

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

**RESOLUTION APPROVING AND AUTHORIZING CHAIRMAN TO SIGN SARPY
COUNTY'S SUMMARY PLAN DOCUMENT WITH EBS**

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, on June 2, 2015 via Resolution 2015-186, the County Board adopted a partial self-funded health plan, administered by Employee Benefit Systems ("EBS") and entered into an agreement regarding same; and,

WHEREAS, EBS provided an updated Summary Plan Document to the County for review and approval (see attached).

NOW, THEREFORE, BE IT RESOLVED by the Sarpy County Board of Commissioners that this Board hereby approves the Summary Plan Document and any other related documents, the same being approved by the Board.

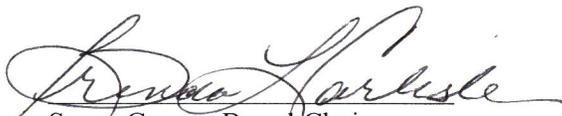
BE IT FURTHER RESOLVED that the Chairman of this Board, together with the County Clerk, are hereby authorized to sign on behalf of this Board the Summary Plan Document.

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 15th day of September, 2015.

Attest

SEAL




Sarpy County Board Chairman


County Clerk



Sarpy County Human Resources

East Annex, 1261 Golden Gate Drive, Suite 4E
Papillion, NE 68046-2845
(402) 593-4486 FAX: (402) 593-5781

To: Sarpy County Board of Commissioners
From: Bonnie Moore, Human Resources Director
Date: August 28, 2015
Re: EBS Summary Plan Document

Each year after the Board approves the Employee Benefit Systems (“EBS”) agreement for the third-party administration of the County’s Partially Self-funded Health Plan, EBS updates our Summary Plan Document. Attached for your review and approval is the finalized Summary Plan Document.

Please feel free to contact me with questions 402-593-4485. Thank you.

***Plan Document and
Summary Plan Description for the
Sarpy County Partial Self Fund Plan***

- Your Partial Self-Fund (“PSF”)
- Your Fully Insured Group Health Plan

EFFECTIVE DATE: 07/01/2015

Introduction

Sarpy County (the “Employer” or “Company”) is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet provides information about your Partial Self Fund Benefit Programs. It serves as the Plan document and the Summary Plan Description (“SPD”) for the Sarpy County Partial Self Fund Plan (“the Plan”).

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

The “Benefit Programs” covered by this SPD are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits, the Certificate of Insurance or Certificate of Coverage and other descriptive documents relating to each Benefit Program (collectively, the “insurance certificates”) are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee normally scheduled to work 30 hours per week or are an elected Official or Chief Deputy.

Unless otherwise communicated to you by the Company (Sarpy County), the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, part-time employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Employer payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- a stepchild as long as you are married to the child's legal parent;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

In addition, an eligible dependent who lives outside the U.S. may be restricted from coverage unless the dependent has established his or her primary residence with you. If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator.

When Coverage Begins

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following your date of hire, if hired on the first of the month, eligible on date of hire. Coverage for your eligible dependents begins on the same day as your initial eligibility provided you enroll your dependents within 31 days of eligibility. Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements to be covered under the Plan.

Look-back Measurement Method for Determining Full-time Employee Status

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees;

The look-back measurement method involves three different periods:

- A measurement period;
- The stability period; and
- An administrative period.

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

For purposes of determining your eligibility for health care benefits for the stability period beginning in 2015, the Company may use a shorter standard measurement period than is used in subsequent years.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for the Plan's health care benefits

based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent’s eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in

the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on July 1 and stay in effect through June 30, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit, with deductible and out-of-pocket expenses based on the policy year. You should refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by Internal Revenue Code Section 125, or the regulations thereunder, the following events may be considered a change in status:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Employer work location or home address that changes your overall benefit options and/or prices;
- employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan; or
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;
- change in employment status to less than 30 hours of service per week on average even if reduction does not result in loss of Plan eligibility;

-
- eligibility for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or seeking to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes in your election must be consistent with your change in status event. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change to the Plan Administrator as soon as possible, but no later than 31 days after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day of the month in which your employment terminates or upon your death, unless benefits are extended, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. Your payments will be made on an after-tax basis, unless you are on paid leave, in which case your premium payments will continue to be deducted on a pre-tax basis. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

Your Partial Self Fund (“PSF”)

A PSF is an arrangement funded by the Employer and Employee. The purpose of the PSF is to reimburse you, up to certain limits, for you and your covered dependents' eligible out-of-pocket health care expenses, as explained below. Claims paid by the PSF generally are excluded from taxable income.

How the PSF Works

Claims from the PSF are made from the general assets of the Employer. Before the start of each Plan Year, the Employer will determine the maximum amount that may be reimbursed during that Plan Year. This amount will be shown in your enrollment materials.

The PSF may be used to reimburse your annual deductible, copayments and coinsurance amounts for you and your eligible dependents. The PSF cannot be used to pay dental and vision expenses.

How to File a Claim

When you (or your medical provider) submit eligible medical expenses incurred during a coverage period, claims will automatically be made from the PSF.

Claim forms are available from the Claims Administrator. Receipts submitted with a claim form should include the name and address of the provider, the date of service, the amounts being submitted for reimbursement, and any other supporting information such as an Explanation of Benefits (EOB) from your insurance carrier or provider. You will be advised of the cut-off date for submitting claims for a coverage period.

