

BOARD OF COUNTY COMMISSIONERS
SARPY COUNTY, NEBRASKA

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

WHEREAS, pursuant to Neb. Rev. Stat. §23-104(6), 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, the powers of the County as a body are exercised by the County Board;

WHEREAS, the County of Sarpy desires to enter into a Master Group Application agreement with Blue Cross Blue Shield of Nebraska effective July 1, 2014 through June 30, 2015 for the purpose of providing health insurance for county employees, as outlined in the agreement attached hereto as Exhibit A;

WHEREAS, the County of Sarpy desires to renew its agreement with Employee Benefit Systems effective July 1, 2014 through June 30, 2015 for the purpose of partial self-funding for health insurance, as outlined in the agreement attached hereto as Exhibit B; and,

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

NOW, THEREFORE, BE IT RESOLVED by the Sarpy County Board of Commissioners that this Board hereby approves and adopts the Master Group Application agreement with Blue Cross Blue Shield of Nebraska, effective July 1, 2014 through June 30, 2015, a copy of which is attached as Exhibit A.

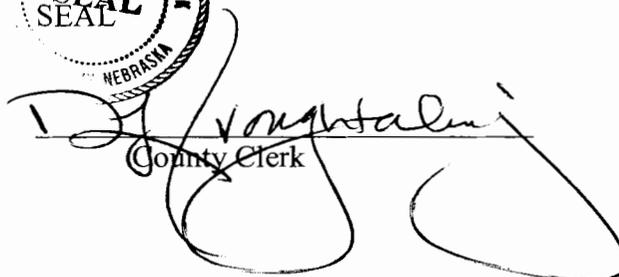
BE IT FURTHER RESOLVED by the Sarpy County Board of Commissioners that this Board hereby approves and adopts the renewal agreement with Employee Benefit Systems, effective July 1, 2014 through June 30, 2015, a copy of which is attached as Exhibit B.

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

The above Resolution was approved by a vote of the Sarpy County Board of Commissioners at a public meeting duly held in accordance with applicable law on the 3rd day of June, 2014.


 Sarpy County Board Chairman




 County Clerk

A



BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association

MASTER GROUP APPLICATION (INSURED)

Group type options: New Group, Renewal, Revision

Insurance options: Fully Insured, Minimum Premium

Group No. 300074, Roll No., Roll Listing Attached

Market Affiliation Code: 3349, Rate Pool Code: 0000, NAICS: 922110

Effective Date: The Master Group Contract shall be effective on 07/01/2014 ("Effective Date") provided this Application is accepted by Blue Cross and Blue Shield of Nebraska ("BCBSNE")...

APPLICANT INFORMATION

A. Applicant/Employer Sarpy County

Address 1261 Golden Gate Dr Ste 4E Papillion NE, 68046-2886

(Street) (City) (State, Zip Code)

Billing Address (if different) (Street/PO Box)

(City) (State) (Zip Code)

Group Leader/Group Health Plan Primary Contact (Name) Karen Buche

(Title) HR Director

(Phone) 402-593-4485

(FAX) 402-593-5781

(E-mail) kbuche@sarpy.com

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

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

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

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

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

Please provide name of the COBRA Administrator: Payflex

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

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

G. Does the Applicant have an HSA Administrator? Yes No If yes, identify the vendor below:

- BNY Mellon (01)
- US Bank (02)
- Other _____

(If BNY Mellon or US Bank is selected, attach completed HSA Employer Setup Form)

H. Does the Applicant have an HRA Administrator? Yes No If yes, identify the vendor:

- Cypress (31)
- MidAmerican (32)
- EBS (34)
- First Concord (35)
- Three Rivers (37)
- Other _____

(Internal use only: load vendor code and rider GEX219)

I. **Employee Data:** The following is from and agrees with your payroll and personnel records:

Total

- | | |
|--|------------------------------|
| 1. Total employees on the payroll (includes full-time, part-time, leased employees): | _____ 500 650 SKN |
| 2. Total eligible employees on the payroll on the effective date of the Contract | _____ |
| 3. Eligible employees not enrolling due to coverage | _____ |
| a. Number of employees with creditable coverage (Medicare, Medicaid, Spousal coverage) | _____ |
| b. Number of employees with individual coverage | _____ |
| c. Number of employees not enrolling due to cost or other reasons | _____ |
| 4. Eligible employees enrolling on the effective date of the Contract | _____ 250 574 SKN |
| 5. Persons on COBRA or State Continuation Coverage | _____ 1 |

J. **Other Applicant Information:** _____

ELIGIBILITY AND ENROLLMENT

A. An employee working a minimum of 30 hours per week (must be at least 17 1/2) on a regular calendar year basis will be eligible for coverage on the Group's next due date after such employee has completed an eligibility (probationary) waiting period of * days of service, and completes the applicable enrollment form. To remain eligible, the employee must continue to work the minimum number of hours per week required. If the Applicant includes Subgroups, the Subgroup application shall indicate the eligibility (probationary) waiting period, and the minimum number of hours necessary for eligibility.

If an otherwise eligible employee is not actively at work on the effective date for other than personal health reasons, coverage for that employee will go into effect on the Group's next due date following his/her return to active employment, subject to the receipt of an enrollment form within 31 days of the return-to-work date. As of the effective date indicated above, there are ~~8~~ 1 SKN such employees not actively working. (Attach list of names and corresponding social security numbers.)

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

Other eligibility provisions: _____

Active employees will be effective the first of the month following date of hire. If hired on the first of the month, effective date will be date of hire. Elected officials and chief deputies will be effective immediately upon taking office.

In the event that an employee suffers a death or disability in the line of duty as a direct result of the performance of his or her duties on behalf of the County, the spouse of said employee and/or any dependents of employee below the age of 26 years may maintain group health coverage through Sarpy County under the provisions of this article upon the payment of the appropriate premiums for family coverage and said spouse and/or dependents will continue to be eligible under the plan of benefits offered to active employees during the period that the spouse and/or dependents remain eligible for coverage. In the event that the spouse obtains coverage or is eligible for coverage through Medicare/Medicaid or through another group health coverage plan as a result of employment, eligibility for benefits under the line of duty death coverage listed herein shall be terminated. Eligibility for benefits under the line of duty death coverage shall also term upon the event of remarriage by the spouse.

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

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

Standard Membership Units

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

Alternate Membership Tiers

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

Other Enrollment Provisions: _____

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

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

Other Waiting Period provisions: For plan years on or after January 1, 2014, pre-existing condition waiting periods and exclusions are not permitted.

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

E. Late Enrollment: Late enrollment is only allowed during the open enrollment period, which is the month prior to the annual renewal date. Enrollment Forms must be signed by the last day of open enrollment and must be received by BCBSNE in a timely manner.

