



options

benefits as individual as you

July 1, 2011 - June 30, 2012

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Enrollment Guide • Retirees and COBRA

Reminders for the 2011-2012 Plan Year

- The federal government has mandated that Social Security numbers must be listed for all enrollees and their covered dependents enrolling in a group health plan
- All employees must re-enroll in the health, dental, and vision plans to have coverage for the new plan year beginning July 1, 2011; current elections in these plans will end on June 30, 2011

IMPORTANT CHANGES FOR 2011-2012 PLAN YEAR

ALL BCBS HEALTH PLANS:

- ✓ Preventive Routine Care covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. Refer to page 20 for more information
- ✓ Coverage for dependent children up to age 26

BCBS WELLNESS PPO PLAN:

- ✓ No age restrictions on routine exams
- ✓ Routine and follow-up mammograms and colonoscopies covered at 100%
- ✓ All lab work paid at 100% up to \$500. Once \$500 is met, all lab work will be applied towards deductible (if not met) then applicable coinsurance
- ✓ Outpatient rehabilitation services change to a \$20 copay rather than deductible and coinsurance

BCBS BLUECHOICE PLAN:

- ✓ In-Network deductible is increasing from \$200/\$400 to \$500/\$1,000
- ✓ Chemotherapy treatments will now have a \$25 copay
- ✓ Home Health Care and Hospice Care now have a \$25 copay
- ✓ Copays for Office visits, Rehabilitation services, and vision have increased to \$25
- ✓ Pathology, Radiology and Office Surgeries will now be paid at deductible/coinsurance

AMERITAS – DENTAL COVERAGE:

- ✓ Coverage for dependent children up to age 26

HEALTHFITNESS-WELLNESS PROGRAM:

- ✓ The number of steps required to complete the Walk This Way program has increased to 600,000
- ✓ **NEW!** Check out the “Millionaire’s Club” for a new optional feature of Feel Like a Million that brings the spirit of friendly competition to the program

EXPRESS SCRIPTS-PRESCRIPTION DRUGS:

- ✓ Employees who prefer to get a 180-day supply of their maintenance medications will now be required to go through the mail order service

EYEMED VISION CARE-VISION COVERAGE:

- ✓ Coverage for dependent children up to age 26

WELCOME

Open Enrollment for 2011-2012 benefits is here!



The Wellness Program has again had a very successful year. We have added spouses to the program and are excited about what was accomplished in only our second year. Over 7500 individuals have participated in at least one or more Wellness Programs. The Walking Program enrollment doubled from last year with over 5,000 people participating. A total of 3,884 people met or exceeded the 450,000 step goal which is more than twice the number achieving the goal in 2010. The "Top Walker" logged more than 8 million steps. The Coaching Program also saw its enrollment grow to approximately 3,000 participants. More and more employees and participants are taking an active role in their overall wellness and improvement of their health. This in return affects our claims expense.

We are already seeing the benefits of prevention and early detection. Participants are going in for their annual physicals and catching illnesses in the early stages. We have seen an increase of 19% of our participants getting their screenings or annual physicals. Through routine screenings, 257 new cases of early stage cancer conditions were detected, 288 new high cholesterol cases were diagnosed, 218 new high blood pressure cases were diagnosed and 191 new diabetic cases were diagnosed.

The goal of the wellness program is to help participants make healthier lifestyle choices, become aware of risk factors and better manage chronic conditions. As you can see from the data above, we are definitely well on our way.

In addition, the State of Nebraska's innovative efforts to encourage wellness have been awarded the Gold Well Workplace Award presented by the Wellness Council of America. Nebraska is one of only two state governments to receive the award.

As you review the Open Enrollment material, you will learn about some of the changes made to the various health plans. We are pleased to say that for the second year in a row, our premium increases are well below the national average/trend. Make the most of this opportunity to select the coverage that best fits your personal needs. Please review the coverage features in this guide carefully. You will find a side-by-side comparison of the health plans on pages 14 and 15 of this guide.

Don't forget, this year's Open Enrollment begins on May 2nd at 7:00 a.m. and ends on May 20th at 5:00 p.m. The decisions you make will take effect on July 1, 2011 and will remain in effect until June 30, 2012. Our Wellness and Benefits staff is available to assist you as needed for questions on the benefit options presented in this guide. They can be reached at 402-471-4443. In addition, you may access their website at www.das.state.ne.us/personnel/benefits/ for more information.

Sincerely,

Carlos Castillo Jr., Director
Administrative Services

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Open Enrollment

BEGINS:
Monday, May 2, 2011
at 7:00 a.m. C.D.T.

ENDS:
Friday, May 20, 2011
at 5:00 p.m. C.D.T.

INTRODUCTION

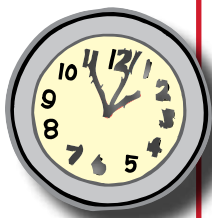
It's time once again to consider your **Options**, our competitive benefits program. Get started by carefully reading this Enrollment Guide and share it with your family. You'll find information about all of your benefit options, how to enroll and where to go if you have any questions.

You must re-enroll in all health, dental, vision and flexible spending account plans to have coverage effective July 1, 2011 through June 30, 2012. All current elections in these plans will end on June 30, 2011. To make any changes to your supplemental and/or dependent life insurance or long-term disability coverage, contact your agency Human Resource office.

Because of new governmental regulations, your Social Security number and the Social Security numbers of your covered dependents who are enrolling in a group health plan must be correct and on file — be sure to check this and make any necessary changes through your agency Human Resource office.

How long do I have to make changes?

Any change in coverage must be made within 30 days of the change in status or you will not be able to change your coverage until the next Open Enrollment period or another qualifying status change. Documentation of the status change must be provided to your agency Human Resource office before the change will be approved.



If you or a covered dependent experience a qualified status change that allows you to terminate your insurance coverage, you have 30 days to complete the necessary paperwork and provide the proper documentation. Coverage will terminate the first of the month following the request; no refunds or retroactive terminations will be allowed.

Making Changes During the Year

It's important that you carefully select your options during Open Enrollment. The choices you make during Open Enrollment remain in effect until June 30, 2012. You can make limited changes at other times during the year only as a result of a qualifying event as defined by the IRS. These qualifying events include:

- A marriage, divorce or legal separation
- The birth or adoption of a child
- The death of a spouse or dependent child
- A dependent losing eligibility due to age or marriage
- A change in employment status for you or your spouse if it affects your benefit eligibility
- A change corresponding with a spouse's open enrollment period at his or her place of employment
- Being newly eligible for Medicare Coverage
- Losing eligibility for coverage under a State Medicaid or CHIP program
- Becoming eligible for State premium assistance under Medicaid or CHIP.

If you are requesting to enroll in any of the State's insurance plans, you will only be eligible to enroll in those benefits that were terminated as a result of the qualified event.

When requesting to add/enroll in coverage due to a loss of other coverage, the effective date is the first day of the month following the loss of coverage.

Term to Know

ELIGIBLE DEPENDENT — Eligible dependents include your:

- Legal spouse
- Children up to age 26
- Children over age 26 who are mentally or physically disabled and dependent upon you for support
- *Step children can be covered if enrolled in Family Coverage only.*



Continuing Your Coverage – COBRA

As a reminder, in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the State of Nebraska's benefit plans ends, you and/or your eligible dependents may be eligible to continue your medical, dental, vision, EAP and medical flex benefits at your own expense for a temporary period of time. To be eligible, a qualifying event causing the loss of coverage must take place. The date that event occurs determines your eligibility status. Your existing coverage is always carried to the end of the month in which the qualifying event occurs as long as the entire monthly premium has been paid.

A qualifying event may be an employee's termination, a divorce or a dependent child is no longer eligible. For a complete list of qualifying events, who may continue coverage and the maximum period of continuation, please refer to your summary plan description (SPD) or contact State Employee Wellness and Benefits at **402-471-4443** in Lincoln or at **877-721-2228** outside of Lincoln.

Continuation of All Eligible Benefits

COBRA is a federal law allowing the continuation of health / dental / vision / EAP / medical flex benefits for any employee or dependent who would otherwise lose group coverage due to a qualifying event.

Qualifying Event

A qualifying event is an event that occurs for an employee or dependent (e.g., employee terminates employment, dependent quits school, see list under Eligible Family Members). The date that event occurs determines eligibility status. Existing insurance is always carried to the end of the month in which the qualifying event occurs as long as the entire monthly premium has been paid.

Eligible Employees

If your employment with the State is terminated or your work hours are reduced below 20 hours per week, and you were covered by a State plan, you become eligible for COBRA for up to 18 months (29 months for disabled employees if not eligible for disability retirement from the State).

Eligible Family Members

Certain family members also have the option to continue all eligible benefits after the benefits would normally cease. Family members who have a qualifying event can continue the eligible benefits for up to a maximum of 18 to 36 months.

Family members are eligible for 18 months of coverage, if the following occurs:

- Employee's termination;
- Reduction in employee's hours of employment to less than 20 hours per week.

