☐ No ☐
If through BCBSNE, select vendor number and attach completed HRA Employer Setup Form	

Does the Group offer a Flexible Spending Account?	Yes ☑ No ☐
Vendor Name:	TASC (Total Administrative Services Corporation)
Does the Group have a direct relationship with the vendor?	Yes ☑ No ☐
If through BCBSNE, select vendor and attach completed FSA Employer Setup Form:	

Is the Group Health Plan subject to the Consolidated Omnibus Reconciliation Act (COBRA), as amended, during this calendar year?	Yes ☑ No ☐
If the above answer is "Yes", please provide the name of the COBRA administrator:	Discovery
Does the Group authorize BCBSNE to administer coverage requests under Qualified Medical Child Support Order (QMCSO)?	Yes ☑ No ☐
Does the Group authorize BCBSNE to provide notice of termination letters to eligible employees/dependents?	Yes ☑ No ☐

Summary Plan Descriptions: BCBSNE will provide the Group with an electronic version of the Summary Plan Description (SPD). The Group is responsible for providing this document to its enrolled employees, including retirees and COBRA participants.

Financial Agreements, Fees and Employer Contributions: The administrative charge, fees and financial arrangements for the claim administrative services provided by BCBSNE are set forth in the Administrative Services Agreement (ASA), and its attachments.

Other Provisions:	N/A

GROUP DATA FOR MEDICARE SECONDARY PAYER	BCBSNE is required to collect information in order to properly pay claims for your employees who are eligible for Medicare benefits. In accordance with Medicare law, depending on the current employment status of your employee and/or employer size, BCBSNE may be required to pay primary to Medicare for certain group health benefits, regardless of an employee's or dependent's entitlement to Medicare.

Employee Information: Do you have employees or covered dependents enrolled in your Group Health Plan who also currently have Medicare coverage or who are turning 65 this year?	Yes ☑ No ☐

Employer Information: When responding to questions 1 through 3 below, include full-time, part-time, leased and seasonal employees, but exclude independent contractors. If your company has affiliated parent or sister companies that are members of the same control group for IRS purposes, all employees in all of the affiliated companies should be included in your total, whether or not the affiliated companies have coverage with BCBSNE.

Do you have 20 or more employees for 20 or more calendar weeks for the current calendar year?	Yes ☑ No ☐	If yes, please provide the date this threshold was reached:	10/1/2012
Did you have 20 or more employees for 20 or more calendar weeks for the previous calendar year?	Yes ☑ No ☐	If yes, please provide the date this threshold was reached:	10/1/2012
Did you have 100 or more employees during 50 percent of your business days during the previous calendar year?	Yes ☑ No ☐		

New Groups Only

For New Groups Only: Will the Group provide BCBSNE with prior carrier accumulations?	Yes ☐ No ☐

If yes, please select type of accumulator and enter date BCBSNE will receive file:

Deductible:	☐	Date file will be received:
Coinsurance:	☐	Date file will be received:
Out-of-Pocket Limit:	☐	Date file will be received:
Session Limits:	☐	Date file will be received:
Dental:	☐	Date file will be received:

Comments:	

Eligibility & Enrollment

Group Information	
Group Name:	City of Grand Island
Effective Date:	10/1/2015

Enrollment Tier Options	
Single:	☑
Employee & Spouse:	☑
Employee & Children:	☑
Family:	☑
Employee + 1:	☐
Employee + 2 or More:	☐
Other (Please define below):	☐

Are Retiree's Eligible? (Attach copy of Retirement Program describing plan eligibility requirements & contribution toward monthly charges.)	No
Comments:	Retirees are a closed class of grandfathered employees.
Are Board of Directors Eligible? (Attach list of Board Members & Resolution passed approving the same contribution toward the health care plan as for employees.)	No
Comments:	

Employee Data	
Total employees on the payroll (includes full-time, part-time, leased employees):	500
Total eligible employees on the payroll:	475
Eligible employees not enrolling due to coverage:	
Number of employees with creditable coverage (Medicare, Medicaid, Spousal coverage):	
Number of employees with individual coverage:	
Number of employees not enrolling due to cost or other reasons:	
Eligible employees enrolling on the effective date:	475
Number of persons on COBRA or State Continuation coverage:	

Effective Date Rules

New Hire Rules	Rules/Applicable Group & Rolls
Minimum hours per week an employee must work to be eligible for coverage?	30
Probation Days:	60
Effective Date of Coverage:	First of the month following applicable probation days
Other:	If the first day of eligibility lands on the first, then the effective day will be that day. Regular Status Part-time employees that maintain an average of 30 hours of work per week are eligible for single coverage benefits only. Group counts eligibility period by months rather than days. Furlough: When it is determined necessary to reduce payroll expenses, employees may be required to participate in furloughs or a reduction of hours worked. The employees' health insurance and other benefits will not be effected as long as the furlough is temporary in nature and does not result in an employee's hours dropping below thirty-five hours per week average on an annual basis.

Re-Hire Rules	
	Same as new hire
Other:	

Special Enrollee Rules	
Marriage:	First of the month following the date of event
Birth/Adoption:	Date of event
STANDARD: All Newborns (including grandchildren) will be added for the first 31 days:	No - Newborns will not be added automatically, group must enroll ALL newborns
Loss of Other Coverage:	STANDARD - first of the month following the loss of other coverage
Other:	Newborn of a dependent daughter is not eligible for coverage, including the first 31 days.

Late Enrollee Rules

STANDARD: Late enrollment is allowed only during the month prior to the annual renewal date. Enrollment Forms must be signed by the last day of open enrollment and must be received by BCBSNE in a timely manner:	Standard
Other:	
Dental - STANDARD: Part A only for the first 12 months:	N/A
Other:	

Termination Date Rules

Employees:	Last day of the month in which eligibility is lost
Dependents:	Last day of the month in which eligibility is lost
Other:	

Eligible Dependents

Spouse - STANDARD: The Spouse of the Subscriber, unless the marriage has been ended by Legal, effective decree of dissolution, divorce or separation (includes same sex marriage, regardless of their State of residence):	Standard
Other:	

If Spouse above is marked "Other", please answer the following questions regarding Same Sex Marriage.

Is Same Sex Spouse eligible?	
If yes, will they be covered regardless of their state of residence?	
Other:	
Children to Age 26 - STANDARD: Biological son(s) and daughter(s), stepchild/children, a child/children for whom the Subscriber is a court appointed guardian, not including foster child/children:	Standard
Other:	
Children age 26 and older - STANDARD: can remain covered if they are incapable of self-sustaining employment or of returning to school as a full-time student, by reason of mental or physical handicap AND dependent upon the Subscriber for support and maintenance	Standard
Other:	
Domestic Partners:	Yes ☐ No ☑
If yes, select all that apply	Same Sex ☐
	Opposite Sex ☐
	Dependents of Domestic Partner ☐
Rules:	

Other Eligibility Provisions

Are Dental Enrollment Tiers required to match Medical?	N/A
Can Dental be elected independent of Medical?	N/A
Waive Dental 2-year Re-enrollment provision?	N/A
Dependent continuation to age 30 (Nebraska Mandate)?	Yes
Other Eligibility Provisions:	

Enrollment Process

Actives:	Blues Enroll
COBRA:	Blues Enroll
Retirees:	Blues Enroll
Other:	

2-Tier Medical Benefits

Group Information	
Group Name:	City of Grand Island
Effective Date:	10/1/2015
Benefit Year	
What is the Benefit Year?	Calendar Year ☑ Plan Year ☐
If Plan Year, define dates: (i.e. 7/1 to 6/30):	
Plan Type	
Type of Plan:	PPO ☑ CDHP (HSA Eligible) ☐
Large Group 2-Tier Standard Medical and RX Standard Option Number:	Non Standard
Option/Total Number of Options (Please type "Option 1 of X"):	1 of 2
Comments:	

Annual Cost Share Information

Deductible

(The amount the Covered Person pays each Benefit Year for Covered Services before the Coinsurance is payable)

	In-Network	Out-of-Network
Individual Deductible:	$500	$1,000
Family Deductible:	$1,000	$2,000
Comments:		

Embedded ☑ Aggregate ☐

Coinsurance

(the percentage amount the Covered Person must pay for most Covered Services after the deductible has been met)

	In-Network	Out-of-Network
Covered Person Pays:	20%	30%
Individual Coinsurance Limit:	N/A	N/A
Family Coinsurance Limit:	N/A	N/A
Comments:		

Embedded ☑ Aggregate ☐

Out-of-Pocket Limit

	In-Network	Out-of-Network
Individual Benefit Year Out-of-Pocket Limit:	$1,800	$2,950
Family Benefit Year Out-of-Pocket Limit:	$3,600	$5,900
Comments:		

Embedded ☑ Aggregate ☐

Aggregate Deductible and/or Out-of-Pocket Limit: Aggregate Deductible means the entire family amount must be met before benefits are available. Aggregate Out-of-Pocket Limit means the entire family amount must be met before cost-sharing is no longer applicable. Family members may combine their covered expenses to satisfy the family amounts.

