

11/001214

**BOARD OF COUNTY COMMISSIONERS
SARPY COUNTY, NEBRASKA**

**RESOLUTION APPROVING AGREEMENTS WITH BLUE CROSS BLUE SHIELD OF
NEBRASKA AND EMPLOYEE BENEFIT SYSTEMS FOR EMPLOYEE HEALTH
INSURANCE**

WHEREAS, pursuant to Neb. Rev. Stat. §23-104(6) (Reissue 2007), the County has the power to do all acts in relation to the concerns of the county necessary to the exercise of its corporate powers; and,

WHEREAS, pursuant to Neb. Rev. Stat. §23-103 (Reissue 2007), the powers of the County as a body are exercised by the County Board; and,

WHEREAS, the County of Sarpy desires to enter into a Master Group Application agreement with Blue Cross Blue Shield of Nebraska effective July 1, 2011 through June 30, 2012 for the purpose of providing health insurance for county employees, as outlined in the agreement attached hereto as Exhibit A; and,

WHEREAS, the County of Sarpy desires to renew its agreement with Employee Benefit Systems effective July 1, 2011 through June 30, 2012 for the purpose of partial self-funding for health insurance, as outlined in the agreement attached hereto as Exhibit B; and,

WHEREAS, said attached agreements with Blue Cross Blue Shield of Nebraska and Employee Benefit Systems are for unique, non-competitive and professional services and are in the best interests of the citizens of Sarpy County; and,

NOW, THEREFORE, BE IT RESOLVED by the Sarpy County Board of Commissioners that this Board hereby approves and adopts the Master Group Application agreement with Blue Cross Blue Shield of Nebraska, effective July 1, 2011 through June 30, 2012, a copy of which is attached as Exhibit A.

BE IT FURTHER RESOLVED by the Sarpy County Board of Commissioners that this Board hereby approves and adopts the renewal agreement with Employee Benefit Systems, effective July 1, 2011 through June 30, 2012, a copy of which is attached as Exhibit B.

BE IT FURTHER RESOLVED that the Chairman of this Board, together with the County Clerk, is hereby authorized to sign on behalf of this Board the contracts with Blue Cross Blue Shield of Nebraska and Employee Benefit Systems, copies of which are attached, and any other related documents, the same being approved by the Board.

DATED this 17th day of May, 2011.

Moved by Jim Thompson, seconded by Jim Nekuda, that the above Resolution be adopted. Carried.

YEAS:

NAYS:

ABSENT:

Jim Thompson

none

Rusty Hike

Jim Nekuda

Tom Richard

ABSTAIN:

Tom Richard

none



Debra J. Houghtaling
County Clerk



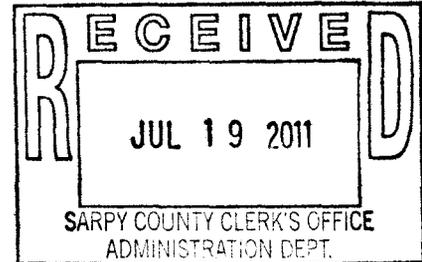
**WILLIAMS - DERAS
& ASSOCIATES**
Insurance Planning

Michael R. Williams
Keith A. Deras, CLU, ChFC

Telephone: (402) 398-9898
Facsimile: (402) 231-8689

July 18, 2011

Sarpy County Clerk
Attn: Chris Vance
1210 Golden Gate Dr
Papillion NE 68046-2895



Re: BlueCross BlueShield Master Group Contract

Hi Mr. Vance,

I have enclosed the executed copy of your Master Group Application, Endorsements and Contract for the Group Health Insurance effective July 1, 2011.

Please look these over and if you should have any questions you can contact Stephanie Dow at 402-398-9898 option 4 or Michael Williams option 1.

Have a great day.

Betty Campbell, Service Coordinator

/enclosure
bc



**BlueCross BlueShield
of Nebraska**

An Independent Licensee of the Blue Cross and Blue Shield Association

MASTER GROUP APPLICATION (INSURED)

New Group

Renewal or Revision *(Please asterisk * amended sections.)*

Fully Insured

Minimum Premium

Group No. 300074 Roll No. 01 (Active), 02 (retirees), 03 (Elected Officials), 99 (COBRA)

Master Group Number: 3349 Rate Pool Code: _____

Effective Date: The Master Group Contract shall be effective on July 1, 2011 provided this Application is accepted by Blue Cross and Blue Shield of Nebraska (BCBSNE), and payment of the charges is made as provided in the Application. Changes in the terms of this Application may only be made during the anniversary month of the effective date, unless prior BCBSNE approval is obtained for an off-anniversary change.

APPLICANT INFORMATION

A. Applicant/Employer: Sarpy County

Address 1308 Gold Coast Rd C/O Personnel Dept STE 200 Papillion NE 68046
(Street) (City) (State, Zip Code)

(PO Box) (City) (State, Zip Code)

Billing Address (if different) _____
(Street) (City) (State, Zip Code)

(PO Box) (City) (State, Zip Code)

Group Leader/Group Health Plan Primary Contact (Name) Linda Welles

(Title) Senior Administrator of Personnel

(Phone) 402-593-4487

(FAX) 402-593-5781

(E-mail) lwelles@sarpy.com

Employer (Tax) Identification Number (EIN) 47-6006504

B. Names of subsidiaries or affiliated organizations to be included (must be majority-owned – 51% or greater):

C. Is the Group Health Plan subject to the Employee Retirement Income Security Act of 1974 (ERISA)? Yes No

D. Is the Group Health Plan subject to the Consolidated Omnibus Reconciliation Act (COBRA), as amended, during this calendar year? Yes No

If yes, does the group have a COBRA Administrator? Yes No

Please provide name of third-party COBRA Administrator: Payflex

E. Does the Applicant authorize BCBSNE to administer dependent coverage requests involving court-ordered alternate recipients, which will include reviewing and determining dependent coverage and notifications required by OBRA '93 regarding Qualified Medical Child Support Orders (QMSCO)? Yes No

F. Does the Applicant authorize BCBSNE to provide Certificates of Creditable Coverage to eligible employees/dependents, as provided by law? Yes No

G. Does the Applicant have an HSA or HRA Administrator? HSA HRA

If yes, please provide name of third-party Administrator: EBS

H. Employee Data: The following is from and agrees with your payroll and personnel records:	Total
1. Total employees on the payroll (includes full-time, part-time, leased employees):	_____
2. Total eligible employees on the payroll on the effective date of the Contract	_____
3. Eligible employees not enrolling due to coverage	_____
a. Number of employees with creditable coverage (Medicare, Medicaid, Spousal coverage)	
b. Number of employees with individual coverage	
c. Number of employees not enrolling due to cost or other reasons	
4. Eligible employees enrolling on the effective date of the Contract	<u>453</u>
5. Persons on COBRA or State Continuation Coverage	_____

ELIGIBILITY AND ENROLLMENT

A. An employee working a minimum of 30 hours per week (must be at least 17 ½) on a regular calendar year basis will be eligible for coverage on the group's next due date after such employee has completed an eligibility (probationary) waiting period of 0* days of service, and completes the applicable enrollment form. To remain eligible, the employee must continue to work the minimum number of hours per week required. If the Applicant includes Subgroups, the Subgroup Application shall indicate the eligibility (probationary) waiting period, and the minimum number of hours necessary for eligibility.

If an otherwise eligible employee is not actively at work on the effective date for other than personal health reasons, coverage for that employee will go into effect on the group's next due date following his/her return to active employment, subject to the receipt of an enrollment form within 31 days of the return-to-work date. As of the effective date indicated above, there are N/A such employees not actively working. (Attach list of names and corresponding social security numbers.)

For dependents who apply for coverage at the same time as the eligible employee, coverage will become effective on the same day as the employee.

Other eligibility provisions: *Employees effective the first of the month following hire date. Elected officials will be effective immediately after they are sworn in.

B. Retirees eligible? Yes No. (Attach list of retirees and copy of Retirement Program describing plan eligibility requirements and contribution toward the monthly charges.)

C. Enrollment Options – Membership Units: (Check all that apply)

Standard Membership Units

- Single – Employee Only
- Employee & Spouse
- Employee & Children
- Family

Alternate Membership Tiers

- Employee & One Dependent
- Employee & Two or More Dependents

Other Enrollment Provisions: _____

D. Waiting Periods for Pre-Existing Conditions (Health Coverage):

- Initial Enrollment of the Group Waived Enforced
(For groups of 99 or less, waiver applies only to those covered under the prior group contract. Attach prior billing.)

Other Waiting Period provisions: _____

Note: Pre-existing condition waiting periods are not applicable to individuals under age 19.

E. Late Enrollment: 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.

Other provisions: _____

F. Dental Eligibility and Enrollment: Employees and dependents whose dental enrollment forms are not received by BCBSNE within 31 days of their eligibility, shall not be eligible to apply for dental coverage until the Annual Enrollment Month which follows the employee's eligibility date, unless BCBSNE approves a special enrollment period or waives this provision. Dental coverage for the first year following the Annual Enrollment Month will be limited to Coverage A only and premiums will not be reduced unless other late enrollment restrictions are otherwise specified on this Master Group Application or attachment(s).

If an enrolled employee voluntarily cancels his/her dental coverage, such employee (and his/her eligible dependents) may not re-enroll for two years from the first month following the date of cancellation, unless other restrictions are specified on this Master Group Application or attachment(s).