Family members (spouse or dependent children) are eligible for up to 36 months of coverage, if the following occurs:

- Death of the employee;
- Divorce involving an employee (upon completion of Nebraska's six-month waiting period for insurance benefits) or legal separation (as granted by a judge);
- Child ceases to be an eligible dependent (reaches 19th birthday and is no longer a full-time student, marries, quits school, obtains full-time employment (this does not mean full-time work through summer months or temporary jobs), or reaches 24th birthday).

Questions concerning Medicare entitlement and continued coverage for dependents should be directed to the State Employee Wellness and Benefits office at **402-471-4443** in Lincoln or at **877-721-2228** outside of Lincoln.

Under COBRA Law, the employee or a family member has the responsibility to inform his/her agency's HR representative of a divorce, or a child losing dependent status, under the employee's present carrier within 60 days of the date of the event. If it is beyond 60 days COBRA will not be offered.

For Retirees Only

During Open Enrollment, you may change your medical plan option (for example, Regular PPO to the Wellness PPO) or your level of coverage (for example, Family + Spouse + Dependent Children [Family Coverage] to Employee + Spouse [Two Party Coverage]). **However, you may not add dependents or coverage/plans not currently**

in effect. If a dependent is dropped during Open Enrollment, the dependent can only be added at a later date with a qualified event, proper documentation and within 30 days of the qualified event. If coverage is dropped, you cannot add the coverage at a later date.

Early Retiree Program and Disability Retirement

This program was created for State employees who meet the qualifications to retire. The program allows a retiree, at his or her own expense, the option to continue medical, dental, vision and EAP coverage if he or she was actively enrolled in the benefit on their last day of employment. Coverage may be continued up to the first of the month in which the employee reaches age 65. If the employee is enrolled in the Medical Flexible Spending Account program on the last day of employment, participation may be continued only through the remainder of the current plan year.

Retirees who become entitled to Medicare part A or part B, prior to the age of 65 can stay on the Early Retiree's program until the first of the month of their 65th birthday, however they need to notify the State Employee Wellness and Benefits office of their entitlement date so coordination of benefits with the health insurance company will take place without any interruption to their medical service payments.

Eligibility of Employee

Employees who retire, including those who retire due to a disability and meet the qualifications regarding disability retirement.

If an employee is 65 years old or older at the time of Retirement they will be offered an 18-month COBRA event.

Eligibility of Family Members

If a family member reaches age 65 before the employee, the family member is ineligible to continue coverage through the retiree program. Contact the insurer for information about conversion options.

Questions concerning Medicare entitlement and continued coverage for dependents should be directed to the State Employee Wellness and Benefits office at **402-471-4443** in Lincoln or at **877-721-2228** outside of Lincoln.

Disability Retirement

An employee under age 55 may retire as a result of a disability. You will need to contact the Nebraska Public Employees Retirement System on how to apply for this. An employee who chooses this option must first elect COBRA and once he/she is approved, the Retirement System will notify the Administrative Services State Employee Wellness and Benefits office. The individual's coverage will be converted to the Early Retiree Health Plan until the first of the month he/she reaches age 65.

CHOOSING YOUR HEALTH COVERAGE

All of our health plan options are provided through BlueCross BlueShield (BCBS) of Nebraska, and offer both in-network and out-of-network coverage. BCBS of Nebraska offers a national network of providers which includes 94 percent of Nebraska doctors. To locate a network provider, visit BlueCross BlueShield of Nebraska online at www.bcbsne.com or call 800-642-3022.

For a comparison of highlights for all health plan options, see the chart on pages 18-19. For additional plan details, refer to the plan's Summary Plan Description (SPD) on the State Employee Wellness and Benefits website at www.das.state.ne.us/personnel/benefits/.

Why use a network provider?

All of our health plan offerings provide benefits for both in-network and out-of-network providers. Although you can choose to visit the provider of your choice at any time, you'll generally receive a higher level of benefit when you choose providers who are part of the plan network. Network providers have agreed to provide their services at negotiated, discounted rates, which saves you and the State money. Provider directories are located on the Wellness and Benefits Websites within each provider's information.

Understanding Your Health Options

The Wellness PPO Plan

The Wellness PPO plan offers comprehensive coverage to meet your health care needs and includes some enhanced features like improved coverage for certain preventive screenings and maintenance medications. All employees may select the Wellness PPO plan as your medical option for the 2011-2012 plan year providing the 3 STEP requirements have been fulfilled to elect or retain eligibility for plan participation.

Wellness PPO Qualifications

In order to qualify for the Wellness PPO plan, both you and your covered spouse (if applicable) needed to complete a program prior to March 31, 2011 (STEP 1). If you have met STEP 1 of the criteria, you and your covered spouse will be required to complete a confidential Biometric Screening (STEP 2) and the Online Insight Health Assessment (STEP 3) to maintain eligibility. If you sign up for the Wellness PPO plan and either you or your spouse fail to complete the 3 STEPS, you will default to the Regular PPO plan at the appropriate tier. See page 11 for more information to finish qualifying for enrollment into the 2011-12 Wellness PPO Plan.

Term to Know

PROVIDER:

A person or organization that systematically delivers professional health care. A provider can be a primary care physician, specialist, dentist, hospital, out-patient facility, mental health facility, nursing home, etc.

Important: To ensure you receive the great preventive Wellness PPO coverage, make sure your doctor's office codes them correctly as 'routine.'

Wellness PPO Plan Design Offerings

Living a healthy lifestyle is certainly a key ingredient to living a healthy, long life. But it is not a guarantee that you will ever be 'exempt' from a serious condition or illness. As a result, it is important to get regular checkups and screenings as recommended by your healthcare provider. The Wellness PPO health plan offers low premiums and high quality coverage related to prevention and early detection, including 100% coverage for a wide range of age and gender based screenings.



Features of the Wellness PPO Plan include:

- **NEW** – All blood work (including preventive) is covered up to \$500
- **NEW** – No age restrictions for preventive screenings
- **NEW** – Thyroid testing
- **NEW** – Bone density testing (age restriction was removed)
- **NEW** – Routine and follow-up Mammograms covered at 100%
- **NEW** – Routine and follow-up Colonoscopies covered at 100%
- Cholesterol medications at a reduced copay or no cost for generics
- Hypertension (high blood pressure) medications at a reduced copay or no cost for generics
- Hemoglobin A1C testing twice per year
- Adult and child immunizations
- Flu shots at no cost (on-site flu shots where available)
- Maternity services
- Well baby exams
- Routine Pap Smear
- Routine Prostate cancer screening
- Diabetes vision screening
- Diabetic prescriptions at a reduced copay
- Tobacco cessation prescription medications at no cost with enrollment in the EMPOWERED Health Coaching program

BlueChoice Plan

- No limit on lifetime maximum benefit
- In-network doctor's office visits for a copay of \$25
- In-network deductible is \$500 individual/\$1,000 family
- Out-of-network deductible is \$600 individual/\$1,200 family
- Access to the **wellnessoptions** programs and website

Regular PPO Plan

- No limit on lifetime maximum benefit
- In-network doctor's office visits for a copay of \$20
- In-network deductible is \$400 individual/\$800 family
- Out-of-Network deductible is \$600 individual/\$1,200 family
- Access to the **wellnessoptions** programs and website

High Deductible PPO Plan

- No limit on lifetime maximum benefit
- In-network doctor's office visits for a copay of \$25
- In-network deductible is \$1,000 individual/\$2,000 family
- Out-of-Network deductible is \$2,000 individual/\$4,000 family
- Access to the **wellnessoptions** programs and website

Congratulations

- 68 State of Nebraska employees who enrolled in the EMPOWERED health coaching program who chose smoking cessation as their 'focus area' are **NOW TOBACCO FREE!**
- Onsite biometric screenings resulted in 288 new high cholesterol cases, 218 new high blood pressure cases and 191 new diabetic cases. **EARLY DETECTION IS KEY!**

You Should Know . . .

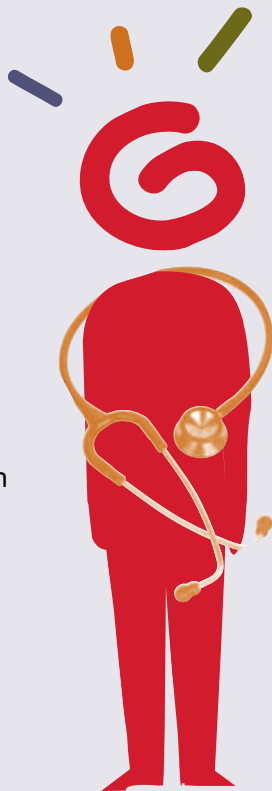
■ **Women's Health and Cancer Rights Act of 1998** — Your State sponsored health coverage provides benefits for mastectomy-related services and complications resulting from a mastectomy (including lymphedemas). These benefits include reconstruction and surgery to achieve breast symmetry and prostheses. Normal copays, deductibles and coinsurance may apply.

■ **Legal Divorce** — If you cover your spouse and/or dependent children on your State health insurance, you must notify your agency Human Resource office within 30 days of your divorce becoming final. Your divorce is considered final **six months after** the decree is rendered. Changes to your coverage will be effective on the first day of the month following the six month waiting period.