Other provisions: _____

F. Other Eligibility Provisions:

Endorsement Title or Description of Provision	Endorsement Number	Medical	Dental
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

EMPLOYER CONTRIBUTION AND MONTHLY CHARGES

A. Do you, as the employer, fund a portion of the employee's deductible and/or coinsurance liability on any option offered? Yes No
If yes, please provide the amount funded and applicable option: Amounts attached - In-Network Only

B. Please indicate the premium and employer's contribution to premium by completing the **App-Att-Employer Contribution and Monthly Charges Form**. The **App-Att-Employer Contribution and Monthly Charges Form** must be completed and attached to this Application.

C. It is understood that the amount shown as employer contribution will be paid by you without charge to the eligible employees and the remainder collected by you from the eligible employees by payroll deduction and remitted monthly to BCBSNE.

The monthly charges will not change prior to 07/01/2015. This rate guarantee and continuation of coverage is subject to the Applicant continuing to meet BCBSNE underwriting guidelines, including minimum requirements for participation and contribution. If the number of covered employees increases or decreases 5% or more, or the terms of the Contract are changed, BCBSNE reserves the right to change the rates.

Other provisions: _____

GROUP DATA FOR CALCULATION OF MEDICAL LOSS RATIO

As part of BCBSNE's compliance with the Patient Protection and Affordable Care Act, BCBSNE must collect information on group size in order to calculate and report medical loss ratios. On average, how many employees did you employ during the calendar year prior to the Effective Date written above? This total should include full-time, part-time, and seasonal employees, but exclude independent contractors. If your company has affiliated parent or sister companies that are members of the same control group for IRS reporting purposes, all employees in all the affiliated companies should be included in your total, whether or not the affiliated companies have coverage with BCBSNE.

- 50 or Fewer
- 51 or More

GROUP DATA FOR MEDICARE SECONDARY PAYER

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

A. **Employee Information:** Do you have employees or covered dependents enrolled in your group health plan who also currently have Medicare coverage or who are turning 65 this year? Yes No [(If yes, please attach a list of covered employees and dependents who currently have Medicare or who are turning 65 this year.)]

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

1. Do you have 20 or more employees for 20 or more calendar weeks during the current calendar year?
 Yes No If yes, please provide the date this threshold was reached 07/01/2007
2. Did you have 20 or more employees for 20 or more calendar weeks during the previous calendar year?
 Yes No If yes, please provide the date this threshold was reached 07/01/2007

3. Did you have 100 or more employees during 50 percent of your business days during the previous calendar year? Yes No

BENEFIT DESIGNS – COVERAGE ELECTION

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

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

- PPO Options – **App-Att-A**
- HSA-HDHP Options – **App-Att-B**
- Rx Nebraska Prescription Drug Program – **App-Att-C**
- Dental Coverage – **App-Att-D**
- Group Medicare Supplemental - Retirees Only – **App-Att-E**
- Three Tier PPO Options – **App-Att-I**
- Three Tier HSA-HDHP Options – **App-Att-J**
- 4718A – Benefit Schedule Attachment
- Other Benefit Plan Design 1 PPO Plan, Endorsement Summary

PROGRAMS AND SERVICES

Please describe: _____

AUTHORIZED PLAN CONTACTS

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

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

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

Authorized Plan Contacts:

Reason for Change: New Delete

Name: _____ Email: _____

Title: _____

Reason for Change: New Delete

Name: _____ Email: _____

Title: _____

Reason for Change: New Delete

Name: _____ Email: _____

Title: _____

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

APPLICANT CERTIFICATION AND SIGNATURE

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

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

Signature [Handwritten Signature]
Jim Thompson
(Typed Name)

Title Chairman
Chairman
(Typed Title)

Date 6-3-14

AGENT CERTIFICATION:

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

Signature [Handwritten Signature]
Mike Williams
(Typed Name)

Title Broker
Broker
(Typed Title)

Date 6-3-14

ACCEPTANCE BY BLUE CROSS AND BLUE SHIELD OF NEBRASKA:

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

Signature (Blue Cross and Blue Shield of Nebraska) Daniel W. Alm

Title **VP UNDERWRITING**

Date 7-14-14

The noted changes in this part are acceptable.

Signature of Applicant

Date

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

FOR OFFICIAL USE ONLY

Contract No.: Health _____ Dental _____ Med. Supp. _____

Endorsements:

APP-ATT-Summary of Benefits & Coverage (SBC)

Contract Form No. 96-067101/14 Group-Roll No. 300074, ALL__

UNIFORM SUMMARY OF BENEFITS & COVERAGE

In compliance with the Patient Protection and Affordable Care Act, beginning September 23, 2012, BCBSNE will make available to the Group Leader/Group Health Plan Primary Contact the Group's Uniform Summary of Benefits and Coverage (SBC).

The Group, on behalf of itself and any of its Subgroups, acknowledges that it has:

- * Received a copy of the SBC for the Group Health Plan; or *WAITING TO RECEIVE FROM ME*
- Been given information about how to access the SBC online.

The Group, on behalf of itself and any of its Subgroups, acknowledges and agrees as follows: (1) that it will provide the SBC to all active and eligible employees and their dependents who reside at another address (collectively "Employee"); (2) agrees to provide the SBC for all plan options available to the Employee; (3) agrees to provide the SBC in compliance with any instructions provided by BCBSNE; and (4) agrees to provide information to BCBSNE upon request to show compliance with this obligation.

The Group agrees to indemnify and hold BCBSNE harmless against any and all loss, damage, expenses, and penalties imposed by law with respect to the Group's failure to provide Employees with the SBC as agreed to herein.

Other Provisions

Schedule of Benefits Summary

Group Name: Sarpy County

Effective Date: July 01, 2014

Payment for Services	In-network Provider	Out-of-network Provider
<p>Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.</p>		
<p>Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$4,000 \$8,000</p>	<p>\$8,000 \$16,000</p>
<p>Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> Covered Person Pays 	<p>30%</p>	<p>50%</p>
<p>Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)</p> <ul style="list-style-type: none"> Individual Family 	<p>\$6,000 \$12,000</p>	<p>\$11,900 \$23,800</p>
<p>Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.</p>		
<p>In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.</p>		
<p>*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.</p>		

Copayment(s) (copay(s)) apply to:

- Physician Office
- Urgent Care Facility
- Emergency Care
- Allergy Injections
- Prescription Drugs

The Copay amount varies by the type of Covered Service. Refer to the appropriate category for benefit information.