Embedded Deductible and/or Out-of-pocket Limit: An "embedded" amount means that no one family member contributes no more than the individual amount to satisfy the family amount under a multi-person membership unit.

Once the annual Out-of-Pocket Limit is reached, most Covered Services are payable by the Plan at 100% for the remainder of the Benefit Year

Out-of-Pocket Limit includes:

Medical Deductible	☑
Medical Coinsurance	☑
Medical Copays	☑
Pharmacy Deductible	☐
Pharmacy Coinsurance	☐
Pharmacy Copays	☑
Other	☐

Amounts not included in the Out-of-Pocket Limit will continue to apply, even after the Out-of-Pocket Limit for the year is reached

Do In-Network and Out-of-Network Deductible and Out-of-Pocket Limits cross accumulate?	Yes
Comments:	

Do all other Limits (days, visits, sessions, dollar amounts, etc.) cross accumulate between In-Network and Out-of-Network?	Yes
Comments:	

Copayment applies to the following:

Physician Office	☑
Urgent Care Facility	☑
Emergency Care	☐
Allergy Injections	☐
Prescription Drugs	☑
Manipulations and Adjustments	☑
Other (if checked, enter below)	☐

Office Visit Copay

Office Visit Copay?	No

Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy), consultations, office psychological therapy and/or substance dependence and abuse counseling/rehabilitation, and medication checks.

Office Services Copay

Office Services Copay?	Yes

Listed below are BCBSNE standard office services included within the Copay. If customization is requested, please select each service where customization is necessary and if Copay applies

The following services will be subject to the Copay when billed by a professional provider in an office setting unless indicated otherwise below:

Allergy testing:	This service IS subject to office Copay (standard)
Diagnostic x-ray, laboratory and pathology services, including pap smears and mammograms when due to an illness:	This service IS subject to office Copay (standard)
Office consultation:	This service IS subject to office Copay (standard)
Supplies:	This service IS subject to office Copay (standard)
Medication checks:	This service IS subject to office Copay (standard)
Mental illness/substance abuse office therapy visits:	This service IS subject to office Copay (standard)
Hearing exam, when due to an illness or injury:	This service IS subject to office Copay (standard)
Vision exam, when due to an illness or injury (excluding refractions):	This service IS subject to office Copay (standard)
Office visit:	This service IS subject to office Copay (standard)
Drugs administered in an office setting:	This service IS subject to office Copay (standard)
Initial visit of diagnoses of pregnancy:	This service IS subject to office Copay (standard)
Comments:	

The following services will NOT be subject to the office services Copay when billed by a professional provider in an office setting unless indicated otherwise below:

Allergy Injections & Serum:	This service is NOT subject to office Copay (standard)
Other Injections:	This service is NOT subject to office Copay (standard)
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine):	This service is NOT subject to office Copay (standard)
Pregnancy Services:	This service is NOT subject to office Copay (standard)
Preventive Services:	This service is NOT subject to office Copay (standard)
Radiation Therapy & Chemotherapy:	This service is NOT subject to office Copay (standard)
Surgery & Anesthesia:	This service is NOT subject to office Copay (standard)
Physical, Occupational and Speech Therapy:	This service is NOT subject to office Copay (standard)
Manipulations and Adjustments:	This service is NOT subject to office Copay (standard)
Durable Medical Equipment:	This service is NOT subject to office Copay (standard)
Sleep Studies:	This service is NOT subject to office Copay (standard)
Biofeedback:	This service is NOT subject to office Copay (standard)
Psychological Evaluations, Assessments, and Testing:	This service is NOT subject to office Copay (standard)
Infusion Therapies:	This service is NOT subject to office Copay (standard)
Comments:	

Primary Care Physician is a physician who has a majority of his/her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A Physician Assistant is covered in the same manner as a Primary Care Physician.

Specialist Physician is a physician who is not a Primary Care Physician.

Office Cost Share Information	In-Network	Out-of-Network
Primary Care Physician:	$35 Copay	Deductible & Coinsurance
Other Covered Services:	Applicable Office Copay	Deductible & Coinsurance
Specialist:	$50 Copay	Deductible & Coinsurance
Other Covered Services:	Applicable Office Copay	Deductible & Coinsurance
Allergy Injections and Serum:	Deductible & Coinsurance	Deductible & Coinsurance
Convenient Care/Retail Clinics (Quick Care):	Same as Primary Care Physician	Deductible & Coinsurance
Comments:		

Urgent Care Services	In-Network	Out-of-Network
Urgent Care Facility Services (a single copay applies to each urgent care visit, if applicable):	$35 Copay	Deductible & Coinsurance
Comments:		

Emergency Care Services (Services received in a Hospital Emergency Room Setting)	In-Network	Out-of-Network
Facility:	Deductible & Coinsurance	In-Network Level of Benefits
Professional Services:	Deductible & Coinsurance	In-Network Level of Benefits
(Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)		
Comments:		

Outpatient Hospital or Facility Services	In-Network	Out-of-Network
Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Inpatient Hospital or Facility Services	In-Network	Out-of-Network
Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Preventive Services		
	In-Network	**Out-of-Network**
ACA-mandated A+B Preventive Benefits Subject to Limits:	Plan pays 100%	Deductible & Coinsurance
ACA-mandated A+B Preventive Benefits outside of Limits:	Plan pays 100%	Deductible & Coinsurance
Other Preventive Benefits Not Mandated by ACA:	Plan pays 100%	Deductible & Coinsurance
Preventive Immunizations - Children (up to age 7):	Plan pays 100%	Coinsurance
Preventive Immunizations - Adults (age 7 and older):	Plan pays 100%	Deductible & Coinsurance
Independent Lab - Preventive:	Plan pays 100%	Plan pays 100%
Comments:		

Mental Illness and/or Substance Dependence and Abuse Covered Services		
	In-Network	**Out-of-Network**
Inpatient Services:	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services:		
Office:	$35 Copay	Deductible & Coinsurance
All Other Outpatient Services:	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
Facility:	Deductible & Coinsurance	In-Network Level of Benefits
Professional Services:	Deductible & Coinsurance	In-Network Level of Benefits
(Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis.)		
Comments:	Autism covered (not following Nebraska state mandate): 3-00286. Residential Treatment Center covered per federal mandate: 3-00337 R.	

Other Covered Services - Illness or Injury		
	In-Network	**Out-of-Network**
Acupuncture	Standard: Not Covered	Standard: Not Covered
Comments:		

	In-Network	**Out-of-Network**
Advanced Diagnostic Imaging: CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Ambulance (to the nearest facility for appropriate care)	**In-Network**	**Out-of-Network**
Ground Ambulance:	Coinsurance	In-Network Level of Benefits
Air Ambulance (In-Network level of benefits if due to an emergency):	Coinsurance	In-Network Level of Benefits
Comments:		

	In-Network	**Out-of-Network**
Biofeedback:	Not covered	Not covered
Comments:		

	In-Network	**Out-of-Network**
Cochlear Implants:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	**Out-of-Network**
Dermatological Services:	Standard: Same as any other illness	
Comments:		

	In-Network	**Out-of-Network**
Diabetic Services - Services include Education, Self-management training, Podiatric appliances and equipment:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Will the exclusion for Drugs Administered in an Outpatient Setting apply?	Yes ☐ No ☑

If yes, specific drugs and covered services provided on an outpatient basis are payable only under the Rx Nebraska Prescription Drug Program, as determined by BCBSNE. A list of these drugs is available on the website www.nebraskablue.com. Those specific drugs are not covered under the Medical provisions. This limitation does not apply to Emergency Room care.

	In-Network	**Out-of-Network**
If No, those specific drugs and covered services will be payable under the Medical Plan subject to the following Cost Share:	Other	Other
Comments:	Covered same as any other illness.	

	In-Network	Out-of-Network
Durable Medical Equipment and Supplies (Including prosthetics) rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Eye Glasses or Contact Lenses: Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury):	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Hearing Aids:	Standard: Not Covered	Standard: Not Covered
Comments:		

Home Health Aide , Skilled Nursing and Respiratory Care	In-Network	Out-of-Network
Home Health Aide (Limited to 60 days per Benefit year) Skilled Nursing Care (Limited to 8 hours per day) Respiratory Care (Limited to 60 days per Benefit year):	Deductible & Coinsurance	Deductible & Coinsurance
Comments:	Home Health Aide and Skilled Nursing Care limited to 60 days per calendar year combined.	

	In-Network	Out-of-Network
Home Infusion Therapy:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Hospice Services	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 347-348	

	In-Network	Out-of-Network
Independent Laboratory (Diagnostic):	Plan pays 100%	Other
Comments:	Out of Network: Pays at the In-network level of benefits	

	In-Network	Out-of-Network
Immunizations (When due to an illness or injury**):**	Other	Other
Comments:	Covered same as any other illness.	

