

Lincoln-Lancaster County 555 South 10th Street
Personnel Department Rooms 201 & 107
Mark A. Koller, Director Lincoln, Nebraska 68508

402-441-7597
fax: 402-441-8748



MAYOR CHRIS BEUTLER

lincoln.ne.gov

Re: LB 551 - Extension of Coverage Requests For Extended Eligibility to Age 30

Dear Lancaster County Employee:

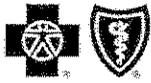
Due to a recent Nebraska statute change, medical and prescription drug coverage for dependent children may be extended beyond age 19 if no longer a full time student, they attain age 24, or no longer satisfy the group eligibility criteria after January 1, 2010. Below is a summary of the extension of coverage provisions:

- A dependent child must be enrolled in the county's medical plan on January 1, 2010 to be eligible for the extension of coverage.
- Extension of coverage is available to age 30 for a dependent that is unmarried, a resident of Nebraska (unless enrolled full time out of state), and not covered by any other health plan.
- Coverage ends when the dependent no longer meets the extension of coverage eligibility criteria or the parent separates from Lancaster County employment.
- A dependent must enroll for the extension of coverage no sooner than 31 days prior to and no later than 31 days after the date which they would otherwise lose coverage. Blue Cross Blue Shield must be contacted to obtain the extension of coverage enrollment form, or it may be printed from the County Benefits web page under Blue Cross/Blue Shield at <http://lincoln.ne.gov/city/person/risk/Enroll/BCBS%20LB551%20extension%20form.pdf>
- The premium for the extension of coverage is equal to the county's Blue Cross Blue Shield Total Single Employee only premium. No employer contribution will be provided. The dependent's extension of coverage premium will be deducted from the parent's salary on an after tax basis.
- Medical expenses incurred by the dependent will count towards the parent's family annual deductible and stop-loss maximum.
- Those dependents eligible for coverage as full time students (ages 19-23) will continue to be covered under the parent's policy with no additional premium.
- At the initial time of eligibility, a dependent will be offered an opportunity to enroll in COBRA or extension of coverage. If continuation coverage is elected, the dependent will not be eligible for COBRA coverage at a later date.
- Once a dependent cancels this extension of coverage, he or she may not re-enroll for coverage at a later date.

If you have any questions in this matter please contact City/County Personnel at 441-7597 or Blue Cross Blue Shield at (402) 390-1820. Extension of coverage requests must be made directly to Blue Cross Blue Shield as follows:

Blue Cross Blue Shield of Nebraska
Atten: Membership
PO Box 3248
7261 Mercy Road
Omaha, NE 68180

* A meeting to discuss this change has been scheduled for **Monday, Dec. 28, 2009** in the Commissioners Hearing Room (City Council Chambers) at **12 noon** with BCBS representatives.



**BlueCross BlueShield
of Nebraska**

An Independent Licensee of the Blue Cross and Blue Shield Association

**Extension of Coverage Request for
Extended Eligibility to Age 30**

Nebraska law allows a Dependent who ceases to be a full-time student or attains an age which exceeds the specified age at which coverage ceases pursuant to the plan, to continue coverage through the end of the month in which the child: (a) marries; (b) ceases to be a resident of the state, unless the child is under 19 years of age or is enrolled on a full-time basis in any college, university or trade school; (c) receives coverage under another health benefit plan or self-funded employee benefit plan; or (d) attains thirty years of age. The Subscriber will be billed an additional premium for such coverage equivalent to that of a single adult.

This form must be completed and returned to Blue Cross and Blue Shield of Nebraska no later than 31 days after the date in which the Dependent would otherwise lose coverage under the plan.

SECTION I

Name of Subscriber: _____

Address of Subscriber: _____

Identification Number or Social Security Number: _____

Name of Dependent: _____

Dependent's Date of Birth (Mo., Day, Year): _____

Address of Dependent: _____

Is the Dependent named above married: Yes No

If yes, provide the date of marriage: _____

Is the Dependent named above a resident of Nebraska: Yes No

If no, provide the date the Dependent moved from Nebraska: _____

Does the Dependent named above have other health insurance coverage: Yes No

If yes, provide the date coverage was effective: _____

SECTION II Acknowledgement & Signature

I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I understand that my premium will be increased in an amount equivalent to a single adult premium, and that I must pay my employer for this coverage. I authorize my employer to deduct from my earnings any required premiums.

Signature of Subscriber: _____

Date: _____

PLEASE NOTIFY YOUR EMPLOYER REGARDING YOUR INTENTION TO MAINTAIN COVERAGE FOR YOUR DEPENDENT

FOR BLUE CROSS AND BLUE SHIELD OF NEBRASKA ONLY

Approved Date: _____

Signature: _____

Rejected Date: _____