

BOARD OF COUNTY COMMISSIONERS  
SARPY COUNTY, NEBRASKA

19

RESOLUTION AMENDING AGREEMENT WITH BLUE CROSS BLUE SHIELD

WHEREAS, pursuant to Neb. Rev. Stat. § 23-104(6) (Reissue 2012), 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;

WHEREAS, pursuant to Neb. Rev. Stat. § 23-103 (Reissue 2012), the powers of the County as a body are exercised by the County Board;

WHEREAS, prior to January 1, 2014, Sarpy County provided dependent care coverage to legally married same-sex spouses if the same-sex couple resided in a state that recognized same-sex marriage;

WHEREAS, as of January 1, 2014, Blue Cross Blue Shield ("BCBS") automatically changed its administrative policies to provide dependent care coverage for all legally married same-sex spouses regardless of residency; however BCBS provided the County the option to amend its agreement with BCBS in order to maintain the pre-January 1, 2014 coverage for same-sex spouses;

WHEREAS, Sarpy County desires to amend its agreement with Blue Cross Blue Shield ("BCBS") to maintain the definition of spouse that was in effect prior to January 1, 2014 and therefore only extend coverage to same-sex spouses if the legally married same-sex couple resides in a state that recognizes same-sex marriage; and

WHEREAS, amending the agreement with BCBS is in the best interests of the citizens of Sarpy County.

NOW, THEREFORE, BE IT RESOLVED by the Sarpy County Board of Commissioners that this Board hereby approves and adopts the attached amendment to the BCBS Employee Health Insurance Agreement, and any other related documents, the same being approved by the Board.

BE IT FURTHER RESOLVED that the Chairman of this Board, together with the County Clerk, are hereby authorized to sign the amendment on behalf of this Board.

The above Resolution was approved by a vote of the Sarpy County Board of Commissioners at a public meeting duly held in accordance with the applicable law on the \_\_\_\_\_ day of \_\_\_\_\_, 2014.

\_\_\_\_\_  
Sarpy County Board Chairman

Attest:

SEAL

\_\_\_\_\_  
County Clerk



**BlueCross BlueShield  
of Nebraska**

An Independent Licensee of the Blue Cross and Blue Shield Association

**Amendment of Application  
for Group Contract**

GROUP NAME <b>Sarpy County</b>	GROUP NUMBER / DEPARTMENT <b>300074</b>
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**A. GROUP REQUESTED CHANGES**

Change group name and/or address to:

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Change probationary period for new hire enrollment eligibility to: \_\_\_\_\_ days.

Medical changes: Please add amendment 1-00051 to keep the 2013 definition of a spouse.

Dental changes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Family Deductible:  Aggregate  Embedded

Effective date of coverage changes: January 1, 2014

**B. RATES AND EMPLOYER CONTRIBUTION**

MONTHLY RATES	HEALTH	EMPLOYER CONTRIBUTION	DENTAL	EMPLOYER CONTRIBUTION
SINGLE:	_____	_____	_____	_____
FAMILY:	_____	_____	_____	_____
EMPLOYEE & SPOUSE:	_____	_____	_____	_____
SINGLE PARENT (EMPLOYEE & CHILDREN):	_____	_____	_____	_____
MEDICARE SUPPLEMENTAL:	_____	_____		

EFFECTIVE DATE OF RATES: \_\_\_\_\_ THESE RATES ARE GUARANTEED UNTIL \_\_\_\_\_ AS LONG AS COMPANY UNDERWRITING GUIDELINES ARE MET. If the number of employees increases or decreases 5% or more, the Company reserves the right to change the rates.

**NOTE:** Rates may be indicated on the attached quote.

**C. RX NEBRASKA PRESCRIPTION DRUG PROGRAM:**

**RX NEBRASKA PRESCRIPTION DRUG CARD PROGRAM**

No Changes

Rush Rx Set-Up

**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)** - Use applicable endorsement

**BluePride / ChamberBlue Benefit Schedule**

**BlueFreedom Benefit Schedule** - Health Option # \_\_\_\_\_ with Rx Option # \_\_\_\_\_ / Health Option # \_\_\_\_\_ with Rx Option # \_\_\_\_\_