Out-of-pocket Limit includes:

- Deductible
- Coinsurance
- Medical Copays
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Other Covered Services and supplies provided in the Physician’s Office (with or without an office visit billed) 	\$30 Copay \$75 Copay Applicable office visit Copay	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<ul style="list-style-type: none"> Allergy Injections and Serum (only one copay applies per day per provider) 	\$10 Copay	Deductible and Coinsurance
<ul style="list-style-type: none"> Other Injections 	Deductible and Coinsurance	Deductible and Coinsurance
<p>Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A physician assistant is covered in the same manner as a Primary Care Physician.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p>Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include: Allergy Injections & Serum; Other Injections; Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.</p>		
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services (a single copay applies to each urgent care visit)	\$45 Copay	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$250 Copay then Coinsurance Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services <ul style="list-style-type: none"> Health Care Reform (HCR) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) HCR required covered preventive services (outside of limits) Other covered preventive services not required by HCR 	Plan Pays 100% Plan Pays 100% Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Immunizations <ul style="list-style-type: none"> Pediatric (up to age 7) Age 7 and older Related to an illness 	Plan Pays 100% Plan Pays 100% Same as any other illness	Coinsurance Deductible and Coinsurance Same as any other illness

Mental Illness and/or Substance Dependence and Abuse covered services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services <ul style="list-style-type: none"> Office Services All Other Outpatient Items & Services 	\$30 Copay Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$250 Copay then Coinsurance Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) <ul style="list-style-type: none"> • Ground Ambulance • Air Ambulance 	\$100 Copay \$100 Copay	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other outpatient settings)	Not Covered	Not Covered
<p>(NOTE: Some prescription drugs and covered services administered in an outpatient setting, other than a hospital emergency room, are only payable under the Prescription Drug category. A list of these drugs and covered services is available on the website www.nebraskablue.com or by contacting the Member Services Department.)</p>		
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory <ul style="list-style-type: none"> • Diagnostic • Preventive 	Plan Pays 100% Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility <ul style="list-style-type: none"> • Services to diagnose • Treatment to promote fertility 	Same as any other illness Not Covered	Same as any other illness Not Covered
Nicotine Addiction <ul style="list-style-type: none"> • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture 	Same as Substance Dependence and Abuse Not Covered	Same as Substance Dependence and Abuse Not Covered
Obesity <ul style="list-style-type: none"> • Non-surgical treatment • Surgical Treatment 	Not Covered Not Covered	Not Covered Not Covered
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care <ul style="list-style-type: none"> • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services <ul style="list-style-type: none"> • Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies (attended sleep study)	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations <ul style="list-style-type: none"> • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Vision Exams <ul style="list-style-type: none"> • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction) limited to one exam per Calendar Year 	See Physician Office Services See Preventive Services	See Physician Office Services See Preventive Services
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs	In-network Provider	Out-of-network Provider
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable) <ul style="list-style-type: none"> • Individual • Family 		Not Applicable Not Applicable
Retail – per 30-day supply <ul style="list-style-type: none"> • Generic drugs (including non-formulary contraceptives) • Formulary Brand Name Drugs • Non-formulary Brand Name Drugs 	\$10 Copay \$40 Copay \$75 Copay	\$10 Copay + 25% Penalty \$40 Copay + 25% Penalty \$75 Copay + 25% Penalty
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy subject to 3 copays		
Mail order – per 90-day supply <ul style="list-style-type: none"> • Generic drugs (including non-formulary contraceptives) • Formulary Brand Name Drugs • Non-formulary Brand Name Drugs 	\$30 Copay \$120 Copay \$225 Copay	Not Covered Not Covered Not Covered
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)	\$100 Copay	Not Covered
Contraceptives <ul style="list-style-type: none"> • Formulary <ul style="list-style-type: none"> - Generic - Brand Name • Non-formulary <ul style="list-style-type: none"> - Generic - Brand Name 	Plan Pays 100% Plan Pays 100%	25% Penalty 25% Penalty
	Same as any other Generic Drugs Same as any other Non-formulary Brand Name	
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity FDA approved prescription drugs	Not Covered	Not Covered

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Sarpy County 2014-15 Partial Self Fund Amounts:

Deductible	Actual	Employee Pays
Single	\$4,000	\$500
Family	\$8,000	\$1,000
Total Out of Pocket Max	Actual	Employee Pays
Single	\$6,000	\$3,500
Family	\$12,000	\$7,000

APP-ATT-C

RX Nebraska Prescription Drug Program

Contract Form No. 96-067-I 1/2014 Group – Roll No. 300074 - ALL Option 1

Standard Benefits – Covered and noncovered services as stated in Master Group Contract.

- Integrated Benefits (RX applies to medical deductible and coinsurance limit)**
- HSA Eligible Plan
 - [Endorsement 3-00083] Other Endorsement: _____
 - Non HSA Eligible Plan
 - Endorsement: _____

A. Benefit Design Options

RX Plan Options:

- Option 1 Option 2 Option 3 Option 4 Option 5 Option 6 Option 7 Option 8

Generics Plus Formulary: Option 9 Option 10

Mail Order Benefits: Yes No

Maximum Day Supply:

Retail: 90-Day Supply ___Day Supply
 Mail Order (if applicable): 90-Day Supply ___Day Supply

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

Calendar Year Copayment/Coinsurance Maximum: Yes No Amount: \$ _____
 Individual: Yes No Amount: \$ _____
 Family: Yes No Amount: \$ _____ Aggregate Embedded _____

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

Copayment/Coinsurance Amounts:

(If Integrated Benefits, the medical deductible applies prior to Copay.)

	<u>Copay \$</u>	<u>Coinsurance%</u>	<u>Minimum \$/%</u>	<u>Maximum \$/%</u>
Retail and Mail Order:				
<input checked="" type="checkbox"/> Generic = Tier 1:	\$10			
<input checked="" type="checkbox"/> Formulary Brand = Tier 2	\$40			
<input checked="" type="checkbox"/> Non-Formulary Brand = Tier 3	\$75			

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

Fertility Drugs and Medicinals: Yes No [Endorsement 3-00019]

- Option 1 - \$2,500 maximum
- Option 2 - \$5,000 maximum
- Option 3 - \$7,500 maximum

B. Specialty Pharmacy Benefit

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

Mandatory Specialty Pharmacy: Specialty Drugs must be purchased at an In-network Specialty Pharmacy. This benefit allows two specialty medication fills at any In-network retail pharmacy.

Cost Share for Specialty Pharmacy:

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

3-Tier Specialty: Same copay/coinsurance structure as retail Different copay/coinsurance structure

	<u>Copay \$</u>	<u>Coinsurance%</u>	<u>Minimum \$/%</u>	<u>Maximum \$/%</u>
<input type="checkbox"/> Generic = Tier 1:	_____	_____	_____	_____
<input type="checkbox"/> Formulary Brand = Tier 2	_____	_____	_____	_____
<input type="checkbox"/> Non-Formulary Brand = Tier 3	_____	_____	_____	_____
OR				
<input checked="" type="checkbox"/> Specialty = Tier 4	\$100	_____	_____	_____

C. Pharmacy Preauthorization Programs: Preauthorization is required for the Programs below, and for the medications identified on the Prescription Drug Preauthorization list maintained on the BCBSNE website www.nebraskablue.com.