Infertility	In-Network	Out-of-Network
Service to diagnose:	Standard: Same as any other illness	
Treatment to promote fertility:	Standard: Not Covered	Standard: Not Covered
Comments:		

Nicotine Addiction	In-Network	Out-of-Network
Medical services and therapy:	Standard: Same as Substance Dependence and Abuse	
Nicotine addiction classes & alternative therapy, such as acupuncture:	Standard: Not Covered	Standard: Not Covered
Comments:		

Obesity	In-Network	Out-of-Network
Non-surgical treatment:	Standard: Not Covered	Standard: Not Covered
Surgical treatment:	Standard: Not Covered	Standard: Not Covered
Comments:		

Oral Surgery and Dentistry	In-Network	Out-of-Network
Oral Surgery and Dentistry:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:	Please see the Additional Provisions & Comments tab line 17.	

Standard Benefit

o Incision and drainage of abscesses, and other nonsurgical treatment of infections. This does not include periodontics or endodontic treatment of infections.
o Excision of exostosis tumors and cysts, whether or not related to the temporomandibular joint of the jaw.
o Services for diagnostic or surgical procedures involving a bone or joint of the face, neck, or head, including osteotomies, for the treatment of temporomandibular joint disorder or craniomandibular disorder.
o Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental injury. Benefits for such services are limited to covered services provided within 12 months of the date of injury. Benefits shall not be provided for such services when the dislocation or fracture occurs as the result of eating, biting or chewing.
o Services, supplies or appliances (not including orthodontics or dental implants) for dental treatment of natural healthy teeth required as the direct result of an accidental injury. Benefits for such services are limited to covered services provided within 12 months of the date of injury. Benefits shall not be provided for such services when the injury occurs as the result of eating, biting or chewing.
o Medically necessary general anesthesia in order for the covered person to safely receive dental care, including covered persons who are under eight years of age or developmentally disabled.
o The fabrication of an orthotic by a dentist of the treatment of a sleep disorder.
o Benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges related to covered services for oral surgery and dentistry, if medically necessary as determined by BlueCross and BlueShield of Nebraska. In addition, benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges for covered or noncovered dental procedures, if such admission is essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment.

Organ and Tissue Transplantation	In-Network	Out-of-Network
	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 349 - 350	

	In-Network	Out-of-Network
Ostomy Supplies	Not covered	Not covered
Comments:	See RX Coverage	

Physician Professional Services	**In-Network**	**Out-of-Network**
Inpatient and Outpatient Services, such as surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical Services	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	**Out-of-Network**
Physical Rehabilitation Services-Inpatient Facility (Must follow within 90 days of discharge from acute hospitalization)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Pregnancy, Maternity and Newborn Care	**In-Network**	**Out-of-Network**
Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery excluding the initial visit to diagnose pregnancy)	Deductible & Coinsurance	Deductible & Coinsurance
Newborn care	Deductible & Coinsurance	Deductible & Coinsurance
Does your Plan cover dependent daughter Maternity?	Yes	
Comments:	Newborn of a dependent daughter is not eligible for coverage, including the first 31 days.	

	In-Network	**Out-of-Network**
Radiation Therapy and Chemotherapy	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	**Out-of-Network**
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Rehabilitation Services	In-Network	Out-of-Network
Cardiac Rehabilitation (Limited to 18 sessions per diagnosis during the preceding 4 months of certain cardiac diagnosis)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Benefit Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Renal Dialysis	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Sexual Dysfunction	Standard: Not Covered	Standard: Not Covered
Comments:		

	In-Network	Out-of-Network
Skilled Nursing Facility (Limited to 60 days per Benefit Year)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Sleep Studies (Attended sleep study)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Temporomandibular and Craniomandibular Joint Disorder	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Therapy and Manipulations	In-Network	Out-of-Network
Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (Limited to 60 combined sessions per benefit year)	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 351-353	

	In-Network	Out-of-Network
Chiropractic or osteopathic manipulative treatments or adjustments (Limited to 30 combined sessions per benefit year)	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 351-353	

Vision Exams	In-Network	Out-of-Network
Diagnostic (To diagnose an illness)	See Physician Office Service	See Physician Office Service
Preventive (Routine exam including refraction) limitited to 1 exam per benefit year	Not covered	Not covered
Comments:		

	In-Network	Out-of-Network
Wigs	Plan pays 100%	Plan pays 100%
Comments:	Limited to 1 wig up to $250 per calendar year for a covered person who has received or is receiving either radiation or chemotherapy.	

	In-Network	Out-of-Network
All Other Covered Services	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Additional Benefit Provisions (Please provide the provision(s) and Cost Share amounts below. Limitations should be provided on the Addl Provisions & Comments tab.	**In-Network**	**Out-of-Network**
Hospice Services: Inpatient and Outpatient	Deductible & Coinsurance	Deductible & Coinsurance
Hospice Services: Bereavement Counseling	Plan Pays 100%	Plan Pays 100%
Organ and Tissue Transplant: Blue Distinction Center	Deductible & 10% Coinsurance	Not Covered
Organ and Tissue Transplant: Other Transplant Facilities	Deductible & 30% Coinsurance	Not Covered
Therapy and Manipulations: Physical or occupational therapy services and osteopathic physiotherapy manipulations and adjustments (combined limit of 60 sessions per calendar year)	Deductible & Coinsurance	Deductible & Coinsurance
Therapy and Manipulations: Speech Therapy (limited to 30 sessions per calendar year)	Deductible & Coinsurance	Deductible & Coinsurance
Therapy and Manipulations: - Office visits - Radiology - Pathology -Physiotherapy - Manipulations or adjustments	$35 Copay	Deductible & Coinsurance
Inpatient Private Duty Nursing: Services provided to a Covered Person confined as an Inpatient, when the services are performed by a graduate registered nurse (R.N.) practicing under the supervision of the Covered Person's attending Physician.	Deductible & Coinsurance	Deductible & Coinsurance

2-Tier Medical Benefits

Group Information

Group Name:	City of Grand Island
Effective Date:	10/1/2015

Benefit Year

What is the Benefit Year?	Calendar Year ☑ Plan Year ☐
If Plan Year, define dates: (i.e. 7/1 to 6/30):	

Plan Type

Type of Plan:	PPO ☐ CDHP (HSA Eligible) ☑
Large Group 2-Tier Standard Medical and RX Standard Option Number:	Non Standard
Option/Total Number of Options (Please type "Option 1 of X"):	2 of 2
Comments:	

Annual Cost Share Information

Deductible

(The amount the Covered Person pays each Benefit Year for Covered Services before the Coinsurance is payable)

	In-Network	Out-of-Network
Individual Deductible:	$3,000	$6,000
Family Deductible:	$5,500	$11,000
Comments:		

Embedded ☑ Aggregate ☐

Coinsurance

(the percentage amount the Covered Person must pay for most Covered Services after the deductible has been met)

	In-Network	Out-of-Network
Covered Person Pays:	0% (unless otherwise noted)	20%
Individual Coinsurance Limit:	N/A	N/A
Family Coinsurance Limit:	N/A	N/A
Comments:		

Embedded ☑ Aggregate ☐

Out-of-Pocket Limit

	In-Network	Out-of-Network
Individual Benefit Year Out-of-Pocket Limit:	$6,350	$12,000
Family Benefit Year Out-of-Pocket Limit:	$12,700	$22,000
Comments:		

Embedded ☑ Aggregate ☐

Aggregate Deductible and/or Out-of-Pocket Limit: Aggregate Deductible means the entire family amount must be met before benefits are available. Aggregate Out-of-Pocket Limit means the entire family amount must be met before cost-sharing is no longer applicable. Family members may combine their covered expenses to satisfy the family amounts.

Embedded Deductible and/or Out-of-pocket Limit: An "embedded" amount means that no one family member contributes no more than the individual amount to satisfy the family amount under a multi-person membership unit.

Once the annual Out-of-Pocket Limit is reached, most Covered Services are payable by the Plan at 100% for the remainder of the Benefit Year

Out-of-Pocket Limit includes:

Medical Deductible	☑
Medical Coinsurance	☑
Medical Copays	☐
Pharmacy Deductible	☐
Pharmacy Coinsurance	☐
Pharmacy Copays	☐
Other	☐

Amounts not included in the Out-of-Pocket Limit will continue to apply, even after the Out-of-Pocket Limit for the year is reached

Do In-Network and Out-of-Network Deductible and Out-of-Pocket Limits cross accumulate?	Yes
Comments:	

Do all other Limits (days, visits, sessions, dollar amounts, etc.) cross accumulate between In-Network and Out-of-Network?	Yes
Comments:	

Copayment applies to the following:

Physician Office	☐
Urgent Care Facility	☐
Emergency Care	☐
Allergy Injections	☐
Prescription Drugs	☐
Manipulations and Adjustments	☐
Other (if checked, enter below)	☐

Office Visit Copay

Office Visit Copay?	No

Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy), consultations, office psychological therapy and/or substance dependence and abuse counseling/rehabilitation, and medication checks.

