AGREEMENT

THIS AGREEMENT is made and entered by and between the County of Lancaster, Nebraska, through the Lancaster County General Assistance Department, hereinafter referred to as "County," and **Eye Surgical Associates**, located at **1710 S. 70th Street, Lincoln, NE 68506**; hereinafter referred to as "Provider." Collectively the County and the Provider may be referred to as "Parties," and individually each may be referred to as a "Party."

WHEREAS, pursuant to Neb. Rev. Stat. § 68-101 et seq, the County provides General Assistance benefits to clients enrolled in the Lancaster County General Assistance program ("GA Clients");

WHEREAS, the County does not possess the resources to provide specialized medical care and assistance to GA Clients, and therefore the County occasionally contracts with private medical providers for such specialized care;

WHEREAS, the Provider is willing and able to provide such specialized care to GA Clients;

WHEREAS, several GA Clients have pending claims with the Social Security Administration and may be eligible for retroactive Medicaid or Medicare benefits, and in such cases, all pending medical bills for these clients are placed in a pending status; and

WHEREAS, it is the County's intent to reimburse Provider for rendering specialized medical care to GA Clients with the understanding that the Provider will reimburse the County if/when GA Clients who received such care are later determined to be eligible for Medicaid or Medicare reimbursement;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, it is agreed between the Parties as follows:

1. TERM, TERMINATION, AND SURVIVAL.

1.1 The Initial Term of this Agreement shall be for five (5) years from the date of execution by both Parties, unless terminated by either Party pursuant to this Agreement. Following the conclusion of the Initial Term, the Parties may renew this Agreement for a Renewal Term(s) by mutual written agreement of both Parties. Together the Initial Term and any Renewal Term shall constitute the Term of this Agreement.

1.2 Either Party may terminate this Agreement for any reason without penalty by giving thirty (30) days written notice to the other Party. Should the Provider breach this Agreement, the County will notify the Provider of the breach in writing and the Contractor will have sixty (60) days to cure. If the breach is not

cured within sixty (60) days, the County may, at its discretion, terminate the Agreement immediately upon written notice to the Provider

1.3 In the event that either Party terminates this Agreement or the Term of the Agreement concludes without the Parties agreeing to a subsequent Renewal Term, and the County later receives notification that a GA Client served by the Provider prior to the date of termination or conclusion has been approved for Medicaid or Medicare ("post-termination notification of eligibility"), the Parties agree that, with respect to the care and services previously rendered to the GA client who is the subject of such a post-termination notification of eligibility, the provisions of this Agreement shall survive termination or conclusion of this Agreement, and Provider agrees to reimburse the County pursuant to the terms of this Agreement for all payments rendered for medical care and services provided within the Medicaid or Medicare eligibility dates, notwithstanding termination or conclusion of the Agreement.

2. PURPOSE. The purpose of this Agreement is to set forth the terms and conditions of the aforementioned reimbursement arrangement between the County and the Provider.

3. SERVICES TO BE PROVIDED.

3.1 Service Description. The Provider agrees to provide only medical care and services that have received prior authorization by the County and that meet all statutory and regulatory requirements for Medicaid and Medicare in force at the time the care and/or service is rendered. The County's prior authorization will be done initially by telephone from the County's Primary Care Provider with written documentation provided via fax or email by the County's Primary Care Provider within one (1) business day. Such authorization shall be done on the "County Service Approval Form." and include a description of the services authorized. The County's current Primary Care Provider is People's Health Center, with a primary office of 1021 North 27th Street, Lincoln, Nebraska, 68503, a business telephone number of 402-476-1455, and a business fax number of 402-441-8491. County will provide written notice to Provider of any changes in the identity of the Primary Care Provider. A copy of the County Service Approval Form is attached to this Agreement as **Attachment A** hereto, and is incorporated herein by this reference.