If your divorce decree requires you to provide coverage for your dependent children, the children may continue coverage if they are currently enrolled in the plan. If the children are not currently enrolled for coverage, you must submit a copy of the divorce decree along with a new enrollment form adding the eligible children.

If you have never had coverage with the State, you may apply for coverage within 30 days after the divorce is final. You must submit the divorce decree along with your enrollment form and a certificate of creditable coverage. Your ex-spouse is not eligible for coverage under the State's plan once the divorce is final, however, he or she is eligible to continue coverage under COBRA if he or she was covered immediately prior to the divorce becoming final.

For more information, contact your agency Human Resource office.



■ **LB551 – Dependents up to Age 30** – Effective January 1, 2011, an employee may elect to continue coverage to age 30 for a dependent child who would otherwise lose coverage when he/she ceases to meet the health plan's student criteria or attains an age which exceeds the plan's limiting age, provided that the following criteria are met:

- The child remains financially dependent upon the employee; and
- The child was covered as an Eligible Dependent at the time coverage would have terminated.

In order to elect **continuation coverage** for a child under age 30 the dependent must currently be covered under the plan and lose coverage due to the eligibility criteria (see page 2) and the employee must:

- Complete and return the enrollment form to their agency Human Resource office. The enrollment form is available at their agency Human Resource office.
- Complete and return the LB 551 election form to BlueCross no sooner than 30 days prior to or no later than 30 days after the date on which the child would otherwise lose coverage. This form is available on the State Employee Wellness and Benefits website.

The premium for continuation coverage will be equal to the plan's full, unsubsidized single adult premium. The employee will be responsible for paying the full premium each month through payroll deduction and are pre-tax.

The coverage will terminate if:

- The employee requests the termination because they no longer meet the criteria
- The employee's coverage with BlueCross terminates
- The covered dependent:
 - ... Marries
 - ... Is no longer a resident of Nebraska
 - ... Receives coverage under another health benefit plan or self-funded employee benefit plan
 - ... Attains age 30

(Continued on next page)

Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage cannot be reinstated once it has been terminated.

- **Mental Health Parity Act** — The Mental Health Parity and Addiction Equity Act of 2008 prohibits separate treatment limits for mental illness and substance abuse. It requires equivalent cost sharing and out-of-pocket expenses for these benefits. Coverage must have the financial requirements as any other illness including: deductibles and coinsurance.

Services must still be provided by a qualified physician or licensed psychologist, licensed special psychologist, licensed clinical social worker, licensed mental health practitioner or auxiliary providers supervised by a qualified physician.

Benefits for ALL inpatient admissions must be pre-certified.

Please refer to your Summary Plan Description booklet and Schedule of Benefits for exact benefit language.

- **Changes to HIPAA Special Enrollment Provisions under the Children's Health Insurance Program Reauthorization Act**

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer new special enrollment opportunities. Effective April 1, 2009, plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

There are also new notice and disclosure requirements associated with CHIPRA.

- Employers must notify all employees of their potential eligibility for the subsidies under Medicaid or CHIP. Model notices are to be developed by the Department of Labor and the Department of Health and Human Services (the Departments) by February 4, 2011. Employers are not required to provide these notices until the first plan year after the model notices are issued (January 1, 2012 for calendar year plans).
- In order for States to evaluate an employment-based plan to determine whether premium reimbursement is a cost effective way to provide medical or child medical assistance to an individual, plans are required to provide, upon request, information about their benefits to State Medicaid or CHIP programs. The Departments, in conjunction with an advisory committee, will develop a model disclosure form by August 4, 2011. States may begin requesting this information from plans beginning with the first plan year after the model disclosure form is issued (January 1, 2012 for calendar year plans).

Individuals need to contact their State's Medicaid or CHIP program to determine if they are eligible for Medicaid or CHIP, and to see if their State will subsidize group health plan premiums. If they are eligible for a premium subsidy, they need to contact their plan administrator or employer to take advantage of the new special enrollment opportunity and enroll in the group health plan.

Individuals needing assistance or with questions about the application of these provisions to their employment-based group health plan can call toll free 1-866-444-3272 (EBSA) to speak to a Benefits Advisor.

THE REALITY IS . . . **wellnessoptions**



Rising health care costs are a concern for all of us as individuals and for the State of Nebraska. A recent study (Mercer Health & Benefits) expected an average increase of 10% nationally in health care costs for 2011. Like all companies that provide health coverage for employees, the State of Nebraska faces health care costs that represent many millions of dollars of expense every year. Because the State of Nebraska pays for 79% of the costs associated with health care, the State provides resources to address modifiable health risks to control health care costs.

The evidence is all around us – the skyrocketing rate of obesity and the growing prevalence of diabetes, coronary heart disease, high blood pressure, and many other conditions can all be addressed by the choices we make – or fail to make – each and every day. A clear and concerning example is comparing obesity rates (BMI > 30) of the State of Nebraska aggregate health assessment data of 39% to National (26%) and state-wide (27%) prevalence rates. This is in addition to another 33% who are classified as 'overweight' (BMI 25-29.9). As a result, this data shows that 72% of our State of Nebraska population is either 'overweight' or 'obese'.



Over the past 15 years, research has documented that up to 70% of total health costs can be preventable through lifestyle choices. Some risk factors, such as age, gender, and family history cannot be controlled and/or prevented. However, key lifestyle choices that are preventable include:

- poor and/or unhealthy nutrition
- excessive weight
- lack of physical activity
- tobacco use
- not managing stress.

A Benefit Available To Those Enrolled In ALL Health Plans

In 2009, the State of Nebraska launched a wellness program, called **wellnessoptions**, to create a healthier workforce by encouraging healthy behaviors and the use of preventive care benefits.

The State of Nebraska is proud to offer its wellness program to all those covered employees and spouses (if applicable) enrolled in any of the four plans (BlueChoice, Regular PPO, High Deductible PPO and Wellness PPO). That's right – you can have your own personal health coach, obtain a pedometer with the Walk This Way program or attend an onsite screening – all at no cost to help you invest in your personal health!

These programs are a benefit available to you – regardless if you want to qualify for the Wellness PPO health plan. We encourage you and your enrolled spouse (if applicable) to take advantage of the voluntary wellness programs being offered through HealthFitness at no cost to you. The wellness program is designed to help you evaluate and identify modifiable health risks, and provide you with guidance for living a more healthful life.

Strong Participation Results in Positive Outcomes

Just after one year of providing the State of Nebraska **wellnessoptions** program, much has been accomplished in terms of improving lifestyles, reducing risk factors and increasing the participation in early detection screenings. At the end of December 2010, over 5,000 employees and 2,000 spouses have enrolled in a wellness program.

Over 5,000 participants are currently enrolled in the Walk This Way program - literally achieving millions of steps. Over 1,000 have logged over 1 million steps and several logged over 6 million steps.

In addition, over 4,000 are receiving guidance and support with their participation in a coaching program, including those with a chronic health condition.

Aggregate results among wellness program participants have shown a reduction in the average number of individual risk factors. Associated health improvement results include increased levels of physical activity and consumption of fruits and vegetables, in addition to decreased prevalence of tobacco use and stress.

“Our success in leading healthy lifestyles is a great example of what is possible when you make a commitment to invest in your personal health.”
-Governor Heineman

Early Detection Efforts Are Paying Off and Saving Lives!

As a **wellnessoptions** program awareness initiative, personalized reminders for various preventive screenings for employees and spouses are mailed to their home. Employees and spouses enrolled in any of the four medical programs receive these mailings.

Life Saving and Cost Saving

Not to mention the impact related to a greater chance of more favorable health outcomes, the average State of Nebraska healthcare cost was found to be 68 times less for treating an early stage of colorectal cancer versus treating a late form of colorectal cancer.

Before the launch of this initiative, only 33% of enrollees were current with their recommended preventive screenings (based on national recommendations). After one year of this initiative, the completion rate for recommended screenings has increased 19%. For many, this was the first time a preventive screening has been completed. The screenings resulted in ‘catching’ many cases of early stage, and even late stage cancers.

Specifically, 257 new cases were detected in an early stage of cancer and 10 new cases were diagnosed with a late stage of cancer. Not to mention the impact related to more favorable health outcomes, significant cost savings are associated with identifying these cases in an early stage. In fact, the average State of Nebraska healthcare cost was found to be 68 times less for treating an early stage of colorectal cancer versus treating a late form of colorectal cancer.

Other conditions newly diagnosed from the onsite biometric screenings include 288 new high cholesterol cases, 218 new high blood pressure cases and 191 new diabetic cases.



wellnessoptions Earns National Wellness Award

The State of Nebraska has been awarded the Gold Well Workplace Award presented by the Wellness Council of America for its wellness program for state employees. Nebraska is one of only two states to



win the award. “I am very pleased with the success of our wellness program and I am even more pleased that state employees are embracing this program,” Gov. Dave Heineman said in reflecting on the early progress of the wellness program.

Wellness PPO Premium Savings

The State of Nebraska has self-funded health plans. This means that both the employee and State of Nebraska share the costs associated with all health and prescription costs. Employees contribute to health care costs by paying premiums, which accounts for 21% of health care costs. The State of Nebraska pays the remaining 79% of your health care costs.