Office Services Copay

Office Services Copay?	No

Listed below are BCBSNE standard office services included within the Copay. If customization is requested, please select each service where customization is necessary and if Copay applies

The following services will be subject to the Copay when billed by a professional provider in an office setting unless indicated otherwise below:

Allergy testing:	N/A
Diagnostic x-ray, laboratory and pathology services, including pap smears and mammograms when due to an illness:	N/A
Office consultation:	N/A
Supplies:	N/A
Medication checks:	N/A
Mental illness/substance abuse office therapy visits:	N/A
Hearing exam, when due to an illness or injury:	N/A
Vision exam, when due to an illness or injury (excluding refractions):	N/A
Office visit:	N/A
Drugs administered in an office setting:	N/A
Initial visit of diagnoses of pregnancy:	N/A
Comments:	

The following services will NOT be subject to the office services Copay when billed by a professional provider in an office setting unless indicated otherwise below:

Allergy Injections & Serum:	N/A
Other Injections:	N/A
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine):	N/A
Pregnancy Services:	N/A
Preventive Services:	N/A
Radiation Therapy & Chemotherapy:	N/A
Surgery & Anesthesia:	N/A
Physical, Occupational and Speech Therapy:	N/A
Manipulations and Adjustments:	N/A
Durable Medical Equipment:	N/A
Sleep Studies:	N/A
Biofeedback:	N/A
Psychological Evaluations, Assessments, and Testing:	N/A
Infusion Therapies:	N/A
Comments:	

Primary Care Physician is a physician who has a majority of his/her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A Physician Assistant is covered in the same manner as a Primary Care Physician.

Specialist Physician is a physician who is not a Primary Care Physician.

Office Cost Share Information	In-Network	Out-of-Network
Primary Care Physician:	Deductible & Coinsurance	Deductible & Coinsurance
Other Covered Services:	Deductible & Coinsurance	Deductible & Coinsurance
Specialist:	Deductible & Coinsurance	Deductible & Coinsurance
Other Covered Services:	Deductible & Coinsurance	Deductible & Coinsurance
Allergy Injections and Serum:	Deductible & Coinsurance	Deductible & Coinsurance
Convenient Care/Retail Clinics (Quick Care):	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Urgent Care Services	In-Network	Out-of-Network
Urgent Care Facility Services (a single copay applies to each urgent care visit, if applicable):	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Emergency Care Services (Services received in a Hospital Emergency Room Setting)	In-Network	Out-of-Network
Facility:	Deductible & Coinsurance	In-Network Level of Benefits
Professional Services:	Deductible & Coinsurance	In-Network Level of Benefits
(Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)		
Comments:		

Outpatient Hospital or Facility Services	In-Network	Out-of-Network
Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Inpatient Hospital or Facility Services	In-Network	Out-of-Network
Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Preventive Services		
	In-Network	**Out-of-Network**
ACA-mandated A+B Preventive Benefits Subject to Limits:	Plan pays 100%	Deductible & Coinsurance
ACA-mandated A+B Preventive Benefits outside of Limits:	Plan pays 100%	Deductible & Coinsurance
Other Preventive Benefits Not Mandated by ACA:	Plan pays 100%	Deductible & Coinsurance
Preventive Immunizations - Children (up to age 7):	Plan pays 100%	Deductible & Coinsurance
Preventive Immunizations - Adults (age 7 and older):	Plan pays 100%	Deductible & Coinsurance
Independent Lab - Preventive:	Plan pays 100%	Plan pays 100%
Comments:		

Mental Illness and/or Substance Dependence and Abuse Covered Services		
	In-Network	**Out-of-Network**
Inpatient Services:	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services:		
Office:	Deductible & Coinsurance	Deductible & Coinsurance
All Other Outpatient Services:	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
Facility:	Deductible & Coinsurance	In-Network Level of Benefits
Professional Services:	Deductible & Coinsurance	In-Network Level of Benefits
(Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis.)		
Comments:	Autism covered (not following Nebraska state mandate): 3-00286. Residential Treatment Center covered per federal mandate: 3-00337 R.	

Other Covered Services - Illness or Injury		
	In-Network	**Out-of-Network**
Acupuncture	Standard: Not Covered	Standard: Not Covered
Comments:		

	In-Network	**Out-of-Network**
Advanced Diagnostic Imaging: CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Ambulance (to the nearest facility for appropriate care)	**In-Network**	**Out-of-Network**
Ground Ambulance:	Deductible & Coinsurance	In-Network Level of Benefits
Air Ambulance (In-Network level of benefits if due to an emergency):	Deductible & Coinsurance	In-Network Level of Benefits
Comments:		

	In-Network	Out-of-Network
Biofeedback:	Not covered	Not covered
Comments:		

	In-Network	Out-of-Network
Cochlear Implants:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Dermatological Services:	Standard: Same as any other illness	
Comments:		

	In-Network	Out-of-Network
Diabetic Services - Services include Education, Self-management training, Podiatric appliances and equipment:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Will the exclusion for Drugs Administered in an Outpatient Setting apply?	Yes ☐ No ☑

If yes, specific drugs and covered services provided on an outpatient basis are payable only under the Rx Nebraska Prescription Drug Program, as determined by BCBSNE. A list of these drugs is available on the website www.nebraskablue.com. Those specific drugs are not covered under the Medical provisions. This limitation does not apply to Emergency Room care.

	In-Network	Out-of-Network
If No, those specific drugs and covered services will be payable under the Medical Plan subject to the following Cost Share:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Durable Medical Equipment and Supplies (Including prosthetics) rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Eye Glasses or Contact Lenses: Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury):	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Hearing Aids:	Standard: Not Covered	Standard: Not Covered
Comments:		

Home Health Aide , Skilled Nursing and Respiratory Care	In-Network	Out-of-Network
Home Health Aide (Limited to 60 days per Benefit year) Skilled Nursing Care (Limited to 8 hours per day) Respiratory Care (Limited to 60 days per Benefit year):	Deductible & Coinsurance	Deductible & Coinsurance
Comments:	Home Health Aide and Skilled Nursing Care limited to 60 days per calendar year combined.	

	In-Network	Out-of-Network
Home Infusion Therapy:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Hospice Services	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 347-348	

	In-Network	Out-of-Network
Independent Laboratory (Diagnostic):	Deductible & Coinsurance	Other
Comments:	Out of Network: Pays at the In-network level of benefits	

	In-Network	Out-of-Network
Immunizations (When due to an illness or injury**):**	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Infertility	In-Network	Out-of-Network
Service to diagnose:	Standard: Same as any other illness	
Treatment to promote fertility:	Standard: Not Covered	Standard: Not Covered
Comments:		

Nicotine Addiction	In-Network	Out-of-Network
Medical services and therapy:	Standard: Same as Substance Dependence and Abuse	
Nicotine addiction classes & alternative therapy, such as acupuncture:	Standard: Not Covered	Standard: Not Covered
Comments:		

Obesity	In-Network	Out-of-Network
Non-surgical treatment:	Standard: Not Covered	Standard: Not Covered
Surgical treatment:	Standard: Not Covered	Standard: Not Covered
Comments:		

Oral Surgery and Dentistry	In-Network	Out-of-Network
Oral Surgery and Dentistry:	Deductible & Coinsurance	Deductible & Coinsurance
Comments:	Please see the Additional Provisions & Comments tab line 17.	

Standard Benefit

o Incision and drainage of abscesses, and other nonsurgical treatment of infections. This does not include periodontics or endodontic treatment of infections.
o Excision of exostosis tumors and cysts, whether or not related to the temporomandibular joint of the jaw.
o Services for diagnostic or surgical procedures involving a bone or joint of the face, neck, or head, including osteotomies, for the treatment of temporomandibular joint disorder or craniomandibular disorder.
o Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental injury. Benefits for such services are limited to covered services provided within 12 months of the date of injury. Benefits shall not be provided for such services when the dislocation or fracture occurs as the result of eating, biting or chewing.
o Services, supplies or appliances (not including orthodontics or dental implants) for dental treatment of natural healthy teeth required as the direct result of an accidental injury. Benefits for such services are limited to covered services provided within 12 months of the date of injury. Benefits shall not be provided for such services when the injury occurs as the result of eating, biting or chewing.
o Medically necessary general anesthesia in order for the covered person to safely receive dental care, including covered persons who are under eight years of age or developmentally disabled.
o The fabrication of an orthotic by a dentist of the treatment of a sleep disorder.
o Benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges related to covered services for oral surgery and dentistry, if medically necessary as determined by BlueCross and BlueShield of Nebraska. In addition, benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges for covered or noncovered dental procedures, if such admission is essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment.

Organ and Tissue Transplantation	In-Network	Out-of-Network
	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 349 - 350	

	In-Network	Out-of-Network
Ostomy Supplies	Not covered	Not covered
Comments:	See RX Coverage	

Physician Professional Services	In-Network	Out-of-Network
Inpatient and Outpatient Services, such as surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical Services	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Physical Rehabilitation Services-Inpatient Facility (Must follow within 90 days of discharge from acute hospitalization)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Pregnancy, Maternity and Newborn Care	In-Network	Out-of-Network
Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery excluding the initial visit to diagnose pregnancy)	Deductible & Coinsurance	Deductible & Coinsurance
Newborn care	Deductible & Coinsurance	Deductible & Coinsurance
Does your Plan cover dependent daughter Maternity?	Yes	
Comments:	Newborn of a dependent daughter is not eligible for coverage, including the first 31 days.	