3.2 The Provider agrees to submit a written claim for services within 90 days of the date of service to the County on the appropriate billing form (HCFA 1500 or UB-92), including an itemized list of all charges, the actual cost of the care, and the Medicaid rate, if possible, for these charges, as established by the Federal Government.

4. PAYMENTS AND REIMBURSEMENT.

4.1 The County agrees to pay the Provider at the established Medicaid rate for pre-authorized medical care and services provided to GA Clients within sixty (60) days of receipt of the claim from the Provider.

4.2 The County will notify the Provider in writing when a Medicaid or Medicare eligibility period is established for any GA Client receiving services from Provider.

4.3 When notified pursuant to Section 4.2, the Provider agrees to reimburse the County within sixty (60) days for all payments rendered for medical care and services provided within the Medicaid or Medicare eligibility dates and submit the appropriate bills to Medicaid or Medicare for payment, as applicable. Reimbursement from Provider to County shall be timely made irrespective of payment from Medicaid or Medicare to Provider.

4.4 Furthermore, notification of a GA client's Medicaid or Medicare eligibility shall constitute notice that the GA client is ineligible for future GA benefits. With respect to any services rendered to a GA client for which Provider has not yet invoiced GA, and with respect to any future services rendered by Provider to the former GA client, Provider shall bill Medicaid or Medicare directly for those services. GA shall not be financially responsible for reimbursing or crediting Provider for services rendered to a former GA client.

4.5 If Medicaid or Medicare denies a claim for which: i) the County has been reimbursed; ii) the County is due to be reimbursed by Provider pursuant to Section 4.3; or iii) the County has not been invoiced pursuant to Section 4.4, except for services rendered to a former GA client; then Provider may submit the Medicaid or Medicare denial, along with supporting documentation, to GA for consideration of the denied claim. If GA determines that the Medicaid or Medicare claim was denied for any reason not the fault of the Provider then County shall either reimburse Provider for past reimbursement to the County or, if reimbursement has not yet been made to County, issue an account credit against Provider's GA account balance. If GA determines that the Medicaid or Medicare claim was denied for any reason that is the fault of the Provider, then the County shall not reimburse Provider for past reimbursement to the County, nor shall County credit Provider's GA account.

4.6 The County agrees to notify the Provider within sixty (60) days when a claim for services is received and the services are not covered by the GA program.

4.7 County will provide written notice to Provider before using a setoff of amounts owed by Provider to County against amounts owed by the County to Provider as a means to recover reimbursements not timely made by Provider to County

pursuant to Section 4.3 of this Agreement. The notice shall explain the reason for the setoff and a calculation of the amount of the reimbursement due as of the date of the notice. County will not implement the setoff if, within fifteen (15) days after the date of the notice: i) County has received from Provider the full amount of the reimbursement due as of the date of the notice pursuant to Section 4.3 of this Agreement; or ii) County has received from Provider a written explanation of why the setoff should not occur along with any supporting documentation. If Provider does not respond with fifteen (15) days as provided herein, the setoff shall occur. If with fifteen (15) days as provided herein County receives from Provider a written explanation of why the setoff should not occur along with any supporting documentation, County shall review the Provider's written explanation and supporting documentation. County shall notify Provider in writing of its decision either to uphold or overturn its initial determination provided in the notice from County to Provider. If County upholds its decision, the setoff shall occur. The Parties agree that all recoupment and any setoff rights under this Agreement will constitute rights of recoupment authorized under State or Federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider.

4.8 Throughout the Term of this Agreement, and as long as Contractor is subject to reimbursement obligations to County arising out of this Agreement, Contractor shall be a participant in each MCO network providing services to Nebraska Medicaid managed care enrollees. MCO shall mean an organization that satisfies the definition of Managed Care Organization (MCO) in 482 NAC § 1-002, as such section may be amended from time to time.