Other provisions: _____

Check here if Dental Coverage not applicable:

G. Certificate of Coverage: BCBSNE will provide the group with an electronic version of the Certificate of Coverage. The group is responsible for providing this document to its enrolled employees. If the group requests BCBSNE send additional paper copies of the Certificate of Coverage to their employees, please check here:

MONTHLY CHARGES AND EMPLOYER CONTRIBUTION

- A. Does your plan have a Section 125 plan which offers employees cash in lieu of health plan benefits? Yes No
- B. Do you, as the employer, fund a portion of the employee's deductible and/or coinsurance liability on any option offered? Yes No
 If yes, please provide the amount funded and applicable option: _____
- C. It is understood that the amount shown as employer contribution will be paid by you without charge to the eligible employees and the remainder collected by you from the eligible employees by payroll deduction and remitted monthly to BCBSNE.

The monthly charges will not change prior to July 1, 2012. This rate guarantee and continuation of coverage is subject to the Applicant continuing to meet BCBSNE underwriting guidelines, including minimum requirements for participation and contribution. If the number of covered employees increases or decreases 5% or more, or the terms of the Contract are changed, BCBSNE reserves the right to change the rates.

Other provisions: If this is a grandfathered plan, you must notify BCBSNE if employer contribution rates change at any time during the plan year.

		HEALTH OPTION 1		HEALTH OPTION 2	
		Employer Contribution	Total Monthly Charge	Employer Contribution	Total Monthly Charge
<input checked="" type="checkbox"/>	Single	90%	\$562.96		
<input checked="" type="checkbox"/>	Family	83%	\$1,384.34		
<input checked="" type="checkbox"/>	Employee and Spouse	83%	\$1,207.72		
<input checked="" type="checkbox"/>	Employee and Child/ren	83%	\$1,207.72		
		DENTAL OPTION 1		DENTAL OPTION 2	
		Employer Contribution	Total Monthly Charge	Employer Contribution	Total Monthly Charge
<input type="checkbox"/>	Single				
<input type="checkbox"/>	Family				
<input type="checkbox"/>	Employee and Spouse				
<input type="checkbox"/>	Employee and Child/ren				

BENEFIT DESIGNS – COVERAGE ELECTION

The Benefit Plan Design options are described in the Application Attachment Forms, as identified below.

Please indicate the Benefit Plan Design(s) requested by marking the applicable box(es) below, and complete the appropriate Attachment Form(s). **The applicable Attachment Form(s) must be attached to this Application.**

- PPO Master Group Contract – Standard Options – **App-Att-A**
- PPO Master Group Contract – HSA Options – **App-Att-B**
- Rx Nebraska Prescription Drug Program – **App-Att-C**
- Dental Coverage – **App-Att-D**
- Group Medicare Supplemental - Retirees Only – **App-Att-E**
- Nebraska BlueChoice Master Group Contract– **App-Att-F**
- 4718A – Benefit Schedule Attachment
- Other Benefit Plan Design _____

A separate Endorsement Summary or list may be used to identify Endorsements and/or special coverage provisions for this group plan. If used, it becomes a part of this Master Group Application and is hereby incorporated by this reference.

Yes, Endorsement Summary/List attached.

AUTHORIZED PLAN CONTACTS

The HIPAA Privacy Rules provide that the Group Health Plan is a separate legal entity from the Employer/Plan Sponsor. In compliance with the Rules, it is necessary to designate Authorized Plan Contacts for the Group Health Plan.

The Group Health Plan (GHP) Primary Contact is indicated on page 1 of this Master Group Application. 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 Group Health Plan's Agent of Record as one of your Authorized Plan Contacts. If you choose not to have the Group Health Plan's Agent of Record authorized to receive this information, please check here:

In addition, the following individuals may be given access to our Group Health Plan Information received from Blue Cross and Blue Shield of Nebraska in accordance to the requirements set forth within the HIPAA Privacy Rules.

Authorized Plan Contacts:

Reason for Change: New Delete

Name: _____

Title: _____

Reason for Change: New Delete

Name: _____

Title: _____

Reason for Change: New Delete

Name: _____

Title: _____

BCBSNE will not release protected health information (PHI) to fully insured groups, except as specifically agreed in writing by BCBSNE the Plan and Plan Sponsor. When there is a written agreement, all disclosure of PHI from BCBSNE shall be made to the Plan, or an Authorized Plan Contact.

APPLICANT CERTIFICATION AND SIGNATURE

I have read and understand the provisions of this Application for a Master Group Contract and certify that all information herein is true and accurate and agree to the provisions specified. I understand that if any information on this Application 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.

By signing this application, I represent that I am authorized to obtain coverage on behalf of the Group Health Plan.

<u>Tom Richards</u> Signature	<u>Chairman, Sarp Co. Bd.</u> Title	<u>5/17/11</u> Date
<u>Tom Richards</u> (Typed Name)	<u>Chairman, Sarp Co. Board</u> (Typed Title)	<u>5/17/11</u> (Typed Date)

AGENT CERTIFICATION:

I certify that I have verified the information in this Application for a Master Group Contract with the records of the Applicant and it is true and accurate to the best of my knowledge.

<u>[Signature]</u> Signature	<u>Broker</u> Title	<u>5/17/11</u> Date
<u>Mike Williams</u> (Typed Name)	<u>Broker</u> (Typed Title)	<u>5/17/11</u> (Typed Date)

ACCEPTANCE BY BLUE CROSS AND BLUE SHIELD OF NEBRASKA:

- This Master Group Application is accepted.
- This Master Group Application is accepted with the following changes: _____

<u>Daniel W. Alm</u> Signature (Blue Cross and Blue Shield of Nebraska)	<u>VP UNDERWRITING</u> Title	<u>6.10.11</u> Date
--	---------------------------------	------------------------

The noted changes in this part are acceptable.

Signature of Applicant _____ Date _____

Please sign both the original and the copy. Retain the copy and return the original to Blue Cross and Blue Shield of Nebraska.

FOR OFFICIAL USE ONLY

Contract No.: Health 46-067; Dental _____ Med. Supp. _____

Endorsements: 3-00018 3-00005 9856 3-00008

Received
MAY 24 2011
MPC 1020

PSF Renewal

EBS System Data

Client Number: 49130
 Plan Year: 7/1/2011-6/30/2012
 Services: PSF only

A) Plan Sponsor - All Information is required for Renewal Groups

Group Name: Sarpy County Tax ID: 47-6006504
 Address: 1210 Golden Gate Drive Papillion, NE 68046-2895
 Telephone: 402-593-4487 Facsimile: 402-593-4360 Website: _____
 Contact: Linda Welles Title: Sr. Admin Personnel Email: lwelles@sarpy.com
 Agency: William-Deras Address: 302 S 36th St. Suite 105 Omaha, NE
 Agent: Mike Williams/Stephanie Dow Phone: 402-398-9898 x3 Email: steph@williamsderas.com

B) PSF Plan Information

PRIMARY PLAN (EMPLOYER PLAN)

PLEASE ATTACH PLAN SUMMARY FROM CARRIER

Carrier:	In-Network		Non-Network	
	Single	Family	Single	Family
Deductible:	\$3000	\$6000	\$6000	\$12000
Out-of-Pocket maximum (OPM):	\$3450	\$6900	\$9900	\$19800
Co-insurance:	70/30		50/50	
Deductible included in OPM:	_____		_____	
Co-pay: OV = \$	<u>30-60</u>	ER = \$ <u>100</u>	Wellness = \$ _____	Supl Accd = \$ _____
Drug Program:	<u>\$10/40/60</u>			

REIMBURSEMENT PLAN (EMPLOYEE PLAN)

	In-Network		Non-Network	
	Single	Family	Single	Family
Deductible:	\$500	\$1000	\$N/A	\$N/A
Out-of-Pocket maximum (OPM):	\$1500	\$3000	\$N/A	\$N/A
Co-insurance:	70/30		_____	
Deductible included in OPM:	_____		_____	
Co-pay: OV = \$	<u>30-60</u>	ER = \$ <u>100</u>	Wellness = \$ _____	Supl Accd = \$ _____
Drug Program:	<u>\$10/40/60</u>			

Maximum dollar exposure to the employer per member, in-network: \$1950/3900
 Maximum dollar exposure to the employer per member, non-network: \$N/A

D) Fees

PSF Admin	<u>\$6.50</u>	EOB Fee	<u>\$</u>	Billing Admin	<u>\$</u>	COBRA Admin	<u>\$</u>
Flex Admin	<u>\$</u>	HRA Admin	<u>\$</u>	Dental Admin	<u>\$</u>	Vision Admin	<u>\$</u>
				Broker Fee	<u>\$</u>	Total Fees (pepm):	<u>\$6.50</u>

E) Plan Confirmation

EBS shall be entitled to rely on information furnished by the Client, Agent, or Broker regarding group set-up, renewal and implementation. The Client, Agent, or Broker will furnish EBS with such other information as EBS may reasonably require in the performance of its duties hereunder. In the case of inaccurate information provided to EBS, EBS will only go back sixty (60) days for reprocessing of claims and EBS will not be held responsible for claims under or overpaid prior to that period.

Signature: Tom Richards Date: 5/17/11
 Print Name: Tom Richards, Chairman, Sarpy County Board

**EMPLOYEE BENEFIT SYSTEMS
THIRD PARTY ADMINISTRATION SERVICE AGREEMENT**

THIS AGREEMENT effective July 1, 2011 is made by and between Sarpy County ("Client"), an Nebraska corporation, and Employee Benefit Systems ("Administrator"), an Iowa corporation.