	In-Network	Out-of-Network
Radiation Therapy and Chemotherapy	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Rehabilitation Services	In-Network	Out-of-Network
Cardiac Rehabilitation (Limited to 18 sessions per diagnosis during the preceding 4 months of certain cardiac diagnosis)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Benefit Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Renal Dialysis	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Sexual Dysfunction	Standard: Not Covered	Standard: Not Covered
Comments:		

	In-Network	Out-of-Network
Skilled Nursing Facility (Limited to 60 days per Benefit Year)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Sleep Studies (Attended sleep study)	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

	In-Network	Out-of-Network
Temporomandibular and Craniomandibular Joint Disorder	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Therapy and Manipulations	In-Network	Out-of-Network
Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (Limited to 60 combined sessions per benefit year)	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 351-353	

	In-Network	Out-of-Network
Chiropractic or osteopathic manipulative treatments or adjustments (Limited to 30 combined sessions per benefit year)	Other	Other
Comments:	Please see the additional benefit provisions section below. Lines 351-353	

Vision Exams	In-Network	Out-of-Network
Diagnostic (To diagnose an illness)	See Physician Office Service	See Physician Office Service
Preventive (Routine exam including refraction) limitited to 1 exam per benefit year	Not covered	Not covered
Comments:		

	In-Network	Out-of-Network
Wigs	Deductible & Coinsurance	Deductible & Coinsurance
Comments:	Limited to 1 wig up to $250 per calendar year for a covered person who has received or is receiving either radiation or chemotherapy.	

	In-Network	Out-of-Network
All Other Covered Services	Deductible & Coinsurance	Deductible & Coinsurance
Comments:		

Additional Benefit Provisions (Please provide the provision(s) and Cost Share amounts below. Limitations should be provided on the Addl Provisions & Comments tab.	In-Network	Out-of-Network
Hospice Services: Inpatient and Outpatient	Deductible & Coinsurance	Deductible & Coinsurance
Hospice Services: Bereavement Counseling	Deductible & Coinsurance	Deductible & Coinsurance
Organ and Tissue Transplant: Blue Distinction Center	Deductible & Coinsurance	Not Covered
Organ and Tissue Transplant: Other Transplant Facilities	Deductible & 30% Coinsurance	Not Covered
Therapy and Manipulations: Physical or occupational therapy services and osteopathic physiotherapy manipulations and adjustments (combined limit of 60 sessions per calendar year)	Deductible & Coinsurance	Deductible & Coinsurance
Therapy and Manipulations: Speech Therapy (limited to 30 sessions per calendar year)	Deductible & Coinsurance	Deductible & Coinsurance
Therapy and Manipulations: - Office visits - Radiology - Pathology -Physiotherapy - Manipulations or adjustments	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Private Duty Nursing: Services provided to a Covered Person confined as an Inpatient, when the services are performed by a graduate registered nurse (R.N.) practicing under the supervision of the Covered Person's attending Physician.	Deductible & Coinsurance	Deductible & Coinsurance

NEBRASKA

Pharmacy Plan

Group Information	
Group Name:	City of Grand Island
Effective Date:	10/1/2015

Benefit Design

Which Medical Option does this Apply to:	1
RX Structured option number:	N/A

Standard Benefits	☐
Non-Standard Benefits (if selected, please complete non-standard benefit schedule)	☑
Standard Formulary	☑
Generics Plus Formulary	☐
Other (explain below)	☐

Deductible

Does your Plan require a Separate RX Deductible?	Yes ☐	No ☑

If yes, complete the following:

Embedded ☐ Aggregate ☐

Individual Amount:	
Family Amount:	

Copayment/Coinsurance Limit

Does your plan include a separate RX Coinsurance/Copay Limit?	Yes ☑ No ☑
If yes, complete the following:	
	Embedded ☑ Aggregate ☐
Will this apply to the medical Out-Of-Pocket Limit?	Yes ☐ No ☑
Individual Amount:	$4,800
Family Amount:	$9,600
Once Coinsurance/Copay Limit has been Met, benefits are payable as follows:	

Will all Covered Benefits listed below be subject only to the Medical Deductible and Coinsurance? If yes, Cost Shares are not needed below.	Yes ☐ No ☑

Extended Supply Network

Does your Plan provide an Extended Supply Network (ESN):	Yes ☐ No ☑
If Yes:	
Maximum Day Supply:	
Copay per ___ Day Supply:	((insert number of days here))

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay			
Coinsurance			
Minimum $/%			
Maximum $/%			

Other:

Retail Benefits

Does your Plan provide Retail Benefits? Yes ☑ No ☐

If Yes:

Maximum Day Supply: 90

Copay per ___ Day Supply: 30

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay	$10.00	$25.00	$40.00
Coinsurance			
Minimum $/%			
Maximum $/%			

Other:

Mail Order Benefits

Does your Plan provide Mail Order Benefits? Yes ☑ No ☐

If Yes:

Maximum Day Supply: 90

Copay per ___ day supply: 90

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay	$25.00	$62.50	$100.00
Coinsurance			
Minimum $/%			
Maximum $/%			

Other:

Specialty Pharmacy Benefits

Does your Plan provide a Specialty Pharmacy Benefit (if yes, must select applicable option below):	Yes ☑ No ☐

Applies to drugs on the specialty pharmacy drug list. Specialty medications are not available through mail order. Standard benefit always defaults to 30-day supply.

☑ **OPTION 1: Mandatory Specialty Pharmacy: Specialty Drugs must be purchased at an In-network Specialty Pharmacy only.**

Allow two specialty medication fills at any In-Network Retail Pharmacy	Yes ☑ No ☐
Do you have a 3 Tier or 4th Tier Specialty Option	3 Tier ☐ 4th Tier ☑

3Tier Specialty Pharmacy Benefit:

Same copay/coinsurance structure as retail?	☐
Different copay/coinsurance structure?	☐

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay			
Coinsurance			
Minimum $/%			
Maximum $/%			
Other:			

OR

4th Tier Only Specialty Pharmacy Benefit:	4th Tier
Copay	
Coinsurance	20%
Minimum $/%	$50
Maximum $/%	$100
Other:	See Additional Provisions below

☐**PTION 2: In/Out of Network Specialty Pharmacy Benefit:**

	In-Network	Out-of-Network
Copay		
Coinsurance		
Minimum $/%		
Maximum $/%		
Other:		

Mandatory Generic Pricing: If the Covered Person requests a Name Brand Medication when a generic version is available, he or she is responsible for the difference in cost between the name brand and generic drug, plus the applicable copayment amount.

Impose Mandatory Generic Penalty:	Yes ☑	No ☐

Pharmacy Preauthorization Programs:

COX-2 Inhibitor Preauthorization Program (NSAIDS)	Yes ☑	No ☐
Proton Pump Inhibitor Therapy Preauthorization Program (PPI)	Yes ☑	No ☐
Angiotensin Receptor Blockers (ARB) Preauthorization Program	Yes ☐	No ☑
Sedative Hypnotics (Insomnia) Preauthorization Program	Yes ☑	No ☐
Statin Preauthorization Program	Yes ☑	No ☐
Diabetic Test Strips Preauthorization Program	Yes ☐	No ☑
Other:		

Non-Standard Benefits Schedule:

Compounds[1]:	Yes ☑ No ☐
Special Copay/Instructions:	
Diabetic Supplies [2]:	Yes ☑ No ☐
Special Copay/Instructions:	30 Day Supply: $10 Formulary $25 Non-Formulary **90 Day Supply:** $25 Formulary $62.50 Non-Formulary (OON apply 25% penalty for retail)
Ostomy supplies [3]:	Yes ☑ No ☐
Special Copay/Instructions:	
Injectable medications:	Yes ☑ No ☐
Special Copay/Instructions:	
Insulin:	Yes ☑ No ☐
Special Copay/Instructions:	
Diabetic medication other than insulin:	Yes ☑ No ☐
Special Copay/Instructions:	
Contraceptives [4]:	Yes ☑ No ☐
Special Copay/Instructions:	
Prescription Vitamins:	Yes ☑ No ☐
Special Copay/Instructions:	
Prescription prenatal vitamins:	Yes ☑ No ☐
Special Copay/Instructions:	
Erectile dysfunction agents [5]:	Yes ☑ No ☐
Special Copay/Instructions:	
Diet, weight loss or appetite suppressant drugs:	Yes ☐ No ☑
Special Copay/Instructions:	
Nutrition care, nutritional supplements & substances, dietary and herbal supplements:	Yes ☐ No ☑
Special Copay/Instructions:	
FDA-exempt infant formulas:	Yes ☐ No ☑
Special Copay/Instructions:	
Cosmetic alteration drugs, health/beauty aids [6]:	Yes ☐ No ☑
Special Copay/Instructions:	
Non-sedating oral antihistamines	Yes ☑ No ☐
Special Copay/Instructions:	
Fertility drugs & medicinals:	Yes ☐ No ☑
Contract Maximum:	
Other:	
Sex Transformation Drugs:	Yes ☐ No ☑
Special Copay/Instructions:	
Nicotine addiction[7]:	Yes ☑ No ☐
Special Copay/Instructions:	

Additional Information

1. Compound prescriptions must contain at least one FDA-approved prescription ingredient; compound ingrediants must be FDA approved.