Health plans that experience higher utilization are going to cost employers and employees more. After seeing double digit annual healthcare cost increases, the State experienced an overall cost increase of 2.2% last year among all State of Nebraska health plans after the initiation of the wellness program.

Healthcare premium costs among each of the four health plans are independently determined based on each plan's utilization experience. When comparing the healthcare and prescription utilization among each of the four State of Nebraska health plans provided by Blue Cross Blue Shield of Nebraska, the Wellness PPO health plan utilization was significantly lower. Last year, the Wellness PPO premium cost decreased 6.3%. Unfortunately, we do have a slight premium increase. However, our premium increases are well below the national average/trend which is between 9% and 10%.

Annual Employee Wellness PPO Premium Savings Wellness PPO Savings Compared to BlueChoice			
Single	Four-Party	Two Party	Family
\$525.36	\$1,079.52	\$1,394.64	\$1,865.76

For more information on all **wellnessoptions** programs, Wellness PPO plan qualification requirements and more, visit the **wellnessoptions** website at www.wellnessoptions.nebraska.gov or call 1-866-956-4285.

Is the Wellness PPO Right for Me?

- Are you willing to invest in your personal health?
- Are you willing to take the time to participate in various wellness programs?
- Are you willing to take the time to learn the 3 STEPS and deadlines?
- Is prevention and early detection important to you?
- Do you have a vested interest in a shared responsibility to control health care costs?
- Are low premium costs important to you?

Congratulations!!!

Those who are taking the time to invest in their personal health by qualifying for the Wellness PPO will be rewarded with these premium costs.

Qualifying For The Wellness PPO

Key features of the Wellness PPO health plan include low premiums and high quality coverage related to preventive screenings. Participants choosing to elect or remain in the Wellness PPO health plan must complete the wellness program criteria (3 STEPS) on an annual basis in order to qualify for the Wellness PPO the upcoming plan year. At the beginning of each annual cycle, participants will choose and enroll in a wellness program (STEP 1), and then finish each annual cycle by completing a biometric screening (STEP 2) and a Health Assessment (STEP 3).

Those individuals who meet the Wellness PPO criteria will have the option of electing or remaining in the Wellness PPO. Those who did not complete the criteria will not qualify for the Wellness PPO plan but will have the option to enroll in the High Deductible PPO, Regular PPO, or BlueChoice health plan.

Check Your Checkmark!

The **wellnessoptions** website now has an easy to read Wellness PPO Checklist to help you track the completion of the three necessary steps to qualify for the Wellness PPO health plan. After you log-in with your unique user name and password, please review your own Wellness PPO Checklist. The 'Checklist Detail' link will also provide you information regarding your wellness program status. The Checklist will update itself on June 1, 2011 to reflect 2012-13 Wellness PPO qualification criteria. Use this tool to guide you towards qualifying for the Wellness PPO!

Wellness PPO Checklist For July 1, 2011 Plan Year

(If checked ✓, step is completed)

- Step 1:** Met criteria for ONE of the following Wellness Programs:
(≥ means greater than or equal to)
 - EMPOWERED Coaching – ≥ 3 calls
 - Condition Management – ≥ 4 calls
 - Walk This Way – ≥ 450,000 steps
 - FLAM – ≥ \$1 Million Virtual Dollars
- Step 2:** 2011 Biometric Screenings
- Step 3:** 2011 Health Assessment

Review your **Checklist Detail** for further information on qualifying for the Wellness PPO.

Learn more about the Wellness PPO qualifications for the July 1, 2011 Plan Year.

Wellness PPO Checklist Questions & Answers

QUESTION: How do I know if I'm enrolled in a wellness program?

ANSWER: Click on 'Checklist Detail'. The 'Checklist Detail' link will say 'In Process' for those currently enrolled in a wellness program or 'Complete' for those who have met the criteria (in addition to a checkmark on the home page Wellness PPO Checklist).

QUESTION: How do I know if I've completed a wellness program or one of the THREE STEPS to qualify for the Wellness PPO?

ANSWER: View your Wellness PPO Checklist and look for a checkmark.

QUESTION: How do I know if I've completed the online Insight Health Assessment?

ANSWER:

- 1) View your Wellness PPO Checklist and look for a checkmark;
- 2) You will receive a Health Assessment completion e-mail to your contact e-mail address (if provided and valid);
- 3) Review the results of each annual Health Assessment you completed, listed by each completion date.

QUESTION: How do I know if I completed a biometric screening?

ANSWER:

- 1) View your Wellness PPO Checklist and look for a checkmark;
- 2) If you have obtained results from your onsite or home kit screening;
- 3) If you receive an e-mail confirming your receipt of the Alternative Means Screening form.

Annual Cycle for Qualifying into Enrollment for the Wellness PPO Plan (3 Steps)

Steps	Wellness PPO Criteria	Program	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul				
Step 1	Enroll in Wellness Program	Feel Like a Million	Step 1: Wellness Program Enrollment Period												Finishing completing program			Step 2			Step 3	Qualify for Wellness PPO
		EMPOWERED Coaching																				
		Walk This Way																				
		Condition Management																				
Step 2	Biometric Screening Options	Onsite Screening																				
		Alternative Means Form																				
		Home Kit Screening																				
Step 3	Health Assessment	On-Line																				

Finish Qualifying for Enrollment into the 2011-12 Wellness PPO Plan

To recap what has been promoted during the past year, the following 3 STEPS need to be completed in order to qualify for enrollment into the 2011-12 Wellness PPO Plan:

STEP 1. With numerous notices and reminders during the past year, many have achieved the first step to qualify for the 2011-12 Wellness PPO health plan by enrollment and completion of one of the following wellness programs (STEP 1):

- EMPOWERED Lifestyle Management Coaching (3 or more calls)
- Walk this Way (450,000 or more steps)
- Condition Management Coaching (4 or more calls)
- Feel Like A Million (\$1 million or more virtual dollars)

STEP 2. Starting April 1, 2011 – Complete your annual Biometric Screening option (see next section)

STEP 3. April 1, 2011 – May 31, 2011 – Complete your annual online Insight Health Assessment (see next section)

Remaining Two Steps To Qualify for the 2011-12 Wellness PPO:

STEP 2. Complete one annual Biometric Screening option

Starting April 1, 2011, a total of three different confidential biometric screening options are available to learn your cholesterol levels, glucose, blood pressure, height and weight. The three options include:

A. **Onsite screenings** will be offered at approximately 30 State of Nebraska locations from April 4, 2011 through May 27, 2011. To view the listing of locations, schedule your appointment and for more information, view www.wellnessoptions.nebraska.gov within the 'wellnessoptions/Biometric Screenings' section (left toolbar). Select 'Health Scheduler' to schedule your appointment.

B. **Home kits** can be requested to obtain a finger-stick blood draw kit mailed to your home. Request your home kit from April 1 – April 20, 2011 by calling 1-866-956-4285 Option 0 to speak with HealthFitness customer service. Kits must be completed and postmarked no later than April 30, 2011 midnight. With this option, participants self-report their blood pressure, height and weight into their online Health Assessment.



C. An **Alternative Means Screening (AMS)** form will be available April 1, 2011 on the [wellnessoptions](http://www.wellnessoptions) website. Print and provide the Alternative Means Screening form to your health care provider to complete (NOTE: Only the AMS form will be accepted - do not submit any other forms!). Use this form to submit recent biometric screening results (height, weight, blood pressure, total cholesterol, HDL, LDL, triglycerides, glucose) from appointments scheduled with your personal physician after Jan 1, 2011. Mail/fax this form with a healthcare provider signature no later than April 30, 2010 midnight. To obtain your AMS form and for further information, view www.wellnessoptions.nebraska.gov within the 'wellnessoptions/Biometric Screenings' section (left toolbar).

IMPORTANT: Qualifying for the Wellness PPO is purely based on participation and completion of specific wellness programs and NOT based on personal results, health risks or conditions.