5. INDEPENDENT CONTRACTOR. It is the express intent of the Parties that this Agreement shall not create an employer-employee relationship. Employees of the Provider shall not be deemed to be employees of the County and employees of the County shall not be deemed to be employees of the Provider. Neither the Provider's employees nor the County's employees shall be entitled to any salary, wages, or benefits from the other Party, including but not limited to overtime, vacation, retirement benefits, workers' compensation, sick leave or injury leave.

6. HOLD HARMLESS. Each Party agrees to indemnify and hold harmless, to the fullest extent allowed by law, the other Party and its principals, officers, and employees from and against all claims, demands, suits, actions, payments, liabilities, judgments and expenses (including court-ordered attorneys' fees), arising out of or resulting from the acts or omissions of their principals, officers, or employees in the performance of this Agreement. Liability includes any claims, damages, losses, and expenses arising out of or resulting from performance of this Agreement that results in any claim for damage whatsoever including any bodily injury, civil rights liability, sickness, disease, or damage to or destruction of tangible property, including the loss of use resulting therefrom. Further, each Party shall maintain a policy or policies of insurance (or a self-

insurance program), sufficient in coverage and amount to pay any judgments or related expenses from or in conjunction with any such claims. Nothing in this Agreement shall require either Party to indemnify or hold harmless the other Party from liability for the negligent or wrongful acts or omissions of said other Party or its principals, officers, or employees.

7. NON-DISCRIMINATION. The Parties agree that in providing services pursuant to this Agreement, they shall not discriminate against any employee, applicant for employment, GA Client, or any other person on the basis of race, color, religion, sex, disability, national origin, age, marital status, receipt of public assistance, or any other basis prohibited by applicable state or federal law.

8. CONFIDENTIALITY. The Provider agrees that it shall be compliant with the Health Insurance Portability and Accountability Act of 1996 and implementing regulations pertaining to confidentiality of health information.

9. NON-ASSIGNABLE. This Agreement cannot be assigned by the Provider without prior written permission from the Lancaster County Board of County Commissioners. Any assignment without such written permission shall be absolutely void.

10. GOVERNING LAW. The laws of the State of Nebraska shall govern the rights and obligations of the Parties under this Agreement.

11. EMPLOYEE VERIFICATION. In accordance with Neb. Rev. Stat. §§ 4-108 through 4-114, Provider agrees to register with and use a federal immigration verification system, to determine the work eligibility status of new employees performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. § 1324a, otherwise known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee pursuant to the Immigration Reform and Control Act of 1986. Provider shall not discriminate against any employee or applicant for employment to be employed in the performance of this section pursuant to the requirements of state law and 8 U.S.C. § 1324b. Provider shall require any subcontractor to comply with the provisions of this section.

12. NOTICES.

12.1 Billing Notices. Each Party shall designate a contact person to handle eligibility notifications, invoicing, reimbursements, and setoffs arising out of the provisions of Section 4 of this Agreement (collectively, "Billing"). All Billing shall be conducted by email, return receipt requested. Such person's contact information is specified below. A Party may change this designation by providing ten (10) business days' notice in writing to the other Party's designee listed in Section 12.2

of this Agreement.

County	Provider
General Assistance Billing gabilling@lancaster.ne.gov	Name: Laura Ekeler Title: Utilization Specialist Email: lekeler@esa-neb.com

For the purposes of the Agreement, all Billing notices shall be deemed to have been given according to the date of receipt on the email return receipt.

12.2 Non-Billing Notices. Except for Billing Notices, all other notices or other communications provided under this Agreement shall be in writing and shall be given to the Lancaster County General Assistance Department or the Provider at the address, email, or facsimile number set forth below or such other address, email, or facsimile number as either Party may specify hereafter in writing:

Lancaster County General Assistance Department	Provider Information
c/o Sara Hoyle, Director	Name: Eye Surgical Associates
3140 N Street, Suite 2106	Contact: Annette Delaney
Lincoln, NE 68510	Address 1: 1710 S 70th St
Fax: 402-441-3099	Address 2: PO Box 6068
shoyle@lancaster.ne.gov	Fax: 402 486 3702
	Email: adelaney@esa-neb.com