2. Diabetic Supplies include but are not limited to: Insulin pump supplies (tubing etc.), Blood Glucose Meters, Blood Glucose Strips (for meters), Blood Glucose Meter Control Solutions, Alcohol Swabs, Insulin Syringes, Lancets, Lancet Devices, Ketone test Strips, Multiple Urine test Strips, Glucose Tablets. Excluded from RX Coverage: Insulin Pumps, Syringes other than Insulin Syringes and Real Time Glucose monitors and supplies.

3. Ostomy Supplies are payable under medical coverage. If also to be covered under RX, check "Yes." Supplies include, but are not limited to: belts, dressings, pouches, skin barrier.

4. Contraceptives: Must be covered unless plan is exempt by state or federal law. Includes oral, intravaginal, and transdermal. (The plan pays 100% on ACA required formulary contraceptives. A 25% Penalty applies when an Out-of Network Pharmacy is used.)

5. Erectile Dysfunction agents include but are not limited to: Viagra, Caverject, Muse, Cialis, Levitra, Alprostadil. If covered, Cialis (tadalafil) daily use strengths are limited to 30 pills per 30 days. Viagra (sildenafil), all other Cialis (tadalafil) strengths, and Levitra (vardenafil) are limited to 8 pills per 30 days. No benefits are available for males through the age of 18 and for all females.

6. Cosmetic alteration drugs include, but are not limited to: Vaniqa; Propecia; Renova; and Botox.

7. Nicotine cessation drugs and deterrents: Plans with the ACA required preventive services will cover In-network Pharmacy claims at 100%. A 25% penalty applies when an Out-of-network Pharmacy is used.)

Additional Provisions:

Specialty Pharmacy is limited to a 30 day fill with the exception of member YED867249137 (Member ID will be removed from CP once the exception has been updated in our system)

Pharmacy Plan

Group Information	
Group Name:	City of Grand Island
Effective Date:	10/1/2015

Benefit Design	
Which Medical Option does this Apply to:	2
RX Structured option number:	N/A
Standard Benefits	☐
Non-Standard Benefits (if selected, please complete non-standard benefit schedule)	☑
Standard Formulary	☑
Generics Plus Formulary	☐
Other (explain below)	☐

Deductible

Does your Plan require a Separate RX Deductible?	Yes ☐	No ☑

If yes, complete the following:

	Embedded ☐ Aggregate ☐
Individual Amount:	
Family Amount:	

Copayment/Coinsurance Limit

Does your plan include a separate RX Coinsurance/Copay Limit?	Yes ☐ No ☑

If yes, complete the following:

Embedded ☐ Aggregate ☐

Will this apply to the medical Out-Of-Pocket Limit?	Yes ☐ No ☐
Individual Amount:	
Family Amount:	
Once Coinsurance/Copay Limit has been Met, benefits are payable as follows:	

Will all Covered Benefits listed below be subject only to the Medical Deductible and Coinsurance? If yes, Cost Shares are not needed below.	Yes ☑ No ☐

Extended Supply Network

Does your Plan provide an Extended Supply Network (ESN):	Yes ☐ No ☑
If Yes:	
Maximum Day Supply:	
Copay per ___ Day Supply:	((insert number of days here))

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay			
Coinsurance			
Minimum $/%			
Maximum $/%			

Other:	

Retail Benefits

Does your Plan provide Retail Benefits?	Yes ☑ No ☐
If Yes:	
Maximum Day Supply:	90
Copay per ___ Day Supply:	30

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay			
Coinsurance			
Minimum $/%			
Maximum $/%			

Other:	

Mail Order Benefits

Does your Plan provide Mail Order Benefits?	Yes ☑ No ☐
If Yes:	
Maximum Day Supply:	90
Copay per ___ day supply:	90

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay			
Coinsurance			
Minimum $/%			
Maximum $/%			

Other:	

Specialty Pharmacy Benefits

Does your Plan provide a Specialty Pharmacy Benefit (if yes, must select applicable option below):	Yes ☑ No ☐

Applies to drugs on the specialty pharmacy drug list. Specialty medications are not available through mail order. Standard benefit always defaults to 30-day supply.

☑ **OPTION 1: Mandatory Specialty Pharmacy: Specialty Drugs must be purchased at an In-network Specialty Pharmacy only.**

Allow two specialty medication fills at any In-Network Retail Pharmacy	Yes ☑ No ☐
Do you have a 3 Tier or 4th Tier Specialty Option	3 Tier ☑ 4th Tier ☐

3Tier Specialty Pharmacy Benefit:

Same copay/coinsurance structure as retail?	☑
Different copay/coinsurance structure?	☐

	Generic Tier 1	Brand Formulary Tier 2	Brand Non-Formulary Tier 3
Copay			
Coinsurance			
Minimum $/%			
Maximum $/%			
Other:			

OR

4th Tier Only Specialty Pharmacy Benefit:	4th Tier
Copay	
Coinsurance	
Minimum $/%	
Maximum $/%	
Other:	

☐ **PTION 2: In/Out of Network Specialty Pharmacy Benefit:**

	In-Network	Out-of-Network
Copay		
Coinsurance		
Minimum $/%		
Maximum $/%		
Other:		

Mandatory Generic Pricing: If the Covered Person requests a Name Brand Medication when a generic version is available, he or she is responsible for the difference in cost between the name brand and generic drug, plus the applicable copayment amount.

Impose Mandatory Generic Penalty:	Yes ☑	No ☐

Pharmacy Preauthorization Programs:

COX-2 Inhibitor Preauthorization Program (NSAIDS)	Yes ☑	No ☐
Proton Pump Inhibitor Therapy Preauthorization Program (PPI)	Yes ☑	No ☐
Angiotensin Receptor Blockers (ARB) Preauthorization Program	Yes ☐	No ☑
Sedative Hypnotics (Insomnia) Preauthorization Program	Yes ☑	No ☐
Statin Preauthorization Program	Yes ☑	No ☐
Diabetic Test Strips Preauthorization Program	Yes ☐	No ☑
Other:		

Non-Standard Benefits Schedule:

Compounds[1]:	Yes ☑ No ☐
Special Copay/Instructions:	
Diabetic Supplies [2]:	Yes ☑ No ☐
Special Copay/Instructions:	
Ostomy supplies [3]:	Yes ☑ No ☐
Special Copay/Instructions:	
Injectable medications:	Yes ☑ No ☐
Special Copay/Instructions:	
Insulin:	Yes ☑ No ☐
Special Copay/Instructions:	
Diabetic medication other than insulin:	Yes ☑ No ☐
Special Copay/Instructions:	
Contraceptives [4]:	Yes ☑ No ☐
Special Copay/Instructions:	
Prescription Vitamins:	Yes ☑ No ☐
Special Copay/Instructions:	
Prescription prenatal vitamins:	Yes ☑ No ☐
Special Copay/Instructions:	
Erectile dysfunction agents [5]:	Yes ☑ No ☐
Special Copay/Instructions:	
Diet, weight loss or appetite suppressant drugs:	Yes ☐ No ☑
Special Copay/Instructions:	
Nutrition care, nutritional supplements & substances, dietary and herbal supplements:	Yes ☐ No ☑
Special Copay/Instructions:	
FDA-exempt infant formulas:	Yes ☐ No ☑
Special Copay/Instructions:	
Cosmetic alteration drugs, health/beauty aids [6]:	Yes ☐ No ☑
Special Copay/Instructions:	
Non-sedating oral antihistamines	Yes ☑ No ☐
Special Copay/Instructions:	
Fertility drugs & medicinals:	Yes ☐ No ☑
Contract Maximum:	
Other:	
Sex Transformation Drugs:	Yes ☐ No ☑
Special Copay/Instructions:	
Nicotine addiction[7]:	Yes ☑ No ☐
Special Copay/Instructions:	

Additional Information

1. Compound prescriptions must contain at least one FDA-approved prescription ingredient; compound ingrediants must be FDA approved.

2. Diabetic Supplies include but are not limited to: Insulin pump supplies (tubing etc.), Blood Glucose Meters, Blood Glucose Strips (for meters), Blood Glucose Meter Control Solutions, Alcohol Swabs, Insulin Syringes, Lancets, Lancet Devices, Ketone test Strips, Multiple Urine test Strips, Glucose Tablets. Excluded from RX Coverage: Insulin Pumps, Syringes other than Insulin Syringes and Real Time Glucose monitors and supplies.

3. Ostomy Supplies are payable under medical coverage. If also to be covered under RX, check "Yes." Supplies include, but are not limited to: belts, dressings, pouches, skin barrier.