	BlueCross BlueShield Wellness PPO Plan		BlueCross BlueShield BlueChoice Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan/lifetime maximum	Unlimited		Unlimited	
Plan Year deductible (must be satisfied before benefits are paid)	\$400/individual \$800/family max	\$600/individual \$1,200/family max	\$500/individual \$1,000/family max	\$600/individual \$1,200 family max
Out-of-pocket maximum (not including deductible, if applicable)	\$1,400/individual \$2,800/family	\$3,400/individual \$5,200 family	\$2,500/individual \$5,000 family	\$3,000/individual \$6,000 family
PHYSICIAN OFFICE VISITS				
Office visit/specialist/consultation/ initial Maternity Visit	\$20 copay	30% after deductible	\$25 copay	40% after deductible
Allergy testing / serum	No copay		\$5 copay	
Allergy shots	No copay			
Maternity Services (beyond initial visit)	No copay		No copay	
Pathology Services	Paid at 100% up to \$500. After \$500, 20% deductible		20% after deductible	
Surgery, Radiology & Pathology (office)	20% after deductible		\$25 copay	
Chemotherapy/Radiation Therapy				
Routine Vision Exam plus Refraction	\$20 copay	Not covered	\$25 copay	Not covered
PREVENTIVE EXAMS				
Flu Shots	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings. (Please refer to page 20 for more information.)	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)
Annual exam (includes foot exams for diabetics)				
Child immunizations				
Adult immunizations				
Pneumococcal Immunizations				
Well baby exams				
Diabetes vision screening				
Mammogram				
Pap smear				
Colonoscopy				
Prostate cancer screening	No copay	30% after deductible	20% after deductible	40% after deductible
EMERGENCY CARE				
Ambulance	No copay	30%; deductible waived	\$25 Copay	40% after deductible
Urgent care center	\$25 copay	30% after deductible	\$25 copay	
Hospital emergency room ⁽³⁾	\$100 ⁽¹⁾ copay		\$100 ⁽¹⁾ copay	
HOSPITAL SERVICES				
Inpatient hospital	20% ⁽²⁾ after deductible	30% ⁽²⁾ after deductible	20% ⁽²⁾ after deductible	40% ⁽²⁾ after deductible
Ambulatory Surgical Center	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Approved skilled nursing facility				
Outpatient hospital services (diagnostic lab., radiology)				
Durable medical equipment			\$25 copay	40% after deductible
Home health care, Hospice care				
Outpatient rehabilitation services (includes OT, PT, ST and chiropractic)	\$20 copay (maximum 60 sessions/ plan yr)	30% after deductible (maximum 60 sessions/plan yr)	\$25 copay (maximum 60 sessions/ plan yr)	40% after deductible (maximum 60 sessions/plan yr)
BEHAVIORAL HEALTH SERVICES				
Inpatient mental health and substance abuse treatment	20% ⁽²⁾ after deductible	30% ⁽²⁾ after deductible	20% ⁽²⁾ after deductible	40% ⁽²⁾ after deductible
Outpatient mental health and substance abuse treatment	20% after deductible	30% after deductible	20% after deductible	40% after deductible

1. Waived if admitted as inpatient for the same diagnosis within 24 hours.
2. Insurance carrier must be notified within 24 hours of all inpatient hospital admissions. Please see SPD for details
3. Facility fee only. All other billed charges are subject to applicable copays and coinsurance..

BlueCross BlueShield Regular PPO Plan		BlueCross BlueShield High Deductible PPO Plan	
In-Network	Out-of-Network	In-Network	Out-of-Network
Unlimited		Unlimited	
\$400/individual \$800/family max	\$600/individual \$1,200/family max	\$1,000/individual \$2,000/family max	\$2,000/individual \$4,000/family max
\$1,400/individual \$2,800/family max	\$3,400/individual \$5,200/family max	\$2,000/individual \$4,000/family max	\$4,000/individual \$8,000/family max
\$20 copay	30% after deductible	\$25 copay	40% after deductible
20% after deductible		30% after deductible	
Covered at 100% for children under age 5 only		Covered at 100% for children under age 5 only	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered. (Please refer to page 20 for more information.)
Not covered		Not covered	
20%; deductible waived	30%; deductible waived	30%; deductible waived	40%; deductible waived
20% after deductible	30% after deductible	30% after deductible	40% after deductible
\$100 copay ⁽¹⁾		\$100 copay ⁽¹⁾	
20% ⁽²⁾ after deductible	30% ⁽²⁾ after deductible	30% ⁽²⁾ after deductible	40% ⁽²⁾ after deductible
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	40% after deductible (maximum 60 sessions/plan yr)
20% ⁽²⁾ after deductible	30% ⁽²⁾ after deductible	30% ⁽²⁾ after deductible	40% ⁽²⁾ after deductible
20% after deductible	30% after deductible	30% after deductible	40% after deductible

Important Information: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official certificates of coverage. This is not a contract. If there are any inconsistencies between this summary and the official certificates of coverage, the certificates of coverage will prevail. Please refer to the certificate of coverage for exact benefits, exclusions and limitations.

STEP 3. Complete your annual online Insight Health Assessment (April 1, 2011 – May 31, 2011)

- A. Log on to the **wellnessoptions** website at www.wellnessoptions.nebraska.gov
- B. Select the orange 'login' button on the left
- C. Enter your User Name and Password
NOTE: Your User Name is your employee or spouse number. Please add enough zeros in front of your number so that it contains a total of 8 digits. (Example: An employee number of 123456 should be entered as 00123456 for the User Name to login to the website.)
- D. Complete the annual online Insight Health Assessment, which is located on the Health Home page within the 'Take your HEALTH ASSESSMENT' section, then select 'Click here to complete your Health Assessment'. Select the 'Save/Finish' button at the end.

The online Insight Health Assessment includes 82 confidential questions regarding your lifestyle choices. Biometric screenings results will be uploaded into your Health Assessment and will override any self reported values.

IMPORTANT: If you enroll in the Wellness PPO during Open Enrollment and fail to meet the THREE STEP criteria, you will automatically be defaulted to the Regular PPO plan for the 2011-12 plan year at the appropriate tier, based on the effective date.

For more information on all **wellnessoptions** programs, Wellness PPO plan qualification requirements and more, visit the **wellnessoptions** website at www.wellnessoptions.nebraska.gov or call 1-866-956-4285.

The Annual "3-STEP" Cycle Starts All Over Again!

Begin Qualifying for the 2012-13 Wellness PPO Plan

Again, participants choosing to elect or remain in the Wellness PPO health plan must complete wellness programs (3 STEPS) on an annual basis in order to qualify for the upcoming plan year. At the beginning of each annual cycle, participants will choose and enroll in a wellness program (STEP 1), and then finish each annual cycle by completing a biometric screening option (STEP 2) and the online Insight Health Assessment (STEP 3).

Both the enrolled employee and enrolled spouse (if applicable) must complete the following 3 STEPS during the current plan year in order to qualify for the following Wellness PPO health plan (2012-13 plan year).

STEP 1. This Spring – Wellness Program (see next section)

- Enroll in your choice of at least one Wellness Program from April 1, 2011 thru December 29, 2011
- Complete your choice of one Wellness Program by March 30, 2012

STEP 2. Next Spring (April 1 - May 31, 2012) – Complete your annual Biometric Screening Option

STEP 3. Next Spring (April 1 - May 31, 2012) - Complete your annual online Insight Health Assessment

Wellness Program Detail (STEP 1)

This Spring (beginning April 1, 2011) – Enroll and begin participation in your choice of at least one Wellness Program

To qualify for enrollment into the Wellness PPO Plan for the next plan year (2012-13), enroll in your choice of at least one of the following wellness programs anytime before December 29, 2011:

Feel Like a Million

Earn virtual dollars on this fun online game show for recording daily activities in the following five areas: Moving

Matters, Food to Fuel, Better Balance, Purpose and Potpourri. This program is located within the 'Featured Programs' section on the website (left toolbar).



Wellness PPO criteria: New and previous participants must enroll before December 29, 2011 at www.wellnessoptions.nebraska.gov and earn a minimum of 1 million individual "virtual" dollars by March 30, 2012.

Feel Like A Million Team Feature – Join the Millionaire's Club!

The 'Millionaire's Club' is a new optional feature that brings the spirit of friendly competition to the program. You have the option to join or form your own Feel Like A Million team! Millionaire's Clubs may be formed from April 1 through May 16, 2011. The team competition goes from May 16, 2011 until August 7, 2011; individual participation will continue until the end of the program (March 30, 2012). During the Millionaire's Club team competition period, you'll be able to see how your club score compares against others for dollars earned during this time. It's all for fun – club scores do not affect the individual Wellness PPO criteria. The Wellness PPO is based on earning at least one million INDIVIDUAL virtual dollars.



In fact, virtual dollars earned throughout the Millionaire's Club period will also apply to your individual balance. For further information and to form your own team, click on the "Millionaire's Club" tab located on the top navigation bar within the Feel Like A Million website.

EMPOWERED Lifestyle Management Coaching

Work with a coach to support and guide you in making lifestyle changes by selecting among 13 different focus areas related to physical activity, healthy eating, stress management and smoking cessation. Participants can enroll at the time of your Health Advisor call OR by calling 1-866-956-4285 Option 2 OR by going to www.wellnessoptions.nebraska.gov ('My Coach' left toolbar selection).

Wellness PPO criteria: New and previous EMPOWERED participants must enroll before December 29, 2011 and complete 3 or more phone calls with your health coach before March 30, 2012.

NOTE: You may use message boards for correspondence, but you must talk with your coach 3 or more times via telephone to qualify for the Wellness PPO.

Walk This Way

Whether you are currently inactive or active, boost your activity level by wearing a pedometer and tracking your steps online.



Wellness PPO criteria: New and previous Walk This Way participants must enroll before December 29, 2011 at www.wellnessoptions.nebraska.gov and log a minimum of 600,000 steps before March 30, 2012.

Walk This Way Achievement

- Over 1,500 participants have logged over 1 million steps.
- Over 15 participants have logged over 5 million steps
- Total steps logged as of December 2010: 1,355,715 miles (equals over 54 times around the world)

Condition Management Coaching

Individuals with a chronic condition (Heart or Respiratory Conditions, Diabetes, Depression, Back Pain) can work with a coach, in conjunction with your physician, to help manage your health, feel better and enjoy the best quality of life.