Such notice or other communication may be mailed by United States Certified mail, return receipt requested, postage prepaid and may be deposited in a United States Post Office Box or a depository for the receipt of mail regularly maintained by the Post Office. Such notices or communication may also be delivered by facsimile transmission, confirmation requested, or by email to the email address listed above, return receipt requested. For the purposes of the Agreement, all notices will be deemed to have been given on the date of mailing on the United States certified mail receipt, the date of receipt on the email receipt, or the date of successful transmission on the facsimile transmission confirmation, as provided above.

13. E-VERIFY. In accordance with Neb. Rev. Stat. §§ 4-108 through 4-114, Provider agrees to register with and use a federal immigration verification system, to determine the work eligibility status of new employees performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. § 1324a, otherwise known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland

Security or other federal agency authorized to verify the work eligibility status of a newly hired employee pursuant to the Immigration Reform and Control Act of § 1986. Provider shall not discriminate against any employee or applicant for employment to be employed in the performance of this section pursuant to the requirements of state law and 8 U.S.C. § 1324b. Provider shall require any subcontractor to comply with the provisions of this section.

14. INSURANCE. The Provider shall, prior to beginning work, provide proof of insurance coverage in a form satisfactory to the County, which shall not withhold approval unreasonably. The coverages and minimum levels required by this Agreement are set forth below and shall be in effect for all times that work is being done pursuant to this Agreement. No work on the Project or pursuant to this Agreement shall begin until all insurance obligations herein are met to the satisfaction of the County, which shall not unreasonably withhold approval. Self-insurance shall not be permitted unless consent is given by the County prior to execution of the Agreement and may require submission of financial information for analysis. Deductible levels shall be provided in writing from the Provider's insurer and will be no more than $25,000.00 per occurrence. Said insurance shall be written on an OCCURRENCE basis, and shall be PRIMARY, with any insurance coverage maintained by the County being secondary or excess.

14.1 The Provider shall provide certificates of insurance and endorsements evidencing compliance with these requirements. The Provider shall provide a Certificate of Insurance demonstrating the coverage required herein and the necessary endorsements and waivers described herein and below before being permitted to begin the work or project. All certificates, endorsements and endorsement forms (where required) must be acceptable to the City Attorney or County Attorney as appropriate. Certificates shall include an endorsement to provide for at least thirty (30) days' firm written notice in the event of cancellation. During the term of the Agreement and during the period of any required continuing coverages, the Provider shall provide, prior to expiration of the policies, certificates and endorsement forms evidencing renewal insurance coverages. The Parties agree that the failure of County to object to the form of a certificate and/or additional insured endorsement or endorsement forms provided shall not constitute a waiver of this requirement.

14.2 The Provider shall provide proof of workers' compensation insurance of not less than minimum statutory requirements under the laws of the State of Nebraska and any other applicable State. Employers' Liability coverage with limits of not less than $500,000.00 each accident or injury shall be included. The Provider shall also be responsible for ensuring that all subcontractors have workers' compensation insurance for their employees before and during the time any work is done pursuant to this Agreement.

14.3 Provider shall maintain Professional Liability insurance covering damages arising out of negligent acts, errors, or omissions committed by Provider in the

performance of this Agreement, with a liability limit of not less than $1,000,000 each claim. Provider shall maintain this policy for a minimum of two (2) years after completion of the work or shall arrange for a two year extended discovery (tail) provision if the policy is not renewed.

14.4 All Liability Insurance policies shall be written on an "Occurrence" basis only. All insurance coverage are to be placed with insurers authorized to do business in the State of Nebraska and must be placed with an insurer that has an A.M. Best's Rating of no less than A:VII unless specific approval has been granted otherwise.

14.5 The Provider may use an Umbrella, Excess Liability, or similar coverage to supplement the primary insurance stated above in order to meet or exceed the minimum coverage levels required by this Agreement.