4. Contraceptives: Must be covered unless plan is exempt by state or federal law. Includes oral, intravaginal, and transdermal. (The plan pays 100% on ACA required formulary contraceptives. A 25% Penalty applies when an Out-of Network Pharmacy is used.)

5. Erectile Dysfunction agents include but are not limited to: Viagra, Caverject, Muse, Cialis, Levitra, Alprostadil. If covered, Cialis (tadalafil) daily use strengths are limited to 30 pills per 30 days. Viagra (sildenafil), all other Cialis (tadalafil) strengths, and Levitra (vardenafil) are limited to 8 pills per 30 days. No benefits are available for males through the age of 18 and for all females.

6. Cosmetic alteration drugs include, but are not limited to: Vaniqa; Propecia; Renova; and Botox.

7. Nicotine cessation drugs and deterrents: Plans with the ACA required preventive services will cover In-network Pharmacy claims at 100%. A 25% penalty applies when an Out-of-network Pharmacy is used.)

Additional Provisions:

Specialty Pharmacy is limited to a 30 day fill with the exception of member YED867249137 (Member ID will be removed from CP once the exception has been updated in our system)

Open Enrollment, SPD & Fulfillment

Group Information	
Group Name:	City of Grand Island
Effective Date:	10/1/2015

Internal Fulfillment Instructions	
Please provide beginning/ending dates for employee Open Enrollment:	8/17/15 - 9/11/15
Will BCBSNE representatives be required at Open Enrollment meetings? If yes, please provide dates, times and locations:	Yes - TBD
Please provide the SBC due date:	8/10/2015
For E-Exchange groups: When will Group send Open Enrollment data to BCBSNE?	N/A
For HR InTouch groups: When does HR In Touch need to be ready?	N/A
Are there any special Open Enrollment instructions that impact BCBSNE?	No

Will Group require packets for Open Enrollment?	No
If packets are needed, please provide the following information:	
Number of Packets:	N/A
Date needed by:	N/A
Physical Address:	N/A
Attention:	
ID card - Standard format?	Yes
ID card - custom logo? (new logos needed 8 weeks prior to mailing)	No
If custom ID card, ID Card Logo (Same as last year, New)	N/A
ID card - custom prefix?	No
ID card - phone number	Standard
	N/A
ID card mailing - Standard?	Standard
Electronic SPDs?	Yes
SPD custom logo?	Yes
Special SPD Language if any	TBD
Special mailing instructions?	No
Does the group want to suppress Fulfillment information? If yes, what information should be suppressed?	No

Plan Information

Plan name:	N/A
Employer:	N/A
Employer Identification Number:	N/A
Plan Identification Number:	N/A
Type of Plan:	N/A
Funding:	N/A
Plan Year:	N/A
Plan Administrator:	N/A
Type of Administration:	N/A
Participating Employers:	N/A
Registered Agent for Service of Legal Process:	N/A
Contributions:	N/A
Amendment or Termination (Plan Sponsor):	N/A

Client Consulting

Group Information

Group Name:	City of Grand Island
Effective Date:	10/1/2015

Data Extracts

Will the Group require data extracts? Yes

If yes, please select all that apply below:

- Medical ☑
- Dental ☐
- Pharmacy ☐
- Eligibility ☐
- RDS ☐
- Stop Loss ☑
- Pre-Certification ☐
- High Dollar Notification ☑
- Nurse Notes ☐

Comments: Case Management notes by request

Reports

Will reports be delivered to the Group?	Yes

If yes, complete the following:

Email ☑ SFTP ☐

Name:	Tami Herald
Email address:	TamiH@grand-island.com
SFTP contact:	

Name:	
Email address:	
SFTP contact:	

Will reports be delivered to the Broker?	Yes

If yes, complete the following:

Email ☑ SFTP ☐

Name:	Cal Strong
Email address:	cstrong@strongfr.com
SFTP contact:	

Name:	
Email address:	
SFTP contact:	

Comments:	

NEBRASKA

Group Roll Listing

Group Information		
Group Name:	City of Grand Island	
Effective Date:	10/1/2015	

	Option 1	$500 PPO
	Option 2	$3000 HDHP

305208	01	Non-union (full-time)
	02	FOP – Police (full-time)
	03	IBEW Union – Service/Clerical (full-time)
	04	IBEW Utilities/Water (full-time)
	05	IAFF – Fire (full-time)
	06	IBEW Utilities/Electric (full-time)
	07	AFSCME Union (full-time)
	08	IBEW – Wastewater (full-time)
	51	Non-union (part-time)
	52	FOP – Police (part-time)
	53	IBEW Union – Service/Clerical (part-time)
	54	IBEW Utilities/Water (part-time)
	55	IAFF – Fire (part-time)
	56	IBEW Utilities/Electric (part-time)
	57	AFSCME Union (part-time)
	58	IBEW – Wastewater (part-time)
	98	Retirees (Grandfathered – to age 65)
	99	COBRA

Additional Provisions & Comments

Group Information		
Group Name:	City of Grand Island	
Effective Date:	10/1/2015	

Additional Provisions and Comments

Date Completed:

Tab Name	Line Number(s)	Internal Ref #	Benefit Title, Additional Provision, and/or Comments	Applicable Option (i.e. Medical/Dental/RX or Other, please include applicable option number
2 - Tier Medical (All)	263	3-00289	**Oral Surgery and Dentistry:** In addition to the benefits listed on the 2-Tier Medical tabs, benefits are also available for: • Impacted Extractions o Evaluation and treatment of impacted teeth • Osteotomies o Covered when performed for a gross congenital abnormality of the jaw that cannot be treated solely by orthodontic treatment or appliances • Dental Implants o Covered when related to trauma, cancer and other tumors, and benign cysts or for persons through age 23 who have two or more congenitally missing adjacent teeth • Bone Grafts o Bone grafts to the jaw in relation to implants or dentures are covered • Accident Dentistry o Benefits available for dental implants and orthodontic services when related to an accident and provided within 12 months of the date of the accident.	Option 1 & 2
2 - Tier Medical PPO Option 2	N/A	3-00232	Orally Administered anti-cancer medications.	Option 1

Internal Claims and Appeals and External Review- NON-ERISA

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal Adverse Benefit Determinations (initial or final). The process for such appeals is outlined below.

1.Internal Appeal:

a. Requesting an Appeal: A request for an internal appeal must be submitted by the claimant within six (6) months of the date the Claim was processed, or Adverse Benefit Determination was made. The request should include the following information:

1) state that it is a request for an appeal;
2) the name and relationship of the person submitting the appeal;
3) the reason for the appeal;
4) any information that might help resolve the issue;
5) the date of service/claim; and
6) if possible, a copy of the Explanation of Benefits (EOB).

This information should be submitted to BCBSNE at the address and telephone number listed on the Covered Person's ID card. Within three days after receipt of a request for an appeal, BCBSNE will provide the claimant an acknowledgment of the receipt of the appeal. This notice will include the name, address and telephone number of a person to contact regarding coordination of the review. A claimant does not have the right to attend, nor to have a representative in attendance at the appeal review, but may submit additional information for consideration.

b. Decision: If the Adverse Benefit Determination was based on a medical judgment, including a Medical Necessity or Investigative determination, BCBSNE will consult with health care professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. Identification of the medical personnel consulted, if any, will be provided to the claimant upon written request. The appeal determination will be made by individuals who were not involved in the original determination. Written notification of the decision will be provided to the claimant as follows:

1) for Preservice Claims (other than Urgent Care), within 15 calendar days after receipt;
2) for Postservice Claims involving an Adverse Benefit Determination based on Medical Necessity, Investigative determination or utilization review, within 15 calendar days after receipt; or
3) for all other Post Service Claims, within 15 calendar days after receipt, unless additional time is needed and written notice is provided to the Claimant on or before the 15th day, in which case the decision will be provided within 30 calendar days after receipt.

c. Expedited Appeal: In the case of an Urgent Care Claim, an expedited appeal may be requested orally or in writing. All information, including the decision, will be submitted by telephone, facsimile or the most expeditious method available.

BCBSNE will make a decision and notify the claimant within 72 hours after the appeal is received. Written notification will be sent within the 72-hour period.

Concurrent Care: A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If requested within this time period, coverage will continue for the health care services pending notification of the review decision, as may be required by law. The decision timeframe will be the same as for other expedited appeals.

d. The decision made pursuant to this appeal is considered a Final Internal Adverse Determination.

2. Rights to Documentation: A claimant shall have the right to have access to, and request copies of the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review. The claimant may submit additional comments, documents or records relating to the Claim for consideration during the appeal process.

3. Request for External Review:

a.Standard Review: The claimant may request a review by an Independent Review Organization (IRO) of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination which was based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment. The claimant must exhaust the internal appeal process prior to a request for External Review. The request must be submitted in writing within four (4) months after the date of receipt of a notice of the Final Internal Adverse Benefit Determination. The Covered Person will be required to authorize the release of any of his or her protected health information, including medical records, which may be needed for the purposes of the External Review.