COX-2 Inhibitor Preauthorization Program
Proton Pump Inhibitor Therapy Preauthorization Program
Other: Diabetic Test Strip Preauthorization Program

D. Other Rx Nebraska or Cost-share Provisions:
RX is non-structured plan. Non-sedating Antihistamines covered.

Blue Cross and Blue Shield of Nebraska

Endorsement Summary

Group Name: Sarpy County Effective Date: 07/01/2014

Market Affiliation Code: 3349 Group Number(s): 300074 Roll Number(s): ALL

Medical Contract No.: 96-067 I 1/2014 Dental Contract No.: _____

This form is intended to identify those endorsements that amend the Master Group Contract of the group coverage described above and should be considered a part of the Master Group Application.

Endorsement #	Title	Applicable Group/Roll/Option Number/Name	Medical	HDHP	Dental
3-00005	Internal Claims and Appeals and External Review (Process G)	All			
3-00232	Orally Administered Anti-Cancer Medications - PPO	All			
3-00018	PREVENTIVE VISION EXAMINATIONS	All			

Please note, additional endorsements may be added as required for legal and/or contractual purposes. You will be notified of any additions after the Master Group Application processing is completed.

Miscellaneous Notes

Medical	Most closely matches structured Option 13, however, also contains Ambulance co-pay.
----------------	--

Dental	
---------------	--

Other	
--------------	--

APP-ATT-EMPLOYER CONTRIBUTION AND MONTHLY CHARGES FORM

Contract Form No. 96-067-1.1/14

Group-Roll No. 300074- All

EMPLOYER CONTRIBUTION AND MONTHLY CHARGES

- Please check this box if you are only contributing towards the cost of the employee only (single) rate for all tiers of coverage.
- For Health Coverage Only:** Please check this box if the employer contribution is different among employees within the same option. (For example, employer pays 85 percent of premium for employees earning less than \$35,000; the employer pays 80 percent for those making 35,000 to \$99,999; and the employer pays 75 percent for those earning more than \$100,000.) If you checked this box, please describe the different employer contribution scenarios:

Option: [Option 1]

Option: []

	Employer Contribution			Total Monthly Charge	Employer Contribution			Total Monthly Charge
	Percent	or	Fixed Amount		Percent	or	Fixed Amount	
<input checked="" type="checkbox"/> Single	90%			\$631.37				
<input checked="" type="checkbox"/> Family	83%			\$1,443.99				
<input checked="" type="checkbox"/> Employee & Spouse	83%			\$1,259.12				
<input checked="" type="checkbox"/> Employee & Child/ren	83%			\$1,259.12				
<input type="checkbox"/> Employee & One Dependent								
<input type="checkbox"/> Employee & Two or More Dependents								

Option: []

Option: []

	Employer Contribution			Total Monthly Charge	Employer Contribution			Total Monthly Charge
	Percent	or	Fixed Amount		Percent	or	Fixed Amount	
<input type="checkbox"/> Single								
<input type="checkbox"/> Family								
<input type="checkbox"/> Employee & Spouse								
<input type="checkbox"/> Employee & Child/ren								
<input type="checkbox"/> Employee & One Dependent								
<input type="checkbox"/> Employee & Two or More Dependents								

Other Monthly Charge or Contribution Provisions: _____



**BlueCross BlueShield
of Nebraska**

An Independent Licensee of the Blue Cross and Blue Shield Association

**MASTER GROUP APPLICATION
Roll Listing**

Group ID	Roll ID	Roll Name
300074	01	SARPY COUNTY
300074	02	SARPY COUNTY-RETIREEES
300074	03	SARPY COUNTY
300074	99	SARPY COUNTY-COBRA

Roll Addition/Deletion		
Group ID	Roll ID	Roll Name

Break Out Code	
Code	Description

	2013 - 2014 Group Health Plan Blue Cross/Blue Shield of Nebraska Blue Preferred PPO		2013 -2014 Partial Self Fund Blue Cross/Blue Shield of Nebraska Blue Preferred PPO	
Referred Provider Organization	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFIT OVERVIEW				
<u>Deductible</u>				
Single	\$4,000	\$8,000	\$500	\$8,000
Family	\$8,000	\$16,000	\$1,000	\$16,000
Coinsurance	70% / 30%	50% / 50%	70% / 30%	50% / 50%
<u>Out of Pocket Maximum</u>				
Single (includes the deductible)	\$5,000	\$11,900	\$2,500	\$11,900
Family (includes the deductible)	\$10,000	\$23,800	\$5,000	\$23,800
BENEFIT HIGHLIGHTS				
<u>Physician Visit</u>	\$30 Copayment per visit \$60 Copayment for Specialist	Deductible then 50% Deductible then 50%	\$30 Copayment per visit \$60 Copayment for Specialist	Deductible then 50% Deductible then 50%
<u>Preventive Services</u>				
ADULT	Plan Pays 100%	Deductible then 50%	Plan Pays 100%	Deductible then 50%
CHILD/BABY	Plan Pays 100%	Deductible then 50%	Plan Pays 100%	Deductible then 50%
<u>Emergency Room Urgent Care Center</u>	\$100 Copayment per visit then 30% \$30 Copayment per visit	\$100 Copayment per visit then 30% Deductible then 50%	\$100 Copayment per visit then 30% \$30 Copayment per visit	\$100 Copayment per visit then 30% Deductible then 50%
<u>Hospital Services</u>				
Inpatient	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Maternity	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
<u>Prescription Drugs</u>	Generic --- \$10.00 / Brand Formulary --- \$40.00 / Brand Non-Formulary --- \$60.00	Generic --- \$10.00 + 25% Brand Formulary --- \$40.00 + 25% Brand Non-Formulary --- \$60.00 + 25%	Generic --- \$10.00 / Brand Formulary --- \$40.00 / Brand Non-Formulary --- \$60.00	Generic --- \$10.00 + 25% Brand Formulary --- \$40.00 + 25% Brand Non-Formulary --- \$60.00 + 25%
<u>Overall Lifetime Maximum</u>	UNLIMITED		UNLIMITED	

NOTE:

) This is a summary of benefits provided by the plans. Refer to the carrier's descriptive material for a full discussion of benefits and rates.