14.6 Nothing contained in this clause or other clauses of this Agreement shall be construed to waive the Sovereign Immunity of the County

15. INTEGRATION. The Parties do hereby agree to all the terms and conditions of this Agreement. This Agreement shall be binding upon the Parties, their heirs, administrators, executors, legal and personal representatives, successors and assigns. The Parties hereby agree that this Agreement constitutes the entire understanding of the Parties and supersedes all prior contracts, agreements and negotiations between the Parties whether verbal or written. This Agreement may be modified, altered, or amended only by written instrument executed by both Parties.

16. CAPACITY. The undersigned person representing the Provider does hereby agree and represent that he or she is legally capable to sign this Agreement and to lawfully bind the Provider to this Agreement.

17. WAIVER. Either Party's failure or neglect to enforce any of its rights under this Agreement will not be deemed to be a waiver of that Party's rights.

18. THIRD-PARTIES. This Agreement is not intended to, and does not, create any rights or benefits on behalf of any person, whether an individual or an entity, other than the Parties to this Agreement. County shall not be obligated or liable hereunder to any person, whether an individual or an entity, other than Provider.

19. VENUE. If either Party brings against the other Party any proceeding arising out of this Agreement, that Party may bring that proceeding against the other Party only and exclusively in the Lancaster County District Court in Lincoln, Nebraska, and each Party hereby submits to the exclusive jurisdiction of that court for purposes of any such proceeding.

20. COUNTERPARTS. This Agreement may be executed in two counterparts, each of which shall be an original, but all of which shall constitute one and the same instrument.

EXECUTED this 29 day of June, 2017, by the Provider.

By: Robin F Linafelter

Name: Robin F Linafelter

Title: Group Administrator

EXECUTED this _____ day of _____, 2017, by Lancaster County, Nebraska.

By: _____

Name: _____

Title: Chair, Lancaster County Board of Commissioners

APPROVED AS TO FORM
this ___ day of _____, 2017

_____
Deputy County Attorney
for Joe Kelly
County Attorney

Lancaster County General Assistance Program
Prior Authorization for Medical Treatment
GA Form 16

CR# SR#
Pending SS:
GA Specialist:
Telephone:

Date:
Client Name:
DOB: SS #
Telephone:

Provider:
Attention:
Telephone #
Fax #

What is Being Requested:

To be completed by Physician or other medical provider:

- Does the diagnosis and/or treatment plan preclude the patient from his/her regular employment?
  Yes ____ No ____
- If Yes, when can the patient be reasonably expected to return to work? _____
- Additional comments _____

☒ **Please fax or send this form along with medical information to:**

Note: Any change in treatment plan after completion of this form MUST BE APPROVED OR PAYMENT CANNOT BE AUTHORIZED even if the client is otherwise eligible for General Assistance. Please contact the General Assistance Specialist listed above.

Notification Regarding General Assistance Service Request ☐ **Approved** ☐ **Denied**

Date_____
Comments: _____

Billing Address: **Lancaster County General Assistance**
Attn: GA Billing
3140 N Street #2106
Lincoln, NE 68510

☐ **Faxed to Provider**
☐ **Faxed to GA Specialist**

_____

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 5/30/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
LMC Insurance & Risk Management, Inc.
4200 University Ave., Suite 200
West Des Moines IA 50266-5945

CONTACT NAME: Connie Redd
PHONE (A/C, No, Ext): 515-237-0113 FAX (A/C, No): 515-244-9535
E-MAIL ADDRESS: connie.redd@lmcins.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Federal Insurance Company	20281
INSURER B : StarStone National Insurance Compan	25496
INSURER C : Accident Fund General Insurance Com	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
EYESURG-01
Eye Surgical Associates LLC
1710 S. 70th Street
Lincoln NE 68506