WHEREAS, the Client desires to retain the Administrator to provide certain Administrative services on behalf of the Client;

WHEREAS, the Administrator agrees to provide these certain Administrative services on behalf of Client;

NOW THEREFORE, in consideration of these promises and the mutual promises set forth in this Agreement, the parties hereby agree as follows:

1. APPOINTMENT.

The Client appoints the Administrator to provide administrative services, subject to the terms and conditions of this Agreement. The Administrator shall have only such authority as granted expressly by this Agreement. The Administrator shall not have any authority to make any agreement binding upon Client.

2. COMPLIANCE WITH LAWS.

The Administrator agrees that it will comply with all laws, statutes, rules and regulations. Except as authorized in writing by Client, Administrator shall not disclose to any person, institution, or company not authorized by Client any information directly or indirectly related to Employees and shall not reveal any individually identifiable medical information, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) privacy and security regulations, without first receiving authorization from the individual involved.

3. BOND.

Administrator shall maintain a Fidelity bond for protection against fraud or dishonesty on the part of any employee of the Administrator in an amount to comply with Employee Retirement Income Security Act (ERISA) guidelines for this size plan.

4. INSURANCE.

Administrator shall obtain and maintain general, E&O liability insurance and other insurance necessary or appropriate to insure its ability to comply with all applicable regulations.

5. INDEPENDENT CONTRACTOR.

The relationship between Client and Administrator is intended to be that of independent contractors. Nothing in this Agreement shall be construed to create any partnership, joint venture or agency or employment relationship of any kind between Client and Administrator or any employee or agent.

6. STATUS OF ADMINISTRATOR.

Administrator hereby represents and warrants that neither Administrator nor, to the best of its knowledge, its employees or subcontractors have been charged with a criminal offense.

7. LICENSES.

Administrator represents and warrants that it possesses the necessary licenses from regulatory authorities to perform its duties under this Agreement and that it is a corporation duly organized and existing and in good standing under the laws of the State of Iowa.

8. RECORDS.

All records in the possession of the Administrator shall be kept by the Administrator for the periods required by law. Client may audit during regular business hours any and all records of Administrator pertaining to claims or premiums paid on behalf of Client's plan participants.

9. CONFIDENTIALITY.

During the course of performance under and during the "fact finding process", each party will obtain or have access to certain proprietary information. Each party acknowledges that all such material is offered on a proprietary basis, for the sole purpose of enhancing this Agreement and will only be used as necessary to carry out the terms and conditions of this Agreement.

10. COMPENSATION.

Client shall pay Administrator an administrative fee, as described in Addendum A to this Agreement, as the sole compensation for the performance under this Agreement. Such fee shall be in full satisfaction of all services performed pursuant to this agreement. In consideration of a monthly administration fee (as outlined in Addendum A), Administrator agrees to provide claims payment, administrative and enrollment services for the Client. These services shall include but not be limited to the processing and payment or denial of claims, monthly and yearly reporting of the financial and quality indicators and claims data, file 1099-Med forms to the IRS and provide copies to the provider, and perform other services as necessary to administer Client's benefit plan.

All benefits will be paid with the care, skill, diligence and impartiality normally expected of a third-party administrator in the insurance industry.

All forms, materials and computerized checks used by Administrator will be provided at Administrator's expense. Booklet printing charges are not contemplated under this agreement and will be separately contracted for as necessary.

11. FINANCIAL REQUIREMENTS.

Client shall adequately fund a checking account, which shall be used exclusively for maintaining reserve funds, payment of Client's claims, premiums and monthly administration fees and other expenses. Client will be responsible for any monthly checking account service charges relating to this account. The funding of the checking account (timing and amount) will be the responsibility of the Client. Administrator will not pre-fund any claim or premium payments. Neither Administrator nor its officers shall be liable to pre-fund any of the costs outlined above in this section, including but not limited to claim payments, premiums, cost or administration costs. Administrator will not be liable for any claims resulting from a group's termination due to lack of adequate funding to Administrator.

12. CLIENT RESPONSIBILITIES.

Client shall provide a method of notification to Administrator detailing the eligibility of new members enrolled and those persons that are no longer eligible for the benefit. In the absence of notification (of termination or loss of benefit coverage), eligibility for payment of the claim or other benefit will continue.

Client hereby authorizes Administrator to draw checks, drafts or other instruments for the payment of Benefits associated with the processing of Benefits in accordance with the terms and conditions of the Plan and this agreement against any account maintained and designated by Client for this purpose.

In the event of delayed filing of subrogation or similar claims by any party, including by any Government agency, Client will retain responsibility for all benefits payable under the Health Care Plan in effect at the time the loss is incurred. Administrator shall handle any such matters in a timely manner. If Client has retained another Administrator when such an event happens, Administrator shall provide any information it may have related to the matter as soon as possible.

13. CLAIMS APPEALS.

Administrator shall refer to Client or its designee, for final determination, any claim for benefits or coverage that is appealed after initial rejection by the Administrator or any class of claims the Client may specify, including: (a) any question of eligibility or entitlement of the claimant for coverage under the Plan; (b) any question with respect to the amount due; or (c) any other appeal.

14. TERM & TERMINATION.

- a. **Term.** The initial term of this Agreement shall be for one (1) year. This Agreement shall renew automatically each year unless either party gives notice of termination to the other party at least sixty (60) days prior to beginning of any term.
- b. **Termination.** This Agreement shall terminate:
 - a. By mutual agreement of the parties;
 - b. By either party, if, after giving written notice of any material breach, the breaching party fails to correct such breach within 30 days of receipt of such written notice.
 - c. Post Termination Duties. The parties shall have no duties upon termination of this Agreement except to settle their accounts, including payment of any indebtedness and, to carry out any residual obligations which arose while this agreement was in force. Administrator can and will offer to process any run-out claims for a fee agreed upon by both parties.
 - d. Administrator can and will offer to process any run-out claims for a fee that is based on the current PEPM cost times the number of participants at date of termination. The agreed upon fee, based upon the number on months of run-out, must be paid in full before any run-out claims will be processed.

15. INDEMNIFICATION.

Each party shall defend, indemnify, and hold the other party or any of its directors, officers or employees harmless from and against all costs, claims, expense, demands, actions, suits or proceedings, liabilities and damages (including, but not limited to, attorney's fees) directly or indirectly arising out of or resulting from any act or omission of the indemnifying party that occurred in the performance of its duties under this Agreement.

16. GENERAL PROVISIONS

- a) Administrator agrees to provide at least 60 days notice prior to future fee increases and to limit such increases to once in a 12-month period. The fee thereafter shall be based on each month's count of participating employees. For fee calculation purpose, Plan participants on Leave of Absence, early retirement and COBRA extensions will be included as employees. Administrator will bill the group monthly for the administration fee.
- b) Entire Contract - This agreement supersedes any and all previous contracts, stipulations and agreements, written or oral.
- c) Applicable Law - This Agreement shall be deemed to be an Iowa contract, and shall be construed and governed by the laws of such state.

Employee Benefit Systems

Mark Lehman

Mark Lehman, CFO

6/13/11

Date

Sarpy County

Tom Richard

Authorized Signature & Title

5/17/11

Date

AGREEMENT BETWEEN
EMPLOYEE BENEFIT SYSTEMS AND
SARPY COUNTY

ADDENDUM (A)
FEE SCHEDULE EFFECTIVE JULY 1, 2011
(All fees are per employee per month)

Partial Self-Funding Administration	\$	6.50 or \$75.00 minimum per month
Plan Amendments	\$	100.00 as required

*Please note these fees include standard reporting only. Additional reports will be charged an additional fee accordingly.

Employee Benefit Systems

Mark Lehman

Mark Lehman, CFO

6/13/11

Date

Sarpy County

Tom Richard

Authorized Signature & Title

5/17/11

Date

**AGREEMENT BETWEEN
EMPLOYEE BENEFIT SYSTEMS AND
SARPY COUNTY**

**ADDENDUM (B)
BUSINESS ASSOCIATE AGREEMENT**

1. PREAMBLE.

Sarpy County ("Covered Entity") and Employee Benefit Systems ("Business Associate") (jointly "the Parties") wish to modify the Administrative Services Agreement ("Agreement") to incorporate the terms of this Addendum to comply with the requirements of: (i) the implementing regulations at 45 C.F.R Parts 160, 162, and 164 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (*i.e.*, the HIPAA Privacy Rule, the HIPAA Security Standards, and the HIPAA Standards for Electronic Transactions (collectively referred to in this Addendum as "the HIPAA Regulations")), and (ii) the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") that are applicable to business associates, along with any guidance and/or regulations issued by the U.S. Department of Health and Human Services ("DHHS") as of September 2009. Covered Entity and Business Associate agree to incorporate into this Addendum any regulations issued by DHHS with respect to the HITECH Act that relate to the obligations of business associates and that are required to be (or should be) reflected in a business associate agreement. Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HITECH Act.

2. DEFINITIONS.

- (a) "*Electronic PHI*" shall mean protected health information that is transmitted or maintained in any electronic media, as this term is defined in 45 C.F.R. § 160.103.
- (b) "*Limited Data Set*" shall mean protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:
 - (i) Names;
 - (ii) Postal address information, other than town or city, State, and zip code;
 - (iii) Telephone numbers;
 - (iv) Fax numbers;
 - (v) Electronic mail addresses;
 - (vi) Social security numbers;
 - (vii) Medical record numbers;
 - (viii) Health plan beneficiary numbers;
 - (ix) Account numbers;
 - (x) Certificate/license numbers;
 - (xi) Vehicle identifiers and serial numbers, including license plate numbers
 - (xii) Device identifiers and serial numbers;

- (xiii) Web Universal Resource Locators (URLs);
 - (xiv) Internet Protocol (IP) addresses numbers;
 - (xv) Biometric identifiers, including finger and voice prints; and
 - (xvi) Full face photographic images and any comparable images.
- (c) "Protected Health Information" or "PHI" shall mean information created or received by a health care provider, health plan, employer, or health care clearinghouse, that: (i) relates to the past, present, or future physical or mental health or condition of an individual, provision of health care to the individual, or the past, present, or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any other form or medium. The use of the term "Protected Health Information" or "PHI" in this Addendum shall mean both Electronic PHI and non-electronic PHI, unless another meaning is clearly specified.
- (d) "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (e) All other terms used in this Addendum shall have the meanings set forth in the applicable definitions under the HIPAA Regulations and/or the security and privacy provisions of the HITECH Act that are applicable to business associates along with any regulations issued by the DHHS.