Sarpy County

Medical Benefit Analysis

Effective Date July 1, 2014

Williams-Deras & Associates
Holmes-Murphy

May-14

	2014 Proposed Renewal Blue Cross/Blue Shield of Nebraska Blue Preferred PPO		2014 Proposed Renewal / Partial Self Fund Blue Cross/Blue Shield of Nebraska Blue Preferred PPO	
Preferred Provider Organization	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFIT OVERVIEW				
<u>Deductible</u>				
Single	\$4,000	\$8,000	\$500	\$8,000
Family	\$8,000	\$16,000	\$1,000	\$16,000
Coinsurance	70% / 30%	50% / 50%	70% / 30%	50% / 50%
<u>Out of Pocket Maximum</u>				
Single (includes the deductible)		\$11,900		\$11,900
Family (includes the deductible)		\$23,800		\$23,800
BENEFIT HIGHLIGHTS				
<u>Physician Visit</u>	\$30 Copayment per visit \$75 Copayment for Specialist	Deductible then 50% Deductible then 50%	\$30 Copayment per visit \$75 Copayment for Specialist	Deductible then 50% Deductible then 50%
<u>Preventive Services</u>				
ADULT	Plan Pays 100%	Deductible then 50%	Plan Pays 100%	Deductible then 50%
CHILD/BABY	Plan Pays 100%	Deductible then 50%	Plan Pays 100%	Deductible then 50%
Emergency Room Urgent Care Center	\$250 Copayment per visit then 30% \$45 Copayment per visit	\$250 Copayment per visit then 30% Deductible then 50%	\$250 Copayment per visit then 30% \$45 Copayment per visit	\$250 Copayment per visit then 30% Deductible then 50%
<u>Hospital Services</u>				
Inpatient	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Maternity	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
<u>Prescription Drugs</u>	Generic --- \$10.00 / Brand Formulary --- \$40.00 / Brand Non-Formulary --- \$75.00 Specialty --- \$100.00	Generic --- \$10.00 + 25% Brand Formulary --- \$40.00 + 25% Brand Non-Formulary --- \$75.00 + 25% Specialty --- NA	Generic --- \$10.00 / Brand Formulary --- \$40.00 / Brand Non-Formulary --- \$75.00 Specialty --- \$100.00	Generic --- \$10.00 + 25% Brand Formulary --- \$40.00 + 25% Brand Non-Formulary --- \$75.00 + 25% Specialty --- NA
Overall Lifetime Maximum	UNLIMITED		UNLIMITED	

NOTE:

1) This is a summary of benefits provided by the plans. Refer to the carrier's descriptive material for a full discussion of benefits and rates.

Sarpy County

Medical Coverage Rate Comparison

Medical Rates	Proposed	COUNTY SHARE PREMIUM	EMPLOYEE SHARE PREMIUM	INCREASE IN EMPLOYEE SHARE CURRENT VS PROPOSED
	\$6,000 / \$12,000 Max OPM / 70-30			
	\$3,500 / \$7,000 PSF OPM			
Employee	\$689.95	\$620.96	\$68.99	\$4.37
Employee / Spouse	\$1,463.42	\$1,214.64	\$248.78	\$15.92
Employee / Child(ren)	\$1,463.42	\$1,214.64	\$248.78	\$15.92
Family	\$1,662.03	\$1,379.48	\$282.55	\$18.26

Medical Rates	Current BC/BS of NE	COUNTY SHARE PREMIUM	EMPLOYEE SHARE PREMIUM
	\$5,000 / \$10,000 Max OPM / 70-30		
	\$2,500 / \$5,000 PSF OPM		
Employee	\$646.25	\$581.63	\$64.62
Employee / Spouse	\$1,369.79	\$1,136.93	\$232.86
Employee / Child(ren)	\$1,369.79	\$1,136.93	\$232.86
Family	\$1,554.66	\$1,290.37	\$264.29

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

B

THIS AGREEMENT effective July 1, 2014 is made by and between Sarpy County ("Client"), a Political Sub-division of the State of Nebraska, and Employee Benefit Systems ("Administrator"), an Iowa corporation.

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

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

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

1. APPOINTMENT.

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

2. COMPLIANCE WITH LAWS.

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

3. BOND.

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

4. INSURANCE.

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

5. INDEPENDENT CONTRACTOR.

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

6. STATUS OF ADMINISTRATOR.

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

7. LICENSES.

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

8. RECORDS.

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

9. CONFIDENTIALITY.

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

10. COMPENSATION.

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

All benefits will be paid with the care, skill, diligence and impartiality normally expected of a third-party administrator in the insurance industry. Client shall indemnify and hold Administrator harmless for any liability relating to Prior Reimbursement Requests and/or Prior Administration.

All forms, materials and computerized checks used by Administrator will be provided at Administrator's expense. Booklet printing charges are not contemplated under this agreement and will be separately contracted for as necessary. Enrollment packet information can be provided in an electronic pdf format upon request. Printed material provided at an additional cost.

11. FINANCIAL REQUIREMENTS.

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

12. CLIENT RESPONSIBILITIES.

Client shall provide a method of notification to Administrator detailing the eligibility of new members enrolled and those persons that are no longer eligible for the benefit. In the absence of notification (of

termination or loss of benefit coverage), eligibility for payment of the claim or other benefit will continue.

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

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

13. CLAIMS APPEALS.

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

14. TERM & TERMINATION.

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

15. INDEMNIFICATION AND HOLD HARMLESS.

- a. Client shall indemnify Administrator and hold it harmless from and against all loss, liability, damage, expense, attorney's fees, or other obligations resulting from, or arising out of, any act or omission of Client in connection with the Program, or claim, demand, or lawsuit by Program Participants and beneficiaries against Administrator in connection with benefit payments or services performed (or not performed) hereunder. In addition, Client shall indemnify Administrator and hold it harmless from and against any liability, expense, demand, or other obligation resulting from or arising out of any premium charge, tax, or similar assessment (federal or state), for which the Program or Client is liable. Client shall also have the indemnification obligation described in Section 10.

- b. Administrator shall indemnify Client and hold it harmless from and against all loss, liability, damage, expense, attorney's fees or other obligations resulting from, or arising out of, any act or omission of Administrator in connection with the Program, or claim, demand, or lawsuit by Program Participants and beneficiaries against Client in connection with benefit payments or services performed (or not performed) by Administrator hereunder. In addition, Administrator shall indemnify Client and hold it harmless from and against any liability, expense, demand, or other obligation resulting from or arising out of any premium charge, tax, or similar assessment (federal or state), for which the Administrator is liable.

16. GENERAL PROVISIONS

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

Employee Benefit Systems



Mark Lehman, CFO

7/14/14

Date

Sarpy County



Authorized Signature & Title

6-3-14

Date

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

**ADDENDUM (B)
BUSINESS ASSOCIATE AGREEMENT**

This Agreement ("Agreement") is effective upon execution by and between Employee Benefit Systems ("Business Associate") and Sarpy County ("Covered Entity").

Covered Entity and Business Associate mutually agree to comply with the requirements of the implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Agreement shall supersede any prior business associate agreement.

1. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION.