**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 type="checkbox"/> Generic = Tier 1:	\$ _____	/ _____	/ _____	/ _____
	<input type="checkbox"/> Formulary Brand= Tier 2	\$ _____	/ _____	/ _____	/ _____
	<input type="checkbox"/> Non-Formulary Brand = Tier 3	\$ _____	/ _____	/ _____	/ _____
	<input type="checkbox"/> Specialty = Tier 4:	\$ _____	/ _____	/ _____	/ _____
Mail Order:	<input type="checkbox"/> Generic = Tier 1:	\$ _____	/ _____	/ _____	/ _____
	<input type="checkbox"/> Formulary Brand= Tier 2	\$ _____	/ _____	/ _____	/ _____
	<input type="checkbox"/> Non-Formulary Brand = Tier 3	\$ _____	/ _____	/ _____	/ _____
	<input type="checkbox"/> Specialty = Tier 4:	\$ _____	/ _____	/ _____	/ _____

• Copayment is applicable per each \_\_\_\_\_ -day supply (retail); per each \_\_\_\_\_ -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.

**\*Specialty medications are not available through mail order.\***

Specialty Network: \$ \_\_\_\_\_ or \_\_\_\_\_ % with max copay per RX \$ \_\_\_\_\_  
 Out-of-Network: \$ \_\_\_\_\_ or \_\_\_\_\_ % with max copay per RX \$ \_\_\_\_\_

**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.

Members are allowed two fills of a specialty medication at a retail network pharmacy, before being required to go through Triessent.  Yes  No

If the doctor indicates DAW Code 1 (dispense as written), and specifies a name brand drug be dispensed, copay is non-formulary brand. ASO groups may choose to apply this penalty. Per Nebraska law, insured groups may not apply Mandatory Generic penalty when DAW Code 1 is indicated.

**Mail Order Maintenance List**  Yes  No Limits the mail order benefit to chronically used medications, thereby increasing the efficiency of mail order process. Available medications are listed on mail order maintenance list.

**C. RX NEBRASKA PRESCRIPTION DRUG PROGRAM - continued:**

**Deductible:**  Yes  No Amount: \$  
 Family:  Yes  No  
 Individual:  Yes  No

**Calendar Year Copayment Maximum:**  Yes  No Amount: \$ \_\_\_\_\_  
 Once co-payment maximum is met for a year, benefits payable as follows: \_\_\_\_\_

**Benefit Maximum Per Year:**  Yes  No Amount: \$ \_\_\_\_\_

**Pharmacy Preauthorization Programs**

- 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.

**Other Rx Nebraska Provisions:** \_\_\_\_\_

**D. 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 the 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 Group Health Plan Information received from Blue Cross and Blue Shield of Nebraska in accordance with 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.

**E. ACCEPTANCE BY APPLICANT**

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

Please check each applicable box:

- I hereby apply for the coverage changes specified in Part A. I acknowledge that this Amendment of Application is subject to Company approval.
- I accept the quoted rates and certify the accuracy of the employer contribution amounts.

It is understood that the changes on this form supersede any previous Application or Amendment of Application. Unless otherwise amended, the contract information in the original Application shall apply.

**By signing this amendment, I represent that I am authorized to obtain coverage on behalf of the Group.**

SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF AGENT	TYPED NAME OF AGENT	DATE

**F. ACCEPTANCE BY COMPANY**

- This Amendment of Application is accepted.
- This Amendment of Application is accepted with the following changes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SIGNATURE	TITLE	DATE
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The noted changes in Part F are acceptable.

SIGNATURE OF APPLICANT	DATE
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If the Applicant's signature is required on Part F, sign both the original and the copy. Retain the copy and return the original to Blue Cross and Blue Shield of Nebraska.

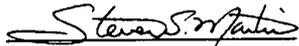
FOR OFFICIAL USE ONLY							
	CONTRACT NO.	PLAN CODE	PACKAGE NO.	ENDORSEMENTS			
HEALTH	_____	_____	_____	_____	_____	_____	_____
MED. SUPP.	_____	_____	_____	_____	_____	_____	_____
DENTAL	_____	_____	_____	_____	_____	_____	_____

**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:

**Eligible Dependent Includes Same Gender Spouse**



Steven S. Martin, President  
and Chief Executive Officer

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

The term Eligible Dependent shall include a spouse of same gender and his/her dependent children, provided that the marriage is legally documented and recognized under the state laws where the marriage took place and the marriage is recognized under the laws of the state of residence.

All other eligibility provisions established by the Master Group Contract and Master Group Application which are not in conflict with this Endorsement, are applicable.