3. **GENERAL TERMS.**

- (a) In the event of an inconsistency between the provisions of this Addendum and a mandatory term of the HIPAA Regulations (as these terms may be expressly amended from time to time by the DHHS or as a result of interpretations by DHHS, a court, or another regulatory agency with authority over the Parties), the interpretation of DHHS, such court or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.
- (b) Where provisions of this Addendum are different from those mandated by the HIPAA Regulations or the HITECH Act, but are nonetheless permitted by the Regulations or the Act, the provisions of this Addendum shall control.
- (c) Except as expressly provided in the HIPAA Regulations, the HITECH Act, or this Addendum, this Addendum does not create any rights in third parties.

4. **SPECIFIC REQUIREMENTS.**

(a) Privacy of Protected Health Information

- (i) *Permitted Uses and Disclosures of PHI.* Business Associate agrees to create, receive, use, or disclose PHI only in a manner that is consistent with this Addendum or the HIPAA Privacy Rule and only in connection with providing the services to Covered Entity identified in the Agreement. Accordingly, in providing services to or for the Covered Entity, Business Associate, for example, will be permitted to use and disclose PHI for "treatment, payment, and health care operations" in accordance with the HIPAA Privacy Rule.
- (1) Business Associate shall report to Covered Entity any use or disclosure of PHI that is not provided for in this Addendum.
 - (2) Business Associate shall maintain safeguards as necessary to ensure that PHI is not used or disclosed except as provided for by this Addendum.

- (ii) *Business Associate Obligations.* As permitted by the HIPAA Privacy Rule, Business Associate also may use or disclose PHI received by the Business Associate in its capacity as a Business Associate to the Covered Entity for Business Associate's own operations if:
- (1) the *use* relates to: (1) the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate, or (2) data aggregation services relating to the health care operations of the Covered Entity; or
 - (2) the *disclosure* of information received in such capacity will be made in connection with a function, responsibility, or services to be performed by the Business Associate, and such disclosure is required by law or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential and the person agrees to notify the Business Associate of any breaches of confidentiality.
- (iii) *Minimum Necessary Standard and Creation of Limited Data Set.* Business Associate's use, disclosure, or request of PHI shall utilize a Limited Data Set if practicable. Otherwise, in performing the functions and activities as specified in the Agreement and this Addendum, Business Associate agrees to use, disclose, or request only the minimum necessary PHI to accomplish the intended purpose of the use, disclosure, or request.
- (iv) *Access.* In accordance with 45 C.F.R. § 164.524 of the HIPAA Privacy Rule and, where applicable, in accordance with the HITECH Act, Business Associate will make available to those individuals who are subjects of PHI, their PHI in Designated Record Sets by providing the PHI to Covered Entity (who then will share the PHI with the individual), by forwarding the PHI directly to the individual, or by making the PHI available to such individual at a reasonable time and at a reasonable location. Business Associate shall make such information available in an electronic format where directed by the Covered Entity.
- (v) *Disclosure Accounting.* Business Associate shall make available the information necessary to provide an accounting of disclosures of PHI as provided for in 45 C.F.R. § 164.528 of the HIPAA Privacy Rule, and where so required by the HITECH Act and/or any accompanying regulations, Business Associate shall make such information available directly to the individual. Business Associate further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations.
Business Associate is not required to record disclosure information or otherwise account for disclosures of PHI that this Addendum or the Agreement in writing permits or requires: (i) for the purpose of payment activities or health care operations (except where such recording or accounting is required by the HITECH Act, and as of the effective dates for this provision of the HITECH Act), (ii) to the individual who is the subject of the PHI disclosed, or to that individual's personal representative; (iii) to persons involved in that individual's health care or payment for health care; (iv) for notification for disaster relief purposes, (v) for national security or intelligence purposes, (vi) to law enforcement officials or correctional institutions regarding inmates; (vii) pursuant to an authorization; (viii) for disclosures of certain PHI made as part of a limited data set; and (ix) for certain incidental disclosures that may occur where reasonable safeguards have been implemented.
- (vi) *Amendment.* Business Associate shall make available PHI for amendment and incorporate any amendment to PHI in accordance with 45 C.F.R. § 164.526 of the HIPAA Privacy Rule.
- (vii) *Right to Request Restrictions on the Disclosure of PHI and Confidential Communications.* If an individual submits a Request for Restriction or Request for Confidential Communications to the Business Associate, Business Associate and Covered Entity agree that Business Associate, on behalf of Covered Entity, will evaluate and respond to these requests according to Business Associate's own procedures for such requests.

- (viii) *Return or Destruction of PHI.* Upon the termination or expiration of the Agreement or this Addendum, Business Associate agrees to return the PHI to Covered Entity, destroy the PHI (and retain no copies), or further protect the PHI if Business Associate determines that return or destruction is not feasible.
- (ix) *Availability of Books and Records.* Business Associate shall make available to DHHS or its agents the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI in connection with this Addendum.
- (x) *Termination for Breach.*
 - (1) Business Associate agrees that Covered Entity shall have the right to terminate this Addendum or seek other remedies if Business Associate violates a material term of this Addendum.
 - (2) Covered Entity agrees that Business Associate shall have the right to terminate this Addendum or seek other remedies if Covered Entity violates a material term of this Addendum.

(b) Information and Security Standards

- (i) Business Associate will develop, document, implement, maintain, and use appropriate administrative, technical, and physical safeguards to preserve the integrity, confidentiality, and availability of, and to prevent nonpermitted use or disclosure of, PHI created or received for or from the Covered Entity.
- (ii) Business Associate agrees that with respect to PHI, these safeguards, at a minimum, shall meet the requirements of the HIPAA Security Standards applicable to Business Associate.
- (iii) More specifically, to comply with the HIPAA Security Standards for PHI, Business Associate agrees that it shall:
 - (1) Implement administrative, physical, and technical safeguards consistent with (and as required by) the HIPAA Security Standards that reasonably protect the confidentiality, integrity, and availability of PHI that Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate shall develop and implement policies and procedures that meet the Security Standards documentation requirements as required by the HITECH Act.
 - (2) As also provided for in Section 4(d) below, ensure that any agent, including a subcontractor, to whom it provides such PHI agrees to implement reasonable and appropriate safeguards to protect it;
 - (3) Report to Covered Entity, Security Incidents of which Business Associate becomes aware that result in the unauthorized access, use, disclosure, modification, or destruction of the Covered Entity's PHI, (hereinafter referred to as "Successful Security Incidents"). Business Associate shall report Successful Security Incidents to Covered Entity as specified in Section 4(e);
 - (4) For any other Security Incidents that do not result in unauthorized access, use, disclosure, modification, or destruction of PHI (including, for purposes of example and not for purposes of limitation, pings on Business Associate's firewall, port scans, attempts to log onto a system or enter a database with an invalid password or username, denial-of-service attacks that do not result in the system being taken off-line, or malware such as worms or viruses) (hereinafter "Unsuccessful Security Incidents"), Business Associate shall aggregate the data and, upon the Covered

Entity's written request, report to the Covered Entity in accordance with the reporting requirements identified in Section 4(e);

- (5) Take all commercially reasonable steps to mitigate, to the extent practicable, any harmful effect that is known to Business Associate resulting from a Security Incident;
- (6) Permit termination of this Addendum if the Covered Entity determines that Business Associate has violated a material term of this Addendum with respect to Business Associate's security obligations and Business Associate is unable to cure the violation; and
- (7) Upon Covered Entity's request, Business Associate will provide Covered Entity with access to and copies of documentation regarding Business Associate's safeguards for PHI.

(c) Compliance with HIPAA Transaction Standards

- (i) *Application of HIPAA Transaction Standards.* Business Associate will conduct Standard Transactions consistent with 45 C.F.R. Part 162 for or on behalf of the Covered Entity to the extent such Standard Transactions are required in the course of Business Associate's performing services under the Agreement and this Addendum for the Covered Entity. As provided for in Section 4(d) below, Business Associate will require any agent or subcontractor involved with the conduct of such Standard Transactions to comply with each applicable requirement of 45 C.F.R. Part 162. Further, Business Associate will not enter into, or permit its agents or subcontractors to enter into, any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of the Covered Entity that:
 - (1) Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;
 - (2) Adds any data element or segment to the maximum defined data set;
 - (3) Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or
 - (4) Changes the meaning or intent of the Standard Transaction's implementation specification.
- (ii) *Specific Communications.* Business Associate and Covered Entity recognize and agree that communications between the parties that are required to meet the Standards for Electronic Transactions will meet the Standards set by that regulation. Communications between the Business Associate and the Covered Entity do not need to comply with the HIPAA Standards for Electronic Transactions. Accordingly, unless agreed otherwise by the Parties in writing, all communications (if any) for purposes of "enrollment" as that term is defined in 45 C.F.R. Part 162, Subpart O or for "Health Covered Entity Premium Payment Data," as that term is defined in 45 C.F.R. Part 162, Subpart Q, shall be conducted between the Business Associate or the Covered Entity. For all such communications (and any other communications), shall use such forms, tape formats, or electronic formats as Business Associate may approve.
- (iii) *Communications Between the Business Associate and the Covered Entity.* All communications between the Business Associate and the Covered Entity that are required to meet the HIPAA Standards for Electronic Transactions shall do so. For any other communications between the Business Associate and the Covered Entity, the Covered Entity shall use such forms, tape formats, or electronic formats as Business Associate may approve. The Covered Entity will

include all information reasonably required by Business Associate to affect such data exchanges or notifications.