Benefit Payment

When you file a claim, the Claims Administrator will make payment directly to the provider.

Maintaining Records

You should keep all receipts to document expenses reimbursed from the PSF. If a payment must be verified at a later date, the Claims Administrator may request receipts from you to ensure that payment was made for a qualified expense. If a claim for benefits is denied, you have the right to appeal (see “Claims Procedure” for additional information) with the Claims Administrator.

Ineligible Claims

If the Claims Administrator determines that you have submitted an ineligible claim or you do not provide required documentation upon request, your transaction will be considered an overpayment. You will have 30 days from the date you receive notification of the overpayment to provide additional information or repay the full amount of the overpayment. Otherwise, any overpayment will be deducted from future claim reimbursements.

When Participation Ends

Your participation in the PSF ends when you terminate employment. You may continue to access your PSF balance as described below.

If you terminate employment, your PSF can be used only for eligible expenses incurred before the end of the month of your termination.

If you die, claims may be submitted by your spouse or estate for eligible expenses incurred before your date of death.

Health Care Flexible Spending Account and PSF

The PSF is different from a Health Care Flexible Spending Account even though both may reimburse similar expenses. If you participate in both a Health Care Flexible Spending Account and a PSF, eligible expenses will be first reimbursed through the PSF.

For More Information

For additional information about your PSF, contact the Claims Administrator or refer to your enrollment materials.

Fully Insured Group Health Plan

The following Benefit Program is fully insured and administered by the Insurer listed in Appendix A:

- Fully Insured Group Health Plan

Participation

To become a participant in the Fully Insured Group Health Plan Benefit Program, you must meet all eligibility requirements and enroll in coverage. You may elect to cover your eligible dependents.

Benefits Provided

The benefits provided under the Fully Insured Group Health Plan Benefit Program are more fully described in the materials provided to you by the Insurer.

Source of Payment

Benefits under the program are paid by the Insurer and are guaranteed under the applicable insurance contract.

Any required premiums for coverage will be shown on your Election Form. Your premiums are deducted on a pre-tax basis.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, exclusions, or reduction for other benefits that may apply to your coverage.

For More Information

If you have any questions about the Fully Insured Group Health Plan Benefit Program, you should consult your Certificate of Insurance or other materials provided by the Insurer.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights Federal laws such as COBRA.

IMPORTANT: This Summary Plan Description may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

Sarpy County is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator

Sarpy County
EAST ANNEX: 1261 Golden Gate Drive
Suite 4E
Papillion, NE 68046
402-593-4485

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) for the Plan is:

EIN: 47-6006504

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

Insurers/Claims Administrators

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that the Plan Documents always control, even if their terms conflict with information given to you by an Insurer or other service provider.

PSF Benefits

Employee Benefit Systems
214 North Main Street
PO Box 1053
Burlington, IA 52601
800-373-1327
www.ebs-tpa.com

Fully Insured Group Health Plan

Coventry of Nebraska
800-471-0240
www.chcnebraska.coventryhealthcare.com/

Agent for Service of Legal Process

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

HR Director
Sarpy County
EAST ANNEX: 1261 Golden Gate Drive
Suite 4E
Papillion, NE 68046
402-593-4485

AND

Sarpy County Clerk
1210 Golden Gate Drive, Suite 1250
Papillion, NE 68046
402-593-2105

Service of Legal Process may also be served on the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the fund established for the payment of benefits under this plan.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Future of the Plan

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer's decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program's provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Definitions

Dependent

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Your “child” includes:

- Your biological child;
- Your legally adopted child (including any child under age 18 placed in the home during a probationary periods in anticipation of the adoption where there is a legal obligation for support;
- A child for whom you are the court-appointed legal guardian; or
- An eligible child for whom you are required to provide coverage under the terms of a QMCSO or NMSN, as defined below.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, refer to your insurance certificate.

Employee

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant’s home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant’s own serious health condition; or
- any qualifying exigency arising from an employee’s spouse, son, daughter, or parent being a member of the military on “covered active duty”. Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have

questions regarding your eligibility for FMLA coverage or your state's family medical leave provisions, if applicable, contact your Employer.

Insurer

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

Adoption of the Plan

The Sarpy County Partial Self Fund Plan, effective 07/01/2009, as amended and restated herein, is hereby adopted as of 07/01/2015. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 1st day of September, 2015.

BY: 

TITLE: Chairman

APPENDIX A

BENEFIT PROGRAMS OFFERED: PARTIAL SELF FUND AND FULLY INSURED GROUP HEALTH PLAN.

BENEFIT PROGRAM/ EFFECTIVE DATE OF COVERAGE	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	BENEFITS PROVIDED	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
GROUP PSF INSURANCE 07/01/2015	EMPLOYEE BENEFIT SYSTEMS CLAIMS ADMINISTRATOR		See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
FULLY INSURED GROUP HEALTH PLAN 07/01/2015	COVENTRY OF NEBRASKA INSURER/CLAIMS ADMINISTRATOR		See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

EXHIBIT A

SARPY COUNTY PARTIAL SELF-FUND PLAN FEATURES

07/01/2015

Calendar Year Deductible (In-Network):	
Per Person	\$500
Per Family	\$1,000
Out-of-Pocket Calendar Year Maximums (In-Network):	
Per Person	\$3,500
Per Family	\$7,000

All other eligible benefits will be paid from your fully-insured plan.