This service offered through HealthFitness is provided by Nurtur®, HealthFitness' condition management partner.

Only new Condition Management participants need to enroll before December 29, 2011; current participants can continue calls and do not need to re-enroll.

Wellness PPO criteria: Enroll before December 29, 2011 by calling 1-866-956-4285 Option 3 and complete 4 or more coaching phone calls before March 30, 2012.

For website log-in support, call

**866-956-4285
option 1.**



What is Allowed on Company Time?

The following items **are allowed** for participation on company time: Open Enrollment, Health Assessment, Biometric screenings, sending and receiving e-mails to/from HealthFitness to/from your work e-mail.

The following items **are not allowed** on company time: Health Advising calls, EMPOWERED Lifestyle Management Coaching calls, Condition Management Coaching calls and Walk This Way participation. Specifically, pedometers can be worn during the workday on company time; however physical activities outside of normal work requirements (example: going for a walk) must be done on personal time (lunch time or break). If in doubt, refer to your Personnel policy, or ask your supervisor.

NOTE: Submitting activities is allowed on a State computer, but is to be done on personal time (lunch time or break). Participation is in no way to be considered part of or arising out of employment for the purposes of workers' compensation or for any other purpose.

Confidentiality is a Top Priority

Privacy of personal information is a top priority with wellness programs. HealthFitness maintains the confidentiality of all personal health information in accordance with federal regulations. That means your personal health information, which is obtained by HealthFitness, will not be released to the State of Nebraska.

No Penalties for Poor Health

The Wellness PPO qualification criteria is based on active participation and completion of specific wellness programs, and is not based on your individual health factors, health assessment results or biometric screening results. That means you will not be penalized for having or reporting poor health behaviors or lifestyle risks.

Federal regulations prohibit a group health plan from discriminating among individuals based on their health status. This means that group health plans cannot charge individuals different premiums or impose different costs (i.e., through deductibles or copays) based on the absence or existence of a health factor. Because the State of Nebraska does not condition eligibility for the Wellness PPO health plan upon a participant's ability to meet a health standard, the program meets the nondiscrimination requirements under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

State Employees Earn Wellness Wall of Fame Recognition

Periodically, we learn about success stories from employees participating in the **wellnessoptions** program with some pretty amazing lifestyle changes, resulting in significant health improvements. For many, it is a life changing experience – almost a second outlook on life. In hopes of being motivating to others, stories such as these receive recognition by being displayed on the Wellness Wall of Fame, which includes a picture with the Governor (if possible), in addition to receiving a personal letter from the Governor.

To see all of the Wall of Fame recipients, view www.wellnessoptions.nebraska.gov under 'wellnessoptions' (left toolbar).

Thanks Wellness Champions!

The Wellness & Benefits Department has utilized a team of Wellness Champions from several different agencies and state-wide locations to provide constructive feedback and help with promoting wellness. Wellness Champions were instrumental in providing their thoughts with several Wellness PPO health plan design enhancements. For further information on Wellness Champion roles and how to sign-up, view www.wellnessoptions.nebraska.gov under 'wellnessoptions' (left toolbar).



HEALTH CARE REFORM

Below are some examples of the preventive services covered under your health plan as part of the Patient Protection and Affordable Care Act (PPACA), the health care reform legislation that went into effect for plan/policy years on and after September 23, 2010. Benefits for services listed here are usually covered at 100% when they are obtained from a Blue Cross and Blue Shield of Nebraska network provider, **subject to gender, age and frequency limits.**

Preventive services do not generally include services intended to treat an existing illness, injury, or condition.

Benefits will be determined based on how the provider submits the bill. Claims must be submitted with the appropriate diagnosis and procedure code in order to be paid at the 100% benefit level. If during your preventive services visit you receive services to treat an existing illness, injury or condition, you may be required to pay a copay, deductible and/or coinsurance for those covered services.

For those who qualified for the Wellness PPO Plan, preventive services are covered at 100% and are not subject to age, gender and frequency limits.

MALE PREVENTIVE SERVICES	FEMALE PREVENTIVE SERVICES
Exams: Periodic preventive examination/office visits	Exams: Periodic preventive examination/office visits
Immunizations: i.e. flu, pneumonia, shingles	Immunizations: i.e. flu, pneumonia, shingles
Screenings: cholesterol, colorectal cancer, depression, diabetes, high blood pressure, HIV, obesity, sexually transmitted diseases	Screenings: cholesterol, colorectal cancer, depression, diabetes, high blood pressure, HIV, mammogram, obesity, osteoporosis, Pap smear, sexually transmitted diseases
PREGNANT WOMEN PREVENTIVE SERVICES	CHILDREN PREVENTIVE SERVICES
Exams: Periodic preventive examination/office visits	Exams: Periodic preventive examination/office visits
Immunizations: i.e. flu	Immunizations: i.e. flu, Diphtheria/Tetanus/Pertussis (DTaP), Varicella (Chicken Pox), Measles, Mumps, Rubella (MMR), Polio, Human Papillomavirus (HPV)
Screenings: In addition to the Female Preventive Services listed above – asymptomatic bacteriuria, hepatitis B, iron deficiency anemia, Rh (D) incompatibility	Screenings: congenital hypothyroidism, hearing loss in newborns, HIV, iron deficiency anemia, major depressive disorders, obesity, phenylketonuria (PKU), sexually transmitted diseases, sickle cell disease, visual impairment

NOTE: This is a partial list of covered preventive services. For a list of the preventive services recommended by PPACA, please visit the Members page of www.bcbsne.com. If you have questions about how your office visit will be covered, before you visit your doctor please call the Member Services number on the back of your Blue Cross and Blue Shield of Nebraska member ID card.

Health Care Premiums – July 1, 2011 – June 30, 2012

Health Care Premiums for COBRA / Retiree Employee Only (Single Coverage) – Monthly

		COBRA	Retiree
BlueCross	Wellness PPO Plan	\$435.17	\$426.64
	BlueChoice Plan	\$649.52	\$636.78
BlueShield Plans	Regular PPO Plan	\$509.22	\$499.24
	High Deductible PPO Plan	\$305.55	\$299.56
Ameritas Dental	Basic Option	\$21.58	\$21.58
	Premium Option	\$24.15	\$24.15
EyeMed	Basic Option	\$5.26	\$5.26
	Premium Option	\$8.14	\$8.14
Employee Assistance Program		\$1.28	\$1.28

Health Care Premiums for COBRA / Retiree Employee + Spouse (Two Party Coverage) – Monthly

		COBRA	Retiree
BlueCross	Wellness PPO Plan	\$1,154.97	\$1,132.32
	BlueChoice Plan	\$1,723.86	\$1,690.06
BlueShield Plans	Regular PPO Plan	\$1,351.52	\$1,325.02
	High Deductible PPO Plan	\$810.92	\$795.02
Ameritas Dental	Basic Option	\$43.21	\$43.21
	Premium Option	\$48.35	\$48.35
EyeMed	Basic Option	\$8.45	\$8.45
	Premium Option	\$13.04	\$13.04
Employee Assistance Program		\$1.28	\$1.28

Health Care Premiums for COBRA / Retiree Employee + Dependent Children (Four Party Coverage) – Monthly

		COBRA	Retiree
BlueCross	Wellness PPO Plan	\$893.85	\$876.32
	BlueChoice Plan	\$1,334.12	\$1,307.96
BlueShield Plans	Regular PPO Plan	\$1,045.97	\$1,025.46
	High Deductible PPO Plan	\$627.59	\$615.28
Ameritas Dental	Basic Option	\$62.26	\$62.26
	Premium Option	\$69.69	\$69.69
EyeMed	Basic Option	\$8.61	\$8.61
	Premium Option	\$13.30	\$13.30
Employee Assistance Program		\$1.28	\$1.28

Health Care Premiums for COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage) – Monthly

		COBRA	Retiree
BlueCross	Wellness PPO Plan	\$1,544.75	\$1,514.46
	BlueChoice Plan	\$2,305.67	\$2,260.46
BlueShield Plans	Regular PPO Plan	\$1,807.64	\$1,772.20
	High Deductible PPO Plan	\$1,084.59	\$1,063.32
Ameritas Dental	Basic Option	\$67.65	\$67.65
	Premium Option	\$75.72	\$75.72
EyeMed	Basic Option	\$13.85	\$13.85
	Premium Option	\$21.42	\$21.42
Employee Assistance Program		\$1.28	\$1.28

PRESCRIPTION DRUG COVERAGE

When you enroll in any of the State sponsored health plan options, you automatically receive prescription drug coverage. Express Scripts administers the prescription drug program. New prescription drug cards will be mailed only if you are enrolling in a health plan for the first time or if you are changing health plans.

The prescription drug program offers three coverage tiers:

- **Tier 1** — Generic drugs
- **Tier 2** — Preferred (Formulary) brand name drugs
- **Tier 3** — Non-preferred (Non-Formulary) brand name drugs

Retail Pharmacy (30-day supply)

When you fill your prescription at a participating retail pharmacy, you can purchase up to a 30-day supply of your medication for just the cost of a copay. Express Scripts has a national network of more than 50,000 retail pharmacies including Walgreens, Kmart, Target and Walmart.