COVERAGES **CERTIFICATE NUMBER:** 248110976 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			36015829	6/1/2017	6/1/2018	EACH OCCURRENCE	$1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER						GENERAL AGGREGATE	$2,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$2,000,000
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
B	X UMBRELLA LIAB X OCCUR			84408J173ALI	6/1/2017	6/1/2018	EACH OCCURRENCE	$5,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$5,000,000
	DED X RETENTION $0							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			2000017021	6/1/2017	6/1/2018	X WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N / N / A (Mandatory in NH)						E.L. EACH ACCIDENT	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER
To Whom It May Concern

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/20/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Nicole Edmundson	
SilverStone Group 11516 Miracle Hills Drive Omaha NE 68154	PHONE (A/C, No, Ext): 402-964-5531	FAX (A/C, No): 402-557-6321
	E-MAIL ADDRESS: nedmundson@ssgi.com	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
11268	INSURER A : ProAssurance Casualty Company	38954
Eye Surgical Associates, LLC 1710 S. 70th St #200 Lincoln NE 68506	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** 230693504 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Medical Professional Liability			MP75156	1/1/2017	1/1/2018	Per Claim Aggregate	$500,000 $1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Eye Surgical Associates, LLC; Retro Date 11/01/1982
Sutton Skin and Eye Clinic, PC; Retro Date 7/01/1979
See attached physicians and providers list:

See Attached...

CERTIFICATE HOLDER

Eye Surgical Associates , LLC
1710 S. 70th St
Lincoln NE 68506

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

AGENCY CUSTOMER ID: 11268

LOC #:

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
SilverStone Group	Eye Surgical Associates, LLC 1710 S. 70th St #200 Lincoln NE 68506
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: CERTIFICATE OF LIABILITY INSURANCE

2017-18 Physicians & Providers

Name	Retro Date
Eye Surgical Associates, LLC	11/01/1982
Sutton Skin and Eye Clinic, PC	7/01/1979
Daniel Chruscicki, MD	10/15/2010
Thomas Graul, MD	7/01/2000
Max Linder, MD	7/01/1979
Donald Sauberan, MD	7/01/2008
Gregory Sutton, MD	11/01/1982
Vincent Sutton, MD	10/01/1981
Matthew Wood, MD	7/01/2004
Margaret Sutton, MD	8/01/1983
Robyn Ryan, MD	8/01/1983
David Pan, MD	7/01/2011
Jordan Rixen, MD	6/19/2014
Leigh Sutton, MD	11/23/2016
David Blodgett, MD	7/01/2017
Kaylyn Jackman, OD	
Jacklynn Kment, PA-C	
Rebecca Reinke, PA-C	
Michelle Sitzman, PA-C	
Kerri Otto, PA	
Kaitlin M. Matthes, PA-C	
Erin C. Hegge, PA-C	
Sarah C. Minarick, PA-C	

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE
Bruce R. Ramge
Director

Pete Ricketts
Governor

December 19, 2016

EYE SURGICAL ASSOCIATES, LLC
ATTN: LORRIE SHREVE
1710 SOUTH 70TH STREET, PO BOX 6068
LINCOLN NE 68506

RE: Nebraska Hospital-Medical Liability Act
See Attached List

Dear Healthcare Provider:

On December 16, 2016, we received $10,632.56, which represents 26% of the premium which you are being charged by ProAssurance Casualty Company for $500,000/$1,000,000 limits coverage. Your renewal coverage with the Act is effective from January 1, 2017 to January 1, 2018. It will be necessary to requalify each policy period.

As a reminder, a qualified health care provider shall post and keep posted in a suitable location where all patients may easily see it, a sign of the size and type prescribed by the Director stating they have qualified under the provisions of the Nebraska Hospital-Medical Liability Act 44-2821(4).

If you have any questions regarding this transaction or the Act, you can contact me at (402) 471-2201 or stephanie.hobelman@nebraska.gov.

Sincerely,

Stephanie Hobelman, CISR, CIC
Insurance Analyst
Nebraska Excess Liability Fund