The request for an External Review may be submitted electronically, by facsimile, or U.S. mail, as stated on the Final Internal Adverse Benefit Determination notice (letter). The request should be submitted to:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, NE 68501-2089
www.doi.nebraska.gov

Upon receipt of a request for an External Review, the Nebraska Department of Insurance (NDOI) will forward the request to BCBSNE to conduct a preliminary review to determine if it is complete and whether it is eligible for External Review, consistent with applicable law. BCBSNE will conduct this preliminary review within 5 business days of receipt, and notify the NDOI and the claimant of the outcome within one business day. If it is determined that the request is not complete, or is not eligible for External Review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete. The NDOI may determine that the request is eligible notwithstanding BCBSNE's determination, consistent with state law.

If the request is eligible for External Review, the NDOI will assign an IRO to conduct the review, and notify BCBSNE and the claimant of the assignment within one business day. BCBSNE will forward all documentation and information considered in making the initial Adverse or Final Internal Adverse Benefit Determination, including a summary of the Claim and explanation for the determination to the IRO within 5 business days. The claimant will also be allowed an opportunity to submit additional information for consideration by the IRO. The IRO shall provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO shall complete its review and provide the claimant written notification and rationale for its decision within 45 days of receipt of the request for review. No deference shall be given to the prior determinations made by BCBSNE pursuant to the internal appeal process.

b. Expedited External Review: An expedited External Review may be requested at the same time a claimant requests an expedited internal appeal (1.c., above) of an Adverse Benefit Determination concerning:

1) an Urgent Care Claim; or

2) a denial on the basis that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process, unless otherwise waived by BCBSNE or directed by the IRO, consistent with state law.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if:

1)the Covered Person has a medical condition where the timeframe for completion of a standard External Review, as described in paragraph 3.a., above, would seriously jeopardize the life or health of the Covered Person or would jeopardize his or her ability to regain maximum function; or

2) the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person has received emergency services, but has not been discharged from a facility; or

3) the Final Internal Adverse Benefit Determination is based on a determination that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

ADDITIONAL INFORMATION

The Department of Insurance may be contacted for assistance with the Appeal and External Review process at any time at:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, NE 68501-2089
(877) 564-7323

Benefits for Orally Administered Anti-cancer Medication (PPO PLANS)

Benefits for orally administered anti-cancer medication are available as follows: 1. When purchased from an In-network Specialty Pharmacy, benefits for orally administered anti-cancer medication will be covered at 100%. 2. When purchased from an In-network non-Specialty Pharmacy or when purchased from an Out-of-network Pharmacy, benefits for orally administered anti-cancer medication will be subject to the cost share amount (applicable copayment, deductible and/or coinsurance) as shown in your Contract or on your Schedule of Benefits Summary. An orally administered anti-cancer medication is a medication that is used to kill or slow the growth of cancerous cells. A list of orally administered anti-cancer medications is available at www.nebraskablue.com or by contacting Blue Cross and Blue Shield of Nebraska Member Services. Specialty Drugs: Designated complex injectable and oral drugs generally covered up to a 30-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty Drugs are drugs including, but not limited to drugs used for: multiple sclerosis; rheumatoid arthritis; hepatitis C; Crohn's disease; anemia; and hemophilia. Specialty Drugs may only be available through designated Specialty Pharmacies. A current list of designated Specialty Drugs and suppliers is available at www.nebraskablue.com or by contacting Blue Cross and Blue of Nebraska Member Services. Blue Cross and Blue Shield of Nebraska reserves the right to change designated Specialty Drugs and suppliers at any time without prior notice. Specialty Pharmacy: A licensed pharmacy designated by Blue Cross and Blue Shield of Nebraska or the Pharmacy Benefit Manager to provide Specialty Drugs. (3-00232)

Residential Treatment 3-00337

BENEFIT DESCRIPTIONS

Mental Illness, Substance Dependence And Abuse Benefits

Inpatient Care

Inpatient Services shall include Covered Services and room and board provided as part of a Residential Treatment Program for treatment of Mental Illness and Substance Dependence and Abuse.

The Residential Treatment Program and/or facility must be licensed, accredited or Certified to provide such Services by the appropriate state agency, or accredited by CARF International or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Benefits for residential Treatment Center Services are available subject to Certification and Medical Necessity criteria and Utilization Management. If Certification is not obtained and the Services requested do not meet BCBSNE's Medical Necessity criteria, coverage for those Services may be denied.

EXCLUSIONS-WHAT'S NOT COVERED
Plan Exclusions

Residential Treatment Program
Benefits are not available under the Residential Treatment Program provision for:
• education, socialization, delinquency or Custodial Care Services;
• foster, homes, halfway houses, group homes and treatment group homes;
• Inpatient confinement for environmental change or similar treatment;
• not Medically Necessary: Services that are not Medically Necessary, including those that are:
- not necessarily directed toward alleviation or prevention of an acute condition; and
- expected to be of long duration without any reasonable predictable date of termination;
• stress reduction classes and pastoral counseling;
• support therapies, including personal counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, cruises, wilderness programs, adventure therapy, residential therapeutic camps and bright light therapy.

Client Profile Signature Page

Group Information

Group Name:	City of Grand Island
Effective Date:	10/1/2015

Applicant Certification and Signature

I represent that I am authorized to obtain coverage on behalf of the Group Health Plan.

I have read and understand the Provisions of this Client Profile for Claim Administration Services and certify that all information herein is true and accurate and agree to the provisions specified. I understand that if any information on this Client Profile is in conflict with the proposal, BCBSNE reserves the right to recalculate and change the rates previously proposed, or to decline coverage. I understand the possible effect of canceling our current group plan coverage or administrative services prior to receiving final approval from BCBSNE.

Signature _____ Title _____

Date _____

_____ _____
(Typed Name) (Typed Title)

Signature _____ Title _____

Date _____

_____ _____
(Typed Name) (Typed Title)

AGENT CERTIFICATION:

I certify that I have verified the information in this Client Profile and it is true and accurate to the best of my knowledge.

Signature _____ Title _____

Date _____

_____ _____
(Typed Name) (Typed Title)

The Client Profile document sets forth group demographic information and specific plan terms, requirements and benefit design elements. The Client Profile is part of the Benefit Plan Document, which includes the Administrative Services Agreement (ASA), Summary Plan Description (SPD), and is incorporated therein by this reference.

R E S O L U T I O N 2015-218

WHEREAS, the City subscribes to health and dental insurance for its employees and other eligible participants, as authorized by the City of Grand Island Personnel Rules and Regulations and federal regulations; and

WHEREAS, a Health Insurance Committee consisting of union, non-union, management and non-management employees, along with the Human Resources Director, the Finance Director, and the Attorney/Purchasing Agent met and reviewed plan changes; and

WHEREAS, Blue Cross and Blue Shield of Nebraska is the Third Party Administrator for the City's health insurance plan; and

WHEREAS, the City's dental insurance benefit is administered by Delta Dental of Nebraska for a fee of $3.85 per employee per month and this fee will remain the same for the duration of the three year contract period; and

WHEREAS, the reinsurance coverage and administration of the health plan is provided under a contract with Blue Cross and Blue Shield of Nebraska. COBRA administration is provided by Discovery Benefits, Inc. The broker is Strong Financial Resources, and the current agreement with Healthways is covered under the Bluepartners Program agreement and;

WHEREAS, contracts were approved in 2015 with Blue Cross and Blue Shield for a period of three years with the aforementioned providers; and

WHEREAS, the City will make a contribution on behalf of the employee participating in the Qualified High Deductible Health Plan with an added Health Savings Account (HSA) contribution of $1250 for single coverage and $2500 for family coverage to be reduced by a quarterly sliding scale for newly hired employees; and

WHEREAS, the contract with Blue Cross and Blue Shield of Nebraska (BCBSNE) specifies administrative fees of $30.00 per employee per month. Stop loss coverage will cost $114.98 per employee per month and the aggregate stop loss coverage will cost $5.64 per employee per month. The contract with Strong Financial will cost $1,654 per month. COBRA administration will be handled by Discovery Benefits, Inc. (DBI) The cost for COBRA administration will be $0.70 per employee per month for the term of the contract. The fees associated with the wellness physicals will be approximately $67.45 per participant.

Approved as to Form ¤ _____
August 7, 2015 ¤ City Attorn

NOW, THEREFORE BE IT RESOLVED BY THE MAYOR AND COUNCIL OF THE CITY OF GRAND ISLAND, NEBRASKA, that the annual renewal contracts with Blue Cross and Blue Shield of Nebraska, Delta Dental of Nebraska, Discovery Benefits, Inc., Strong Financial Resources and Bluepartners Program for the administration of health insurance, COBRA administration, broker services and wellness program as set out by the contracts as well as the HSA contributions are hereby approved.

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Adopted by the City Council of the City of Grand Island, Nebraska, August 11, 2015.

_____
Jeremy L. Jensen, Mayor

Attest:

_____
RaNae Edwards, City Clerk