For a list of additional pharmacies, contact Express Scripts at **866-790-8277** or visit online at www.express-scripts.com.

Home Delivery Pharmacy (180-day supply)

When you fill a new prescription through Express Scripts' Home Delivery Pharmacy, you can receive a 180-day supply of your medication. For new orders, you will need to complete the New Patient Home Delivery Form along with your 180-day prescription. Contact Express Scripts at **866-790-8277** to obtain a Home Delivery Form.



Preferred Mail Order

Maintenance medications for 180-day supply can no longer be filled at a retail pharmacy. They can only be filled using the home delivery method. Maintenance medications may still be filled at a retail pharmacy at the applicable copay for a 30-day supply.

By using the home delivery method you will also typically spend less in copayments as you will see in the copayment chart on page 24

CuraScript – ESI's Specialty Pharmacy

All specialty medications will need to be filled through CuraScript.

CuraScript employs over 2,500 team members and is headquartered in Orlando, FL. In addition to their facility in Orlando, they have a network of satellite distribution pharmacies to serve all your needs.

At CuraScript, they emphasize the importance of patient care and quality customer service. As a CuraScript patient, you will have access to a team of specialists including pharmacists, nurse clinicians, social workers, patient care coordinators and reimbursement specialists who will work closely with you and your physician throughout your course of therapy. CuraScript also provides an on-call pharmacist 24 hours a day, 7 days a week.

90-day Supply Will Reject

Prescriptions written for maintenance medications for a 90-day supply will REJECT at the retail pharmacy and also through the Express Home Delivery. The prescribing doctor will need to provide another prescription written for the correct day supply in order for the prescription to process at the correct copay level.

Important Information regarding your Express Scripts Prescription Drug Benefit

Effective July 1, 2011, you will no longer be able to fill a 180-day supply prescription at a retail pharmacy. You will now need to utilize the mail order service through Express Scripts if you wish to obtain a 180-day supply. You will still be able to obtain a 30-day supply at retail but the copay is higher.

If you are currently filling a 180-day supply at a retail pharmacy, you will receive the below letter from Express Scripts explaining the change in the plan and how to transfer your prescription to the mail service.




Administrative Services
State of Nebraska Welfare & Benefits
P.O. Box 94952
Lincoln, NE 68509

April 1, 2011

Sally Smith
123 Main Street
Lincoln, NE 68501

Dear Sally Smith,

The State of Nebraska and Express Scripts, the company managing your prescription-drug benefit, want to make you aware of an important change in your benefit. **Beginning July 1st, 2011, per your plan, you will no longer be able to fill a 180-day prescription for a maintenance medication at a retail pharmacy.** Maintenance medications are those prescription drugs you take regularly to treat ongoing conditions.

Starting July 1st you will have two options to fill your maintenance medications:

1. Express Scripts Pharmacy (180-day supply)

When you fill your prescription through home delivery from the Express Scripts Pharmacy, you can receive a 180-day supply of your medication delivered right to your door. And, with lower copayments, the Express Scripts Pharmacy may save you money.

Express Scripts will make the switch easy. Our highly-trained patient care advocates will even contact your doctor on your behalf to get a new 180-day prescription for the Express Scripts Pharmacy.

2. Retail Pharmacy (30-day supply)

When you fill your prescription at a participating retail pharmacy, you can purchase up to a 30-day supply of your medication.

Prescriptions currently written for a 180-day supply will reject at the retail pharmacy. Please ask your doctor to write a new prescription for a 30-day supply if you choose to continue filling at a retail pharmacy.

Thank you for being a valued member; we appreciate the opportunity to serve you. If you have any other questions regarding your prescription-drug benefit, please call the number on your prescription ID Card.

Sincerely,

Express Scripts
Enclosure

IMPORTANT INFORMATION: Your prescription-drug benefit has changed.

- **Savings** — With lower copayments, you can save money.
- **Safety** — Every order checked for accuracy by pharmacists who are available 24/7.
- **Satisfaction** — Ranks higher than retail pharmacies in customer satisfaction.²
- **Convenience** — 180-day supply, free standard shipping, payment options and Auto Refills.

You Have Three Easy Ways to Start:

- **Mail in the enclosed order form,** your 180-day prescription and copayment to Express Scripts.
- **Visit StarHomeDelivery.com.**
- **Call 866.790.8277, 7:30 am to 5 pm Central, Monday through Friday.**

We will make the transition easy by contacting your doctor to get a new prescription for the Express Scripts Pharmacy.

 EXPRESS SCRIPTS®

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Understanding Your Pharmacy Copays

Your pharmacy benefit offers three categories of drugs that determine the amount you pay for your prescription drugs:

- **Generics** contain the same active ingredient as their brand name equivalents. Generics often help you save on your prescriptions. You get the same quality and effectiveness as that of a brand name drug.
- **Preferred medications** (Formulary) are brand name medications that have higher copays than generics but are usually less costly than non-preferred (Non-formulary) medications.
- **Non-preferred medications** (Non-formulary) have the highest copays and are not listed on Express Scripts' National Preferred Formulary List.

Visit www.express-scripts.com to view the Formulary List.

Manage Your Prescription Drugs Online

By visiting www.express-scripts.com, you can:

- Check drug coverage and copayments
- Find generic alternatives
- Review your prescription history
- Confirm eligibility
- Register for mail order delivery
- Order refills
- Print a temporary ID card
- Search for a nearby pharmacy



Your Prescription Drug Benefits

Wellness PPO Plan*	Generic	Preferred Medications (Formulary)	Non-Preferred Medications (Non-Formulary)
Retail 30-day supply	\$5 copay	\$25 copay	\$40 copay
Home Delivery 180-day supply	\$20 copay	\$100 copay	\$150 copay
Diabetic, hypertension and high cholesterol prescriptions			
Retail 30-day supply	No copay	\$15 copay	\$30 copay
Home Delivery 180-day supply	No copay	\$75 copay	\$120 copay

Diabetic supplies covered under the prescription drug benefit include syringes, needles, insulin pump supplies, swabs, lancets, blood monitor kits, test strips, blood glucose calibration solutions, urine tests, and blood test strips. Insulin pumps are covered under the health benefit as Durable Medical Equipment.

! Wellness PPO plan participants are eligible, with prior approval, to receive one (1) course of tobacco cessation prescription drugs for up to 12 weeks, within a rolling 12 month period, at no cost. There is a lifetime limit of three (3) courses of treatment.



BlueChoice Plan* Regular PPO Plan* High Deductible PPO Plan*	Generic	Preferred Medications (Formulary)	Non-Preferred Medications (Non-Formulary)
Retail 30-day supply	\$10 copay	\$25 copay	\$40 copay
Home Delivery 180-day supply	\$35 copay	\$100 copay	\$150 copay

* All plans will utilize the Express Scripts' National Preferred Formulary List. All medications on the Formulary List have been approved by the Food and Drug Administration (FDA). The list can be found at Express Scripts website www.express-scripts.com.

DENTAL BENEFITS

Regular, professional dental care is not only essential to good health, but it can also prevent serious and costly medical and/or dental problems. That's why the dental benefit plan encourages you and your family to see a dentist regularly. The plan places special emphasis on preventive care, but also covers many other dental services you may need.

Whether or not you elect health coverage, you can choose dental coverage for yourself and your eligible dependents. The dental plan is a preferred provider organization (PPO) with a network of participating providers. You have the option of selecting dental care in- or out-of-network each time you receive dental care, but the plan pays the greatest benefit for care received from a provider in the Ameritas network.

Dental Rewards

Dental Rewards is a valuable program that encourages good dental habits through regular dental check-ups. If you file at least one dental claim during the plan year (July 1, 2011 – June 30, 2012) and total benefits paid are less than \$500, you will qualify for a reward of \$250.00 (\$350.00 if using a PPO dentist) increase in your annual maximum the following plan year (beginning July 1, 2012). This continues until you reach a total reward of \$1,000. The Dental Reward amount earned is reduced by any amount used in any plan year.

NOTE: Orthodontia and TMJ procedures are excluded from Dental Rewards as they have their own maximum benefit.

Enrollment for Late Entrants

If you and/or your dependents do not enroll within 30 days from being eligible for insurance (this includes enrolling as a new hire, or being eligible due to a mid year qualified event) or elects to become insured again after dropping out of the dental plan, you and/or your dependents will be considered "late entrants." As an example, if an employee is hired on 4/15/2011 and elects the dental coverage, this would become effective on 6/1/2011. However, if the employee does not elect to enroll in the dental coverage as a new hire and, elects to enroll in the dental coverage during any subsequent open enrollment period they would be considered a late entrant and have the late entrant penalty (waiting period) for the first 12 months. As late entrants, your benefits will be limited to only Preventive Procedures for the first 12 months that you are covered. After 12 months, you will have access to all of the plan's benefits.