(a) Permitted Uses and Disclosures. Business Associate is permitted to use and disclose Protected Health Information that it creates or received on Covered Entity's behalf or receives from Covered Entity (or another business associate of Covered Entity) and to request Protected Health Information on Covered Entity's behalf (collectively, "Covered Entity's Protected Health Information") only:

- (i) *Functions and Activities on Covered Entity's Behalf.* Except as otherwise limited in this Agreement, to perform functions, activities, or services for, or on behalf of Covered Entity as such services may be specified in any underlying agreement(s), provided that such use or disclosure would not violate 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information" (the "Privacy Rule") or 45 C.F.R. Part 164, Subpart C "Security Standards for the Protection of Electronic Protected Health Information" (the "Security Rule") if done by Covered Entity.
- (ii) *Business Associate's Operations.* For Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities, provided that, with respect to disclosure of Covered Entity's Protected Health Information, either:
 - (a) The disclosure is Required by Law; or
 - (b) Business Associate obtains reasonable assurance from any person or entity to which Business Associate will disclose Covered Entity's Protected Health Information that the person or entity will:
 - (1) Hold Covered Entity's Protected Health Information in confidence and use or further disclose Covered Entity's Protected Health Information only for the purpose of which Business Associate disclosed Covered Entity's Protected Health Information to the person or entity or as Required by Law; and
 - (2) Promptly notify Business Associate (who will in turn notify Covered Entity in accordance with Section 4(a)) of any instance of which the person or entity becomes aware in which the confidentiality of Covered Entity's Protected Health Information was Breached.
- (iii) *Minimum Necessary.* Business Associate will, in its performance of the functions, activities, services, and operations specified in Section 1(a), make reasonable efforts to use, to disclose, and to request only the minimum amount of Covered Entity's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that Business Associate will not be obligated to comply with this minimum necessary limitation if neither Business Associate nor Covered Entity is required to limit the use, disclosure or request to the minimum necessary. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in

accordance with the American Recovery and Reinvestment Act and government guidance on the definition.

- (b) Prohibition on Unauthorized Use or Disclosure. Business Associate will neither use nor disclose Covered Entity's Protected Health Information, except as permitted or required by this Agreement or in writing by Covered Entity or as Required by Law. This Agreement does not authorize Business Associate to use or disclose Covered Entity's Protected Health Information in a manner that will violate the Privacy Rule or the Security Rule if done by Covered Entity, except as set forth in Section 1(a)(ii).
- (c) Information Safeguards.
 - (i) *Privacy of Covered Entity's Protected Health Information.* Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of Covered Entity's Protected Health Information. The safeguards must reasonably protect Covered Entity's Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.
 - (ii) *Security of Covered Entity's Electronic Protected Health Information.* Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C. Business Associate shall comply with all applicable provisions of the Security Rule, 45 C.F.R. Part 164, Subpart C.
- (d) Subcontractors and Agents. Business Associate will require any of its subcontractors and agents, to which Business Associate is permitted by this Agreement or in writing by Covered Entity to disclose Covered Entity's Protected Health Information and/or Electronic Protected Health Information, to agree to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information, including but not limited to compliance with the applicable requirements of 45 C.F.R. Parts 160, 162 and 164. Such agreement between Business Associate and the subcontractor or agent must be made in writing and must comply with the terms of this Agreement and the requirements outlined at 45 C.F.R. §§ 164.504(e) and 164.314.
- (e) Prohibition on Certain Activities. Business Associate shall not: (i) sell Protected Health Information (within the meaning of 45 C.F.R. § 164.508); (ii) use or disclose Protected Health Information for fundraising purposes (within the meaning of 45 C.F.R. § 164.514); (iii) use or disclose Protected Health Information for research (within the meaning of 45 C.F.R. § 164.512); (iv) use genetic information for underwriting purposes (within the meaning of 45 C.F.R. § 164.514); or (v) use or disclose Protected Health Information for marketing purposes (within the meaning of 45 C.F.R. §164.508). Business Associate shall not de-identify Covered Entity's Protected Health Information except if required to perform activities on behalf of Covered Entity, as specified in Section 1(a)(i) of this Agreement.

2. COMPLIANCE WITH TRANSACTION STANDARDS.

If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which DHHS has established Standards, Business Associate will comply, and will require any subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Transaction Rule, 45 C.F.R. Part 162 and any related operating rules. Business Associate shall comply with the National Provider Identified requirements, if and to the extent

applicable. Business Associate shall provide to Covered Entity any documentation or compliance with the Transaction Rule with Covered Entity may reasonably need, if any, pursuant to section 1104(b) of the Patient Protection and Affordable Care Act, as amended. Business Associate will not enter into, or permit its subcontractors or agents to enter into, any Trading Partner Agreement in connection with the conduct of Standard Transactions on behalf of Covered Entity that:

- (a) Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;
- (b) Adds any data element or segment to the maximum defined data set;
- (c) Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or
- (d) Changes the meaning or intent of the Standard Transaction's implementation specification.

3. **INDIVIDUAL RIGHTS.**

- (a) **Access.** Business Associate will, within 30 calendar days following Covered Entity's request, make available to Covered Entity or, at Covered Entity's direction, to an individual (or the individual's personal representative) for inspection and obtaining copies Covered Entity's Protected Health Information about the individual that is in Business Associate's custody or control, so that Covered Entity may meet its access obligations under 45 C.F.R. §164.524. Effective as of September 23, 2013 and thereafter, if the Protected Health Information is held electronically in a designated record set, then the individual shall have a right to obtain from Business Associate a copy of such information in the electronic form and format requested by the individual, if it is readily producible in such form and format. If it is not so readily producible, Business Associate will provide it in a readable electronic form and format as reasonably requested by Covered Entity or, if Business Associate is dealing directly with the individual, the individual. Business Associate shall provide such a copy to Covered Entity or, alternatively, to the individual directly, if such alternative choice is clearly, conspicuously and specifically made by the individual or Covered Entity. In addition, if the individual's request for access directs that the Protected Health Information be transmitted directly to another person designated by the individual, Business Associate must provide the copy to the person designated by the individual, provided the individual's request: (i) is in writing; (ii) is signed by the individual; and (iii) clearly identifies the designated person and where to send the copy of Protected Health Information. If Business Associate provides such a copy to that designated person, Business Associate will promptly notify Covered Entity of this fact.
- (b) **Amendment.** Business Associate will, within 60 calendar days following notice from Covered Entity, amend or permit Covered Entity access to amend any portion of Covered Entity's Protected Health Information, so that Covered Entity may meet its amendment obligations under 45 C.F.R. §164.526.
- (c) **Disclosure Accounting.** So that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. §164.528:
 - (i) ***Disclosures Subject to Accounting.*** Business Associate will record the information specified in Section 3(c)(iii) below ("Disclosure Information") for each disclosure of Covered Entity's Protected Health Information, not excepted from disclosure accounting as specified in Section 3(c)(ii) below, that Business Associate makes to Covered Entity or to a third party.