- (d) Agents and Subcontractors. Business Associate shall include in all contracts with its agents or subcontractors, if such contracts involve the disclosure of PHI to the agents or subcontractors, the same restrictions and conditions on the use, disclosure, and security of such PHI that are set forth in this Addendum.
- (e) Breach of Privacy or Security Obligations.
 - (i) *Notice and Reporting to Covered Entity.* Business Associate will notify and report to Covered Entity (in the manner and within the timeframes described below) any use or disclosure of PHI not permitted by this Addendum, by applicable law, or permitted in writing by Covered Entity.
 - (ii) *Notice to Covered Entity.* Business Associate will notify Covered Entity following discovery and without unreasonable delay but in no event later than ten (10) calendar days following discovery, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by the HITECH Act and any implementing regulations. Business Associate shall cooperate with Covered Entity in investigating the Breach and in meeting the Covered Entity's obligations under the HITECH Act and any other security breach notification laws. Business Associate shall follow its notification to the Covered Entity with a report that meets the requirements outlined immediately below.
 - (iii) *Reporting to Covered Entity.*
 - (1) For Successful Security Incidents and any other use or disclosure of PHI that is not permitted by this Addendum, the Agreement, by applicable law, or without the prior written approval of the Covered Entity, Business Associate - without unreasonable delay and in no event later than thirty (30) days after Business Associate learns of such non-permitted use or disclosure - shall provide Covered Entity a report that will:
 - a. Identify (if known) each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed during such Breach;
 - b. Identify the nature of the non-permitted access, use, or disclosure including the date of the incident and the date of discovery;
 - c. Identify the PHI accessed, used, or disclosed (e.g., name; social security number; date of birth);
 - d. Identify who made the non-permitted access, use, or received the non-permitted disclosure;
 - e. Identify what corrective action Business Associate took or will take to prevent further non-permitted accesses, uses, or disclosures;
 - f. Identify what Business Associate did or will do to mitigate any deleterious effect of the non-permitted access, use, or disclosure; and
 - g. Provide such other information, including a written report, as the Covered Entity may reasonably request.
 - (2) For Unsuccessful Security Incidents, Business Associate shall provide Covered Entity, upon its written request, a report that: (i) identifies the categories of Unsuccessful Security Incidents as described in Section 4(b)(iii)(4); (ii) indicates whether Business Associate believes its current defensive security measures are adequate to address all

Unsuccessful Security Incidents, given the scope and nature of such attempts; and (iii) if the security measures are not adequate, the measures Business Associate will implement to address the security inadequacies.

(iv) *Termination for Breach.*

- (1) Covered Entity and Business Associate each will have the right to terminate this Addendum if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of Business Associate's or the Covered Entity's respective obligations regarding PHI under this Addendum and, on notice of such material breach or violation from the Covered Entity or Business Associate, fails to take reasonable steps to cure the material breach or end the violation.
- (2) If Business Associate or the Covered Entity fail to cure the material breach or end the violation after the other party's notice, the Covered Entity or Business Associate (as applicable) may terminate this Addendum by providing Business Associate or the Covered Entity written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. Such termination shall be effective 60 days from this termination notice.

(v) *Continuing Privacy and Security Obligations.* Business Associate's and the Covered Entity's obligation to protect the privacy and security of the PHI it created, received, maintained, or transmitted in connection with services to be provided under the Agreement and this Addendum will be continuous and survive termination, cancellation, expiration, or other conclusion of this Addendum or the Agreement. Business Associate's other obligations and rights, and the Covered Entity's obligations and rights upon termination, cancellation, expiration, or other conclusion of this Addendum, are those set forth in this Addendum and/or the Agreement.

5. **AMENDMENT.**

The parties agree that this Addendum may be amended by mutual agreement of the parties, in writing. In the event an amendment to this Addendum is required by modifications to the HIPAA Privacy Rule, EBS may unilaterally amend this Addendum to comply with the HIPAA Privacy Rule, and the Plan shall be bound by such amendment.

Employee Benefit Systems

Mark Lehman

Mark Lehman, CFO

6/13/11

Date

Sentry County
Tom Rickard

Authorized Signature & Title

5/17/11

Date

**AGREEMENT BETWEEN
EMPLOYEE BENEFIT SYSTEMS AND
SARPY COUNTY**

ADDENDUM (C) RESPONSIBILITY AGREEMENT

Responsibility of Sarpy County – hereafter referred to as “Client”.

1. Group Setup and Renewal Information

- a. The Client and or the Agent is responsible for completing, signing, and returning the Setup or Renewal Forms and Re-enrollment Forms by the designated deadline.

2. Adds, Changes or Terminations

- a. Notices of additions, changes or terminations of members should be sent to the EBS Billing and Enrollment Specialist in a timely manner.
- b. The maximum adjustment for late notification of additions, changes, or terminations is 60 days from date of receipt by EBS. (Ex: Employee terminates coverage December 1st. EBS is notified April 10th . Credit will be given for prior 60 days, February and March).
- c. EBS will not be responsible for claims paid in the event that a change or termination was not sent to EBS in a timely fashion.

3. Report Verification

- a. The Client is responsible for reviewing the EBS Monthly Reports if applicable and the Monthly Billing Statement against their payroll and other records for accuracy.

4. Payroll Reporting for Flex Spending Accounts (if applicable)

- a. The Client is responsible to provide the payroll contributions information to EBS in a timely manner.

5. Claim Funding (if applicable)

- a. The preferred method of funding the claims account is by ACH.
- b. If another method is used to fund processed claims, EBS will not hold claims longer than four business days.
- c. EBS will not be responsible for any overdraft fees or bank charges due to non-funded accounts.

6. IRS Reporting (if applicable)

- a. Clients with over 100 lives are required to file Form 5500 Annual Report / Report of Employee Benefit Plan.

7. Fees on Self Insured Health Plans (if applicable)

- a. Clients with self insured health plans are responsible for the payment of any fees assessed (i.e. Comparative Effectiveness Research (CER fees) in accordance with any new or revised federal and/or state regulations.

Responsibility of Employee Benefit Systems, hereafter referred to as “Administrator”.

1. Adds, Changes or Terminations

- a. Administrator will process adds, changes, or terminations in a timely manner, one to three business days after receipt of notification.

2. Claims Processing (if applicable)

- a. Claims will be paid in a timely manner consistent with normal business practices.
- b. Administrator will contact the Client in the case where additional funds are needed to release processed claims. Administrator will not hold claims longer than four business days.

3. Reports

- a. Administrator will generate a Monthly Billing Statement and send by email to the Client. If EBS bills the client for payroll contributions and additional funding has been collected throughout the year, an adjustment to the monthly billing will be made on the twelfth -12th-month bill of the Plan Year.
- b. Check registers will be sent by email to the Client.
- c. Monthly Reports and Financials will be sent by email to the Client if applicable.

4. ID Cards (if applicable)

- a. Administrator will create and send out ID cards for the members.

Employee Benefit Systems

Mark Lehman

Mark Lehman, CFO

6/13/11

Date

Sarpy County

Tom Richards

Authorized Signature & Title

5/17/11

Date

Preferred Provider Organization Master Group Contract Standard Design Options

Contract Form No. 96-067-I Group – Roll No. 300074-01,02,99This Attachment may be duplicated as necessary to include additional options. Please indicate number of options here: 1OPTION 1 Structured Option 13

A. Deductible/Coinsurance	In-network	Out-of-network
Deductible:		
Individual	<u>\$3,000</u>	<u>\$6,000</u>
Family Maximum	<u>\$6,000</u>	<u>\$12,000</u>
Coinsurance Limit (not including the deductible):		
Individual	<u>\$450</u>	<u>\$3,900</u>
Family Maximum	<u>\$900</u>	<u>\$7,800</u>
Coinsurance Percentage for:		
Hospital/Medical/Surgical	<u>30%</u>	<u>50%</u>

Family Deductible/Coinsurance: Aggregate Embedded - If embedded, each family member must only meet the embedded single Deductible of \$3,000/\$6,000 and the embedded single Coinsurance Limit of \$450/ \$3,900

Unless otherwise noted, Out-of-network benefits for the Covered Services listed below will be subject to the Out-of-network Deductible/Coinsurance indicated in this item.

B. Physician Office (In-Network Benefit):

 Deductible and Coinsurance Copayment

- Primary \$30 Copay
- Specialist \$60 Copay

- Office Service Copay OR Office Visit Copay

o If Office Visit selected: Other Covered Services and Supplies provided in the Physician's Office (deductible waive): Medical Coinsurance OR Plan Pays 100%

 Other _____

C. Allergy Injection/Serum (In-Network Benefit):

 Deductible and Coinsurance Copayment (\$10 Copayment) Medical Coinsurance OR Plan Pays 100% Other _____

D. Urgent Care Services (In-Network Benefit):

 Deductible and Coinsurance Copayment

- \$30 Copay

E. Emergency Care Services (In-Network Benefit):

 Deductible and Coinsurance Copayment

- Facility: \$100 Copay, then Medical coinsurance
- Professional: Medical Coinsurance, deductible waived

 Other _____

Note: Out-of-network benefits are paid at the In-network level.