Your Dental Benefits

Basic Plan

AMERITAS DENTAL PLAN BENEFITS		
Plan Feature	PPO In-Network Dentist	Non-PPO Out-of-Network Dentist
Deductible for both Basic and Major Procedures (waived for preventive care, orthodontia and TMJ)	\$50 per individual \$150 per family	\$50 per individual \$150 per family
Maximum Benefit	\$1,000	\$1,000
Orthodontia & TMJ lifetime maximum (per person)	\$2,000	\$2,000
Preventive Procedures (exams, cleanings – 2 per year, x-rays, sealants)	Plan covers 100%	Plan covers 50%
Basic Procedures (fillings, root canals, gum disease treatment, extractions)	Plan covers 80%	Plan covers 50%
Major Procedures (initial and replacement crowns, dentures, bridges)	Plan covers 50%	Plan covers 25%
Orthodontia (to age 19) & TMJ Procedures	Plan covers 50%	Plan covers 25%

Premium Plan

Plan Feature	PPO In-Network Dentist	Non-PPO Out-of-Network Dentist
Deductible for both Basic and Major Procedures (waived for preventive care, orthodontia and TMJ)	\$50 per individual \$150 per family	\$50 per individual \$150 per family
Maximum Benefit	\$1,500	\$1,500
Orthodontia & TMJ lifetime maximum (per person)	\$2,000	\$2,000
Preventive Procedures (exams, cleanings – 2 per year, x-rays, sealants)	Plan covers 100%	Plan covers 80%
Basic Procedures (fillings, root canals, gum disease treatment, extractions)	Plan covers 80%	Plan covers 80%
Major Procedures (initial and replacement crowns, dentures, bridges)	Plan covers 50%	Plan covers 50%
Orthodontia (FOR ADULTS AND CHILDREN) & TMJ Procedures	Plan covers 50%	Plan covers 50%

VISION CARE BENEFITS

Proper vision care is an essential part of good health. Routine eye exams can help determine the need for prescription glasses, but can also help detect symptoms of serious conditions such as glaucoma, cataracts and diabetes.

When you use the services of providers who participate in the EyeMed Vision Care network, you generally pay a small copay and the plan pays the rest. Here's how it works:

- Choose an EyeMed Vision Care participating provider at www.eyemedvisioncare.com or call 877-861-3459
- Make an appointment and tell the provider you are an EyeMed Vision Care member
- Two personalized ID cards will be issued with the subscriber's name for the new enrollees only; eligible dependents can use one of the

cards for identification purposes. You will need to verify with your provider that they accept your plan when scheduling an appointment. Included with your ID cards will be a listing of the EyeMed Vision Care providers near you. Present your ID card at the time of service

- Choose from thousands of convenient locations including private practitioners and leading optical retailers, such as LensCrafters, Pearle Vision, Sears Optical, Target Optical and JC Penney Optical

You have a choice of two affordable eye care plans – the Basic Option and the Premium Option. Here's how they compare:

VISION PLAN BENEFITS		
Coverage	Basic Option	Premium Option
EXAM covered in full (after \$10 copay)	every 12 months	every 12 months
PRESCRIPTION GLASSES		
LENSES covered in full (after \$10 copay) — Includes single vision, lined bifocal, lined trifocal lenses, and polycarbonate lenses for dependent children	every 24 months	every 12 months
OR		
CONTACT LENS allowance applied toward the cost of contacts.	\$105 every 24 months	\$130 every 12 months
FRAMES — Includes a frame of your choice	every 24 months \$105 allowance, 20% off balance over \$105	every 12 months \$120 allowance, 20% off balance over \$120

LEGAL DISCLAIMER: Member will receive a 20% discount on items not covered by the plan at network Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Allowances are one-time use benefits; no remaining balance. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. The plan design is offered with the EyeMed Access panel of providers. Limitations and exclusions apply. Insured plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri except in New York. Fidelity Security Life Policy Number VC-19/VC-20 form number M-9083.

COUNSELING SERVICES — YOUR EAP

The Employee Assistance Program (EAP), provided through Best Care, offers free, confidential counseling and referral services to help you and your family deal with issues that may be affecting your job performance or personal well-being. Counselors are trained to help with such issues as:

- marital or family distress
- financial matters
- legal assistance
- alcoholism
- drug dependency
- mental illness

Not all State agencies have elected to provide EAP coverage for their employees. Please contact your agency Human Resource office to determine whether your agency is participating in the EAP provided through Best Care.

When you contact the EAP, you'll speak with a specialist who can help identify the issue, determine the most suitable type of assistance

and work with you on a course of action. The EAP is available 24 hours a day, seven days a week. All consultations and counseling are completely confidential.

Contact the EAP at **800-666-8606** or **402-354-8000** to arrange for a private and confidential appointment.

Why is Asking for Help So Difficult?

You may be afraid of looking weak, needy or incompetent; however, stalling can let a situation grow from a problem into a crisis. Asking for assistance during a personal or professional challenge shows good judgment. Best Care EAP is available to support you through difficult situations.

"I was scared at first because I didn't know what to expect. My Best Care counselor was very helpful and really put me at ease."

"I would highly recommend Best Care to co-workers/friends/family. Wonderful-talented-sensitive-caring and helpful! Helped improve my quality of life all around! Very beneficial!"

TIME TO ENROLL

Open Enrollment

BEGINS:

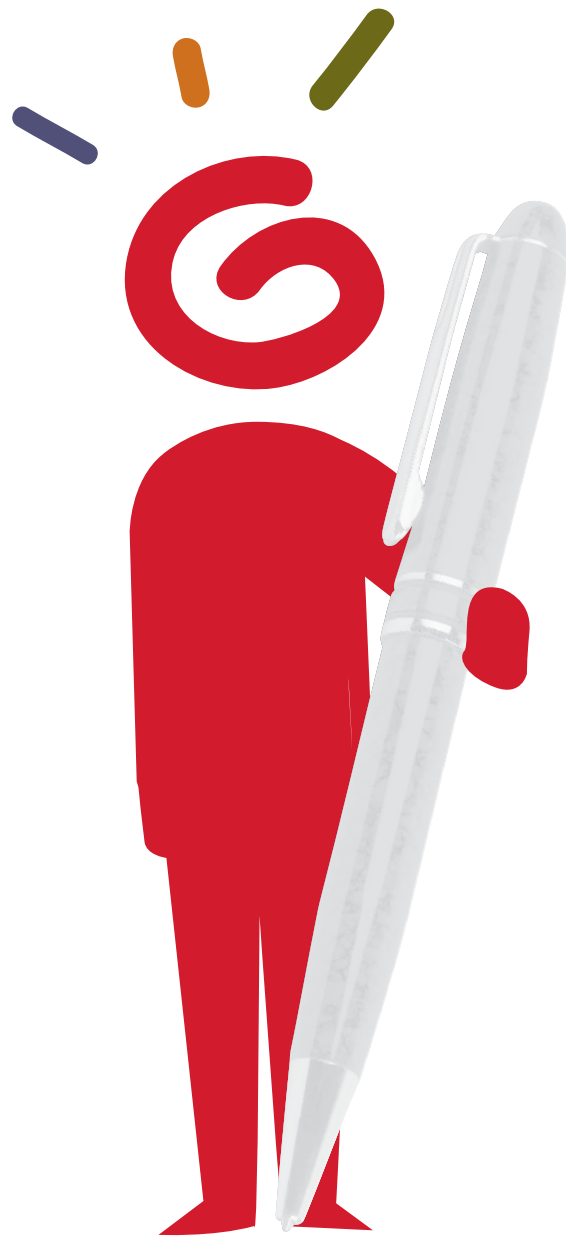
**Monday, May 2, 2011
at 7:00 a.m. C.D.T.**

ENDS:

**Friday, May 20, 2011
at 5:00 p.m. C.D.T.**

Before you enroll, consider this checklist of items:

- ✓ Read this guide
- ✓ Keep in mind that the elections you make are in effect from July 1, 2011 through June 30, 2012
- ✓ Become familiar with your benefit options
- ✓ Talk to your family and share benefit decisions
- ✓ Gather the Social Security numbers of all of your enrolled dependents
- ✓ Get questions answered through vendor telephone numbers and websites (see back cover)
- ✓ View Open Enrollment informational meeting located on the Wellness and Benefits website
- ✓ **Optional:** Complete the worksheet found on the State Employee Wellness and Benefits website at www.das.state.ne.us/personnel/benefits/



Contact Information

Here are resources to contact if you have questions about your coverage options.

FOR MORE INFORMATION ABOUT...	GO TO...	OR CALL...
Health Plans BlueCross BlueShield	www.bcbsne.com	800-642-3022
Prescription Drug Plan Express Scripts	www.express-scripts.com	866-790-8277
CuraScript Drug Plan Specialty Medications	www.curascript.com	866-848-9870
Dental Plan Ameritas	www.ameritasgroup.com	800-487-5553
Vision Plan EyeMed Vision Care	www.eyemedvisioncare.com	877-861-3459
EAP Best Care	www.bestcareeap.org	800-666-8606
Wellness Provider HealthFitness	www.wellnessoptions.nebraska.gov	866-956-4285
Nebraska State Employee Wellness and Benefits	www.das.state.ne.us/personnel/benefits/	402-471-4443 (in Lincoln) 877-721-2228 (outside Lincoln)