- (ii) *Disclosures Not Subject to Accounting.* Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of Covered Entity's Protected Health Information if Covered Entity need not account for such disclosures.
- (iii) *Disclosure Information.* With respect to any disclosure by Business Associate of Covered Entity's Protected Health Information that is not excepted from disclosure accounting by Section 3(c)(ii) above, Business Associate will record the following Disclosure Information as applicable to the type of accountable disclosure made:
 - (a) *Disclosure Information Generally.* Except for repetitive disclosures of Covered Entity's Protected Health Information as specified in Section 3(c)(iii)(b) below, the Disclosure Information that Business Associate must record for each accountable disclosure is (i) the disclosure date, (ii) the name and (if known) address of the entity to which Business Associate made the disclosure, (iii) a brief description of the Covered Entity's Protected Health Information disclosed, and (iv) a brief statement of the purpose of disclosure.
 - (b) *Disclosure Information for Multiple Disclosures.* For multiple disclosures of Covered Entity's Protected Health Information that Business Associate makes for a single purpose to the same person or entity (including Covered Entity), the Disclosure Information that Business Associate must record is either the Disclosure Information specified in Section 3(c)(iii)(a) above for each accountable disclosure, or (i) the Disclosure Information specified in Section 3(c)(iii)(a) above for the first of the repetitive accountable disclosures; (ii) the frequency, periodicity, or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.
- (iv) *Availability of Disclosure Information.* Business Associate will maintain the Disclosure Information for at least 6 years following the date of the accountable disclosure to which the Disclosure Information relates.

Business Associate will make the Disclosure Information available to Covered Entity within 60 calendar days following Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting.

- (d) Restriction Agreements and Confidential Communications. Business Associate will comply with any agreement that Covered Entity makes that either (i) restricts use or disclosure of Covered Entity's Protected Health Information pursuant to 45 C.F.R. §164.522(a), or (ii) requires confidential communications about Covered Entity's Protected Health Information pursuant to 45 C.F.R. §164.522(b), provided that Covered Entity notifies Business Associate in writing of the restriction or confidential communication obligations that Business Associate must follow. Covered Entity will promptly notify Business Associate in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct Business Associate whether any of Covered Entity's Protected Health Information will remain subject to the terms of the restriction agreement.

4. **BREACHES AND SECURITY INCIDENTS.**

- (a) Reporting.
 - (i) *Privacy or Security Breach.* Business Associate will report to Covered Entity any use or disclosure of Covered Entity's Protected Health Information not permitted by this Agreement or in writing by Covered Entity, along with any Breach (or possible Breach) of Covered Entity's Unsecured Protected Health Information. In connection with this report to Covered Entity, Business Associate will prepare a written risk assessment for

each Breach or possible Breach and shall provide a copy of such risk assessment to Covered Entity. Business Associate will treat the Breach as being Discovered in accordance with HIPAA's requirements. Business Associate will make the report to Covered Entity's Privacy Official not more than 30 calendar days after Business Associate learns of such non-permitted use or disclosure. If a delay is requested by a law enforcement official in accordance with 45 C.F.R. §164-412, Business Associate may delay notifying Covered Entity for the time period specified by such regulation. Business Associate's report will at least:

- (a) Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;
 - (b) Identify Covered Entity's Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, social security number, date of birth, home address, account number or other information were involved) on an individual-by-individual basis;
 - (c) Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;
 - (d) Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;
 - (e) Identify what steps the individuals who were subject to a Breach should take to protect themselves; and
 - (f) Provide such other information, including a written report, as Covered Entity may reasonably request.
- (ii) *Security Incidents.* Business Associate will report to Covered Entity within 30 calendar days any attempted or successful (A) unauthorized access, use, disclosure, modification, or destruction of Covered Entity's Electronic Protected Health Information or (B) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware. Business Associate will make this report upon Covered Entity's request, except if any such security incident resulted in a disclosure or Breach of Covered Entity's Protected Health Information or Electronic Protected Health Information not permitted by this Agreement, Business Associate will make the report in accordance with Section 4(a)(i).

(b) Termination of Agreement.

- (i) *Termination Resulting from the End of Relationship, Functions or Services.* This Agreement shall terminate in the event that the underlying relationship, functions, or services that give rise to the necessity of a Business Associate Agreement terminate for any reason.
- (ii) *Right to Terminate for Breach.* Covered Entity may terminate Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement and upon written notice to Business Associate of the breach, Business Associate fails to cure the breach within 30 calendar days after receipt of the notice. Covered Entity may exercise this right to terminate Agreement by providing Business Associate written notice of termination, stating the failure to cure the breach of the Agreement that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in Covered Entity's notice of termination.

(iii) *Obligations on Termination.*

- (a) Return or Destruction of Covered Entity's Protected Health Information as Feasible. Upon termination or other conclusion of Agreement, Business Associate will, if feasible, return to Covered Entity or destroy all of Covered Entity's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived there from that allow identification of any individual who is a subject of Covered Entity's Protected Health Information. Business Associate will require any subcontractor or agent, to which Business Associate has disclosed Covered Entity's Protected Health Information as permitted by Section 1(e) of this Agreement, to if feasible return to Business Associate (so that Business Associate may return it to Covered Entity) or destroy all of Covered Entity's Protected Health Information in whatever form or medium received from Business Associate, including all copies thereof and all data, compilations, and other works derived there from that allow identification of any individual who is a subject of Covered Entity's Protected Health Information, and certify on oath to Business Associate that all such information has been returned or destroyed. Business Associate will complete these obligations as promptly as possible, but not later than 60 calendar days following the effective date of the termination or other conclusion of Agreement.
- (b) Procedure When Return or Destruction Is Not Feasible. Business Associate will identify any of Covered Entity's Protected Health Information, including any that Business Associate has disclosed to subcontractors or agents, as permitted by Section 1(e) of this Agreement, that cannot feasibly be returned to Covered Entity or destroyed and explain why return or destruction is infeasible. Business Associate will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. Business Associate will require such subcontractor or agent to limit its further use or disclosure of Covered Entity's Protected Health Information that such subcontractor or agent cannot feasibly return or destroy to those purposes that make the return or destruction of such information infeasible. Business Associate will complete these obligations as promptly as possible, but not later than 60 calendar days following the effective date of the termination or other conclusion of Agreement.
- (c) Continuing Privacy and Security Obligations. Business Associate's obligation to protect the privacy and safeguard the security of Covered Entity's Protected Health Information as specified in this Agreement will be continuous and survive termination or other conclusion of this Agreement.

5. **GENERAL PROVISIONS.**

- (a) Inspection of Internal Practices, Books, and Records. Business Associate will make its internal practices, books, and records relating to its use and disclosure of Covered Entity's Protected Health Information available to Covered Entity and to DHHS to determine Covered Entity's compliance with the Privacy Rule, 45 C.F.R. Part 164, Subpart E.
- (b) Definitions. All terms that are used but not otherwise defined in this Agreement shall have the meaning specified under HIPAA, including its statute, regulations and other official government guidance. For purposes of this Agreement, Covered Entity's Protected Health Information encompasses Covered Entity's Electronic Protected Health Information.