F. **Manipulations (In-network Benefit):**

- Deductible and Coinsurance
 Copayment
 • \$_____ Copay

G. **Preventive Benefits:**

In-network

- Health Care Reform (HCR) required Preventive Services (may be subject to limits that include, but are not limited to, age, gender & frequency)
- HCR required covered Preventive Services (outside of limits)
- Other covered Preventive Services not required by HCR

Plan Pays 100%

_____ Deductible and Coinsurance
 Plan Pays 100%
 _____ Other _____

_____ Deductible and Coinsurance
 Plan Pays 100%
 _____ Other _____

Note: Out-of-network Preventive Services subject to Out-of-network Deductible/Coinsurance in Item A.

H. **Independent Laboratory Benefits:**

- Diagnostic
 o _____ Deductible and Coinsurance
 o _____ Coinsurance Only
 o Plan Pays 100%
 - Preventive
 o Same as Preventive Benefits in Item G.

Note: Out-of-network benefits are paid at the In-network level.

_____ Other _____

I. **Mental Illness and/or Substance Dependence and Abuse:**

(Benefits based upon actuarial analysis of most predominant financial requirements applied to substantially all medical/surgical benefits covered by the plan.)

In-network

Out-of-network

Inpatient Services:

Deductible and Coinsurance

Deductible and Coinsurance

Outpatient Services:

Deductible and Coinsurance
 _____ Copayment
 • \$_____ Copay
 _____ Coinsurance Only
 _____ Plan Pays 100%

Deductible and Coinsurance

Office Visit/Service

Same cost-share as described in Item B. (Copayment for Mental Illness and/or Substance Dependence and Abuse will be at the PCP level.)

Emergency Care:

In-network & Out-of-network (same benefit)

_____ Deductible and Coinsurance
 Copayment
 • Facility: \$100 Copay, then Medical Coinsurance
 • Professional: Medical Coinsurance Only, Deductible waived
 _____ Plan Pays 100%
 _____ Other _____

J. Appeals Procedure Endorsement: (F – Self-insured) 3-00002 (G – Insured) 3-00005

K. Optional Endorsements:

Yes No Preventive Vision Exam (Endorsement 3-00018 – 1 exam per calendar year)

Yes No Nicotine Dependence or Addiction Classes and Acupuncture (Endorsement 3-00020)

Yes No Treatment of Infertility (Endorsement 3-00019)

- Option 1 _____ Up to a \$10,000 Contract Maximum (\$7,500 for medical and \$2,500 for prescription drug)
- Option 2 _____ Up to a \$ 20,000 Contract Maximum (\$15,000 for medical and \$5,000 for prescription drug)
- Option 3 _____ Up to a \$ 30,000 Contract Maximum (\$22,500 for medical and \$7,500 for prescription drug)

L. Other Endorsements/Benefits:

Yes No Exclude Coverage for Sexual Dysfunction (Endorsement Number 3-00016)

Yes No Exclude Coverage for Elective Abortion (Endorsement Number 3-00029)

Yes No Exclude Coverage for Contraceptive Services & Supplies (Endorsement Number 3-00033)

Other: _____ (Endorsement Number _____)

Other: _____ (Endorsement Number _____)

Other Cost Share Amounts not reflected above or limits not shown in the Master Group Contract

Provision	Limits	In-Network	Out-of-Network

RX Nebraska Prescription Drug Program

Rush Rx Set-Up Group – Roll No. 300074-01.02.99

Standard Benefit Schedule – Covered and noncovered services as stated in Master Group Contract. (If the designated Master Group Contract does not include RX Nebraska provision, use Endorsement 9856 to add standard RX Nebraska.)

Non-Standard Benefit Schedule - Endorsement 99-841 and Form 4718A (please complete)

Rx Nebraska Prescription Drug Pass-Thru – Endorsement 9-1313

Rx Nebraska Prescription Drug Benefits Integrated with Medical Benefits (IPS) – Endorsement 3-00004

A. Patient Protection and Affordable Care Act

Is this a grandfathered health plan: Yes (Endorsement 9-2576/3-00010) No (Endorsement 9-2575/3-00008)

(If no, Preventive Services as defined in PPACA are required to be covered.)

B. Benefit Design Options (Standard and Non-Standard Benefits)

Mail Order Benefits: Yes No

Maximum Day Supply:

Retail: 90-Day Supply ___ -Day Supply

Mail Order (if applicable): 90-Day Supply ___ -Day Supply

Copayment Amounts:

		<u>Copay \$</u>	<u>Coinsurance%</u>	<u>Minimum \$/%</u>	<u>Maximum \$/%</u>
Retail:	<input checked="" type="checkbox"/> Generic = Tier 1:	\$ 10	/	_____ /	_____
	<input checked="" type="checkbox"/> Formulary Brand= Tier 2	\$ 40	/	_____ /	_____
	<input checked="" type="checkbox"/> Non-Formulary Brand = Tier 3	\$ 60	/	_____ /	_____
Mail Order:	<input checked="" type="checkbox"/> Generic = Tier 1:	\$ 10	/	_____ /	_____
	<input checked="" type="checkbox"/> Formulary Brand= Tier 2	\$ 40	/	_____ /	_____
	<input checked="" type="checkbox"/> Non-Formulary Brand = Tier 3	\$ 60	/	_____ /	_____

- Copayment is applicable per each 30-day supply (retail); per each 30-day supply (mail order).

Specialty Pharmacy Benefit* Yes No Applies to drugs on the specialty pharmacy drug list. Place of dispensing overrides the formulary status for copayments for these drugs. Must choose either Specialty Pharmacy Retail Lock Out or Network Benefit.

* Specialty medications are not available through mail order. Standard benefit always defaults to 30 day supply.

Specialty Pharmacy Retail Lock Out. Choosing this Option means that Specialty Drugs must be purchased at an In-network Specialty Pharmacy. If this Option is chosen, will this benefit include two specialty medication fills at any In-network retail pharmacy? Yes No

Specialty: 3-tier Specialty Pharmacy Benefit Specialty Pharmacy Tier 4 only

	<u>Copay \$</u>	<u>Coinsurance%</u>	<u>Minimum \$/%</u>	<u>Maximum \$/%</u>
Generic = Tier 1:	\$ _____	/	_____ /	_____
Formulary Brand= Tier 2	\$ _____	/	_____ /	_____
Non-Formulary Brand = Tier 3	\$ _____	/	_____ /	_____

CR

Specialty = Tier 4: \$ _____ / _____ / _____ / _____

Specialty Pharmacy Network Benefit. Two prescription fills at any In-network retail pharmacy is not available with this Option.

Specialty In-network: \$ _____ or _____% with maximum copay per prescription \$ _____
Specialty Out-of-network: \$ _____ or _____% with maximum copay per prescription \$ _____

Mandatory Generic Penalty **No Mandatory Generic Penalty**

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.

If the doctor indicates DAW Code 1 (dispense as written), and specifies a name brand drug be dispensed, copay/ coinsurance is the applicable brand tier.

Deductible: Yes No
 Aggregate Embedded
Family: Yes No Amount: \$ _____
Individual: Yes No Amount: \$ _____

Calendar Year Copayment Maximum: Yes No Amount: \$ _____

Once Copayment maximum is met for a year, benefits payable as follows: _____

C. Pharmacy Preauthorization Programs

Angiotensin Receptor Blockers (ARB) Preauthorization Program: Yes No

COX-2 Inhibitor Preauthorization Program: Yes No

Leukotriene Modifier Preauthorization Program: Yes No

Proton Pump Inhibitor Therapy Preauthorization Program: Yes No

Sedative Hypnotics (Insomnia) Preauthorization Program: Yes No

Statin Preauthorization Program: Yes No

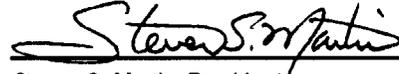
D. Other Rx Nebraska Provisions: _____

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. Please read it carefully. This Endorsement becomes a part of your Master Group Contract and should be attached to it.

This Endorsement applies to:

Preventive Vision Examinations



Steven S. Martin, President
and Chief Executive Officer

The Master Group Contract to which this Endorsement is attached is amended as follows:

1. The Part titled **EXCLUSIONS AND LIMITATIONS** is amended to delete the following exclusion:

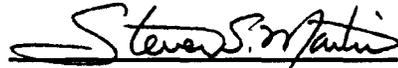
Preventive vision examinations or care and screening eye examinations, including eye refractions, except as specifically covered elsewhere in this Contract.

2. Benefits shall be provided for preventive vision examinations and screening eye examinations, including refractions to determine the need for vision correction. Benefits shall be subject to any applicable Copayment, Deductible and/or Coinsurance Amounts in the same manner as any other Preventive Services. Benefits for preventive vision examinations and screening eye examinations shall be limited as indicated on the Master Group Application and Schedule of Benefits Summary.
3. Benefits provided according to this Endorsement will be considered when calculating the Total Benefits available under the Master Group Contract to which this Endorsement is attached.
4. Benefits provided according to this Endorsement are subject to all other terms, conditions, exclusions, limitations and definitions of the Master Group Contract to which this Endorsement is attached.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska (BCBSNE) to change your coverage. Please read it carefully. This Endorsement becomes a part of your Master Group Contract and should be attached to it. This Endorsement applies to:

**Internal Claims and Appeals
and
External Review
(Process G - Insured Group Health Plans)**



Steven S. Martin, President
and Chief Executive Officer

The Master Group Contract to which this Endorsement is attached is amended at the section titled "**CLAIM DETERMINATIONS**" to provide that in the case of an Urgent Care Claim, the claimant/provider will be notified of the decision (whether adverse or not), not later than 24 hours after receipt of the claim, unless further information is needed. *(Other provisions in this section of the Contract, regarding requests for the additional information for an Urgent Care Claim are not amended by this Endorsement.)*

The Master Group Contract to which this Endorsement is attached is amended at the section titled "**PROCEDURE FOR FILING AN APPEAL**" to state as follows:

DEFINITIONS

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

1. the application of Utilization Review;
2. a determination that the Service is Investigative;
3. a determination that the Service is not Medically Necessary or appropriate;
4. an individual's eligibility for coverage or to participate in a plan.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as set forth herein.

Preservice Claim(s): Any claim for a benefit under this Contract with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

PostsERVICE Claim(s): Any claim that is not a Preservice Claim.

Urgent Care Claim: A claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

PROCEDURE FOR FILING AN APPEAL

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. First Level Appeal:

a. Requesting an Appeal: A request for a first level 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.

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:

- 1) for Preservice Claims (other than Urgent Care), within 15 calendar days after receipt; or
- 2) for Postservice Claims, 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.

2. Second Level Appeal:

a. **Request:** If the claimant is not satisfied with the first level determination, he/she has sixty (60) days from the receipt of determination of the first level appeal to submit a written request for a second level appeal. The letter requesting the appeal must be submitted to BCBSNE's Appeals Unit at the address listed on the Covered Person's Identification Card.

b. **Review:** The Covered Person and/or his representative may appear in person to present the case before an appeal committee (panel) appointed by BCBSNE. Supporting material may be submitted both before and at the review.

The majority of the panel will be health care professionals with appropriate expertise when reviewing appeals requiring a medical judgment. Deference will not be given to either the initial Adverse Benefit Determination or the first level appeal decision. The review and decision will be made by individuals who were not involved in the original determination(s).

c. **Decision:** Written notification of the decision will be made:

- 1) for Preservice Claims, within 15 calendar days after receipt; and
- 2) for Postservice Claims, within 30 calendar days after receipt.

d. The decision made pursuant to the second level appeal shall be considered a Final Internal Adverse Benefit Determination.

3. 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.

4. Request for External Review:

a. **Standard Review:** The claimant may request that a Final Internal Adverse Benefit Determination be reviewed by an Independent Review Organization (IRO). The claimant must have exhausted all levels of internal appeal review 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 a Final Internal Adverse Benefit Determination.

An Adverse Benefit Determination based upon an individual's eligibility for coverage or to participate in a plan is not eligible for External Review as described in this section.

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).

[Request may be e-mailed to DisputedClaim@opm.gov; Fax to 202-606-0036; Mail to P.O. Box 791, Washington, D.C. 20044]

Upon receipt of a request for an External Review, the IRO and/or BCBSNE shall review the request to determine if it is complete and whether it is eligible for External Review. 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.

If the request is eligible for External Review, all documentation and information considered in making the initial Adverse or Final Adverse Benefit Determination, including a summary of the claim and explanation for the determination, will be forwarded by BCBSNE to the IRO. The claimant will be allowed an opportunity to submit additional information for consideration by the IRO. The IRO will 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 of 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 first level appeal (1.c., above) of an Adverse Benefit Determination of an Urgent Care Claim. However, unless otherwise waived by BCBSNE, the claimant must first exhaust the internal appeal process.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard External Review, as described in paragraph 4.a., above, would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which the claimant has received emergency services, but has not been discharged from a facility.

An expedited External Review decision shall be made by the IRO within 72 hours after receipt of the request.

c. The decision of the IRO is the final review decision, and is binding upon BCBSNE and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

A Covered Person or his or her representative may not file a subsequent request for External Review involving the same Adverse Benefit Determination for which the Covered Person has already received an External Review decision pursuant to this provision.

ADDITIONAL INFORMATION

The Department of Insurance may be contacted for assistance at any time during the appeal process at:

Nebraska Department of Insurance
941 O Street, Suite 400

Lincoln, NE 68508-3969
(402) 471-2201

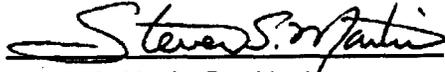
If the group health plan is subject to ERISA, the claimant has the right to bring a civil action under Section 502(a) of the Act. The group health plan may have other voluntary alternative dispute resolution options. The claimant may contact the local U.S. Department of Labor office and/or the state regulatory agency for information.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement applies to:

Changes to Comply with the Patient Protection and Affordable Care Act and Subsequent Rules and Regulations for Non-grandfathered Plans


Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended as follows:

1. The following statement is added to the section titled WAITING PERIODS or WAITING PERIODS FOR PRE-EXISTING CONDITIONS:

This provision does not apply to enrolled individuals under the age of 19.

2. Benefits will be provided for In-network Preventive Services, which are defined as:
 - a. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task force;
 - b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 - c. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - d. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Services, as outlined above, will not be subject to cost-sharing requirements, such as copayment, coinsurance or deductible, if provided by an In-network Provider. A listing of the Preventive Services outlined above is available upon request. Out-of-network Preventive Services and those not described above will be paid as indicated on the Master Group Application or Schedule of Benefits Summary.

3. Annual dollar limits in regard to essential health benefits will be deleted, including but not limited to Durable/Home Medical Equipment, diabetes self management training and prescription drug benefits. Annual dollar limits on benefits considered to be nonessential may still be applicable as indicated in the Master Group Application.

Essential benefits include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

4. The TOTAL BENEFITS section is deleted. Covered Services paid under this Contract are not subject to a Total Benefits limit.

5. The Part titled CERTIFICATION or INPATIENT NOTIFICATION, CERTIFICATION AND CONCURRENT REVIEW is revised to delete the reference to the 25% benefit reduction for failure to certify benefits. The reduction, or any other penalty for failure to certify benefits which may be stated in the Contract or an Endorsement, will no longer be applicable.
6. Out-of-network Emergency Services will be considered as having been provided by an In-network Provider.

Emergency Services are defined as any Covered Services provided in a Hospital emergency room setting.

7. The Definition of Eligible Dependent is hereby deleted and replaced with the following:

Eligible Dependent:

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.

2. Children to age 26.

"Children" means:

- the Subscriber's biological and adopted sons and daughters,
- a grandchild who lives with the Subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the Subscriber is a court-appointed guardian of the grandchild,
- a stepchild (i.e. the son or daughter of the Subscriber's current spouse), or
- a child, other than a grandchild or stepchild, for whom the Subscriber is a court-appointed guardian, but does not include a foster child.

3. Reaching age 26 will not end the covered child's coverage under this Contract as long as the child is, and remains, both:

- a. incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and

- b. dependent upon the Subscriber for support and maintenance.

Proof of the requirements of paragraphs a. and b. from the Subscriber must be received within 31 days of the child's reaching age 26 and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by Us. Any extended coverage under this paragraph will be subject to all other provisions of this Contract.

8. The following definition is added or replaces the current definition of Primary Care Physician:

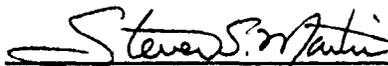
Primary Care Physician: A Physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

9. This Endorsement supersedes any and all Contract provisions or Endorsements which relate to the provisions described above. All other terms and conditions stated in the Contract remain applicable.

ENDORSEMENT

This is an Endorsement. Blue Cross and Blue Shield of Nebraska uses an Endorsement to amend your health care benefits contract. This Endorsement becomes part of your Contract and should be attached to it.

Rx Nebraska Prescription Drug Program



Steven S. Martin, President
and Chief Executive Officer

The terms of this Endorsement and Schedules A and B, attached hereto and incorporated by this reference, replace those provisions of your Contract which provide benefits for prescription medications and other specified Covered Services purchased from a pharmacy, as listed on Schedule A. This Endorsement does not apply to prescription medication and services prescribed or provided during or for Inpatient Hospital or Treatment Center care.

I. DEFINITIONS:

The following definitions are provided in place of or in addition to the definitions found in the Master Group Contract:

Copayment: The amount payable by the Covered Person for the Covered Services identified on Schedule A. The Copayment amount is indicated in the Master Group Application.

Covered Services: Prescription medications, services and supplies identified on Schedule A, for which benefits are payable.

Deductible Amount: An amount which the Covered Person must pay each calendar year for the Covered Services identified on Schedule A., before benefits are payable. The Deductible Amount is indicated in the Master Group Application.

Identification Card: A card issued by Blue Cross and Blue Shield of Nebraska, which identifies the individual as a Covered Person under the Rx Nebraska Prescription Drug Program.

Noncovered Services: Prescription medications, services and supplies as identified on Schedule B., for which benefits are not payable, according to the terms of this Endorsement.

Non-Participating Pharmacies: Licensed pharmacies which have not entered into written agreements with Blue Cross and Blue Shield of Nebraska or its pharmacy benefit manager.

Participating Pharmacies: Licensed pharmacies which have entered into written agreements with Blue Cross and Blue Shield of Nebraska or its pharmacy benefit manager.

Prime Therapeutics, Inc. (formerly ProPar Services, Inc.): A pharmacy benefit management company retained by Blue Cross and Blue Shield of Nebraska to administer this prescription drug program.