- (c) Amendment to Agreement. Upon the compliance date of any final regulation or amendment to final regulation promulgated by DHHS that affects Business Associate's use or disclosure of Covered Entity's Protected Health Information or Standard Transactions this Agreement will automatically amend such that the obligations imposed on Business Associate remain in compliance with the final regulation or amendment to final regulation.
- (d) No Third Party Beneficiaries. Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.
- (e) Delegation to Business Associate. To the extent the parties agree that Business Associate will carry out directly one or more of Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations.
- (f) No Agency Relationship. Both parties agree that Business Associate is not, and shall not be deemed to be, an agent of Covered Entity.

Employee Benefit Systems

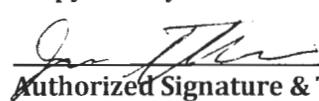


Mark Lehman, CFO

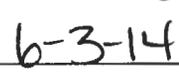


Date

Sarpy County



Authorized Signature & Title



Date

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

ADDENDUM (C) RESPONSIBILITY AGREEMENT

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

1. Group Setup and Renewal Information

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

2. Adds, Changes or Terminations

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

3. Report Verification

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

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

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

5. Claim Funding (if applicable)

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

6. IRS Reporting (if applicable)

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

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

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

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

1. Adds, Changes or Terminations

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

2. Claims Processing (if applicable)

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

3. Reports

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

4. ID Cards (if applicable)

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

Employee Benefit Systems

Mark Lehman
Mark Lehman, CFO

7/12/14
Date

Sarpy County

[Signature]
Authorized Signature & Title

6-3-14
Date





PSF Renewal

Client Number: 49130

Plan Year: 07/01/2014 - 06/30/2015

Section A- Client Information

Client: Sarpy County Tax ID: 47-6006504
 Address: EAST ANNEX: 1261 Golden Gate Dr. Suite 4E City, State, ZIP: Papillion, NE 68046-2895
 Telephone: 402-593-4485 Fax: 402-593-5781
 Contact: Karen Buche Title: HR Director
 Email: kbuche@sarpy.com
 Agency: Williams-Deras Address: 10040 Regency Cir, Ste. 345, Omaha, NE 68114
 Agent: Mike Williams/Stephanie Dow Telephone: 402-398-9898
 Email: steph@williamsderas.com

Section B- PSF Plan Information

PRIMARY PLAN (PURCHASED PLAN)

Carrier: BCBS NE Group Plan Number: 300074
 Is this a Grandfathered Plan? Yes No 4th Quarter Carryover? Yes No
 Please indicate any changes: Deductible OPM Co-insurance Co-pays Other No changes
 Does the family plan pay after one person in the family meets the single deductible or does the total family deductible have to be met?
 1 person Total family
 Do the in-network and non-network deductibles apply toward each other? Yes No

	In-Network		Non-Network	
	Single	Family	Single	Family
Deductible	\$4000	\$8000	\$8000	\$16000
Out-of-Pocket Maximum (OPM)	\$6000	\$12000	\$11900	\$23800
Co-insurance	70/30		50/50	
Deductible included in OPM	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

OV Co-pay \$30/75 ER Co-pay \$250 Drug deductible \$ Drug co-pay \$10/40/75/\$100
 Additional details/comments: Urgent Care Copay \$45

REIMBURSEMENT PLAN (EMPLOYEE PLAN)

Plan: _____
 Please indicate any changes: Deductible OPM Co-insurance Co-pays Other No changes
 Does the family plan pay after one person in the family meets the single deductible or does the total family deductible have to be met?
 1 person Total family
 Do the in-network and non-network deductibles apply toward each other? Yes No

	In-Network		Non-Network	
	Single	Family	Single	Family
Deductible	\$500	\$1000	\$n/a	\$n/a
Out-of-Pocket Maximum (OPM)	\$3500	\$7000	\$n/a	\$n/a
Co-insurance	70/30			
Deductible included in OPM	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

OV Co-pay \$30/75 ER Co-pay \$250 Drug deductible \$ Drug co-pay \$10/40/75/\$100
 Additional details/comments: Urgent Care Copay \$45.00
 Maximum dollar exposure to the employer per member/family, in-network \$2500/5000
 Maximum dollar exposure to the employer per member/family, non-network \$n/a





Employee Benefit Systems Third Party Administration Services

Section C- Fees

PSF Admin \$6.50 or \$75.00 minimum Annual Document Fee \$
Online Enrollment Fee \$ EOB Fee \$ Broker Fee \$

Section D- PSF Funding, if applicable

Single \$52.08 EE/CH \$104.17 EE/SP \$104.17 Family \$104.17

Section E- Summary of Benefits and Coverage (SBC)

The Affordable Care Act (ACA) requires that all group health plans, group health plan administrators, and health insurance issuers provide a Summary of Benefits and Coverage (SBC) to contract holders prior to their enrollment period. The SBC is required to follow a standard format, and is designed to provide clear, easy to understand information about coverage and benefits. Please be aware that complying with the SBC requirements in ACA is a Plan Sponsor responsibility.

Do you want EBS to prepare the SBC for your PSF plan? Yes No

If no, who will prepare your SBC? _____

When is your Enrollment Period (e.g. 12/1/2013-12/15/2013): 6/16/2014 - 6/27/2014

EBS must have this completed signed renewal form and a copy of the fully insured plan SBC 30 days prior to the group's annual open enrollment period.

Section F- Plan Information

Are there any changes from the previous plan year to the information below? Yes No

When does a new employee become eligible for the plan? _____
(ex. First of the month following date of hire) A. First of the month following date of hire; if hired on the first, immediately eligible B. Elected Official/Deputy - immediately upon taking office

When does an employee terminate from the plan? End of the month

How many hours does an employee need to work in a week to be eligible? 30

For covered spouse, which of the following are covered? Legally married Common law Domestic partners

For covered dependent children, which of the following are covered? Natural Adopted Step Foster Grandchildren
 Court-appointed legal guardian Legal dependents of domestic partner

What is the TITLE of the person authorized to make legal decisions within your organization? HR Director

Section G- Authorization

EBS shall be entitled to rely on information furnished by the Client, Agent or Broker regarding Client set up, renewal and implementation. The Client, Agent or Broker will furnish EBS with such other information as EBS may reasonably require in the performance of its duties hereunder. In the case of inaccurate information provided to EBS, EBS will credit monthly bills and reprocess claims retroactive 60 days upon notification. EBS will not be held liable for claims under or over paid prior to that period.

Client Signature
Print Name Jim Thompson

Date: 6-3-14

EBS F018 (8/2013)