II. BENEFIT ADMINISTRATION:

A. **Overview:** This Endorsement provides benefits for a Covered Person's purchase of prescription drugs and other Covered Services, as identified on Schedule A. All services must be Medically Necessary in order for benefits to be payable. Benefits are available for up to a 30-day supply per medication and for each subsequent refill, except as otherwise may be specified for a Covered Service. Benefits will be available for the purchase of a reasonable quantity of covered supplies. A Covered Person may obtain Covered Services from either a Participating or Non-Participating Pharmacy. If mail order benefits are selected in the Master Group Application, benefits are available for purchases from a Participating Mail Order Pharmacy, for up to a 90 day supply, subject to the Copayment amount per each 30-day supply.

B. **Participating Pharmacies:** When a Covered Person obtains Covered Services from a Participating Pharmacy, and presents his or her Identification Card at the time of purchase, he or she is responsible to pay the Copayment amount directly to the dispensing Participating Pharmacy. Participating Pharmacies will not bill or collect any amount for Covered Services from the Covered Person in excess of this Copayment amount, except as provided in paragraph D., Generic Drugs, and paragraph E., Deductible Amount.

When a Covered Person obtains Covered Services from a Participating Pharmacy, and presents his or her Identification Card at the time of purchase, the Participating Pharmacy's charge for the Covered Service will be the lesser of: a) the usual retail price; b) the maximum allowable charge (MAC), plus dispensing fee; or c) the average wholesale price (AWP) minus a negotiated percentage of AWP plus dispensing fee. If the pharmacy's charge is less than the Copayment amount, the Covered Person is responsible for payment of the charge.

If the Covered Person does not present his or her Identification Card to the Participating Pharmacy at the time of purchase, the Participating Pharmacy may collect their usual retail price for the item from the Covered Person. The Covered Person is responsible to make payment of this amount, and to submit the claim directly to Blue Cross and Blue Shield of Nebraska for benefit payment. Benefits will be provided to the Covered Person in an amount equal to the billed charge less the Deductible amount (if applicable), the Copayment amount and less a 25% penalty amount (or as otherwise provided in the Master Group Application).

C. **Non-Participating Pharmacies:** When a Covered Person obtains Covered Services from a Non-Participating Pharmacy, the Covered Person will be responsible to make payment to the pharmacy of their usual retail price for the Covered Service. The Covered Person is required to submit the claim directly to Blue Cross and Blue Shield of Nebraska for benefit payment. Benefits will be provided to the Covered Person in an amount equal to the billed charge less the Deductible amount (if applicable), Copayment amount and less a 25% penalty amount (or as otherwise provided in the Master Group Application).

D. **Generic Drugs:** Whenever appropriate, generic drugs will be used to fill prescriptions. If the prescribing Physician or Dentist does not indicate "no drug product substitution" for the prescription, a Participating Pharmacy may fill it with the generic drug. If the Covered Person refuses a generic drug in favor of a brand name drug, the Participating Pharmacy may then charge the Covered Person for the difference in cost between the generic drug and the brand name drug, and such difference will be the responsibility of the Covered Person. This difference will be in addition to the Copayment amount. The Master Group Application may include other specifications regarding the applicable Copayment amount for the purchase of generic drugs.

E. Deductible Amount: If so indicated in the Master Group Application, benefits for Covered Services identified on Schedule A are subject to a calendar year Deductible Amount. Until the Deductible is met, the Covered Person is responsible to make payment of the full charge for a Covered Service to the pharmacy. A Covered Person's Deductible will be met when claims submitted for charges paid for Covered Services provided in a calendar year equal the Deductible amount specified in the Master Group Application for the Rx Nebraska Prescription Drug Program. Once the calendar year Deductible is met, the Covered Person is responsible for payment of the Copayment amount and/or penalty amount, as described in paragraphs B. and C., above.

F. In the event that we determine that a Covered Person's utilization of a prescription medication in a 6-month period exceeds certain threshold amounts, and that such utilization reasonably demonstrates a pattern of usage that is not Medically Necessary, we reserve the right to limit such Covered Person to a Participating Pharmacy of their choice for obtaining Covered Services. If a Covered Person is limited to such a Pharmacy, no benefits will be provided for prescription medications obtained from any other pharmacy.

III. CLAIM FILING:

A. Submission of Claims by a Participating Pharmacy: Participating Pharmacies will submit claims for a Covered Person's purchase of Covered Services, if the Covered Person presents his or her Identification Card at the time of purchase.

B. Submission of Claims by the Covered Person: The Covered Person must submit a claim for Covered Services purchased from a Non-Participating Pharmacy, or for purchases from a Participating Pharmacy when the Identification Card is not presented at the time of purchase.

A complete itemized statement identifying the Covered Service must be attached to an appropriate claim form. To process a claim, Blue Cross and Blue Shield of Nebraska must always have the Covered Person's identification number, an itemized statement identifying each item purchased, prescription number, quantity and date purchased, and amount charged. Blue Cross and Blue Shield of Nebraska is entitled to any additional information needed to process the claim.

C. Time Limit for Filing a Claim: A claim should be filed within 90 days of the time the services are provided, or as soon thereafter as is reasonably possible. If the Covered Person does not file a claim within 18 months of the date of service, and it was reasonably possible to do so, benefits will not be paid.

It is suggested that all claims be filed with Blue Cross and Blue Shield of Nebraska as soon as possible after expenses are incurred.

D. Claims should be sent to: Blue Cross and Blue Shield of Nebraska, P. O. Box 3248, Omaha, Nebraska 68180-0001.

IV. PRE-EXISTING CONDITIONS:

The benefits provided by this endorsement **are not** subject to any Exclusion or Limitation for Pre-existing Conditions that may be applicable to other benefits provided by the Contract to which this Endorsement is attached. Payment of benefits pursuant to this Endorsement shall not waive such Exclusions or Limitations as they apply to other benefits provided by the Contract.

V. ADDITIONAL PROVISIONS:

A. Primary/Secondary Coverage: If a Covered Person has prescription drug coverage under more than one health plan, the coverage first used by the Covered Person becomes the primary coverage. When

another coverage (or drug card) is used first, the Rx Nebraska Prescription Drug Program will become the secondary payer. Unless otherwise specified in the Master Group Application, Allowable Expenses will be determined and any remaining amounts available after benefit payment, will be credited to the separate Credit Savings for a prescription drug program. No penalty will be imposed for submission of paper claims when Rx Nebraska is paying as secondary payer.

B. The Covered Person, by accepting benefits under this Endorsement, authorizes and directs the Participating Pharmacies and Prime Therapeutics, Inc. to furnish copies of all information and records concerning the Covered Person to Blue Cross and Blue Shield of Nebraska.

C. Blue Cross and Blue Shield of Nebraska and Prime Therapeutics, Inc. will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of prescriptions) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any prescription or supply.

D. The Master Group Application may specify additional provisions regarding the Rx Nebraska Prescription Drug coverage, including but not limited to, benefit maximums and mail order benefits.

E. The Rx Nebraska Copayment amount, Deductible Amount and/or penalty amount are not included in the computation of the Maximum Coinsurance Liability Limit.

F. Unless otherwise indicated in the Master Group Application, benefits paid pursuant to this Endorsement are not included in the computation of the Total Benefits payable under the Master Group Contract.

G. Benefits provided pursuant to this Endorsement are subject to all other terms, conditions, definitions, limitations and exclusions of the Master Group Contract which are not in conflict with this Endorsement.

SCHEDULE A

Covered Services

1. FDA-approved drugs requiring a Physician's or Dentist's prescription, dispensed in compliance with a permit to conduct a pharmacy or as otherwise permitted by state law. All FDA-approved drugs shall have a valid NDC number. Drugs listed on Schedule B shall not be Covered Services.
2. Compound prescriptions that contain at least one FDA-approved prescription ingredient and have a valid NDC number.
3. AIDS therapy drugs.
4. Anti-rejection drugs.
5. Cosmetic alteration drugs.
 - Retin-A, Differin, Azelex, Renova (covered through age 40; after age 40, preauthorization required).
6. Covered diabetic supplies including but not limited to needles, syringes, test strips, lancets and swabs.
7. Covered ostomy supplies including, but not limited to belts, dressings, pouches and skin barrier.
8. Injectables, not to include home infusion.
9. Insulin.
10. Oral contraceptives.
11. Prescription vitamins, including prenatal vitamins.
12. Erectile dysfunction agents, including Viagra, Caverject, Muse and Alprostadil.
 - Viagra (sildenafil) is limited to 8 pills per 30 days, and is excluded for males through the age of 18 and for all females.

The following drugs require preauthorization of benefits:

- Dexedrine. This drug is covered through age 21. After age 21, preauthorization is required.
- Growth hormones.
- IVIG.
- Regranex.
- Retin-A, Differin, Azelex, Renova. These drugs are covered through age 40; after age 40, preauthorization is required.

SCHEDULE B

Noncovered Services

1. Diet or appetite suppressant drugs.
2. Dietary supplements (nutritional supplements).
3. Drugs or medicinals for treatment of fertility/infertility.
4. Health or beauty aids.
5. Home infusion therapy. (Covered under the medical contract only.)
6. Home Medical Equipment or devices of any type, including, but not limited to: contraceptive devices; therapeutic devices; or artificial appliances.
7. Investigative drugs or drugs classified by the FDA as experimental.
8. Nicotine Polacrilex (Nicorette), Nicotine Transdermal System (Habitrol, Nicoderm, Nicotrol, ProStep) or any other medication whose primary purpose is to treat nicotine addiction.
9. Non-prescription medications.
10. Over-the-counter medications.
11. Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).
12. Topical Minoxidil (Rogaine).