

**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 Star Anesthesia, located at P.O. Box 67099, Lincoln, NE 68510-7099; 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 27<sup>th</sup> 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@lanaster.ne.gov

Name: Jody Olsen  
Title: Billing Manager  
Email: jody@staranesthesia.net

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  
c/o Sara Hoyle, Director  
3140 N Street, Suite 2106  
Lincoln, NE 68510  
Fax: 402-441-3099  
shoyle@lanaster.ne.gov

Provider Information

Name: Star Anesthesia, PC  
Contact: Crystal Lynch  
Address 1: PO Box 67099  
Address 2: Lincoln, NE 68505-7099  
Fax: 402-423-7774  
Email: Crystal@staranesthesia.net

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



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

07/12/2017

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

**State Farm**

State Farm Insurance, Andy Van Horn  
8421 Amber Hill Ct, Ste 1  
Lincoln, NE 68526

CONTACT NAME: Amanda Bodfield

PHONE (A/C No. Ext): 402-483-2802

FAX (A/C No.): 402-483-8086

E-MAIL ADDRESS: amanda@thevanhornsteam.com

INSURER(S) AFFORDING COVERAGE

NAIC #

INSURER A: State Farm Fire and Casualty Company

25143

INSURER B: State Farm Mutual Automobile Insurance Company

25178

INSURER C:

INSURER D:

INSURER E:

INSURER F:

INSURED

Star Anesthesia PC  
PO Box 67099  
Lincoln, NE 68506

## COVERAGES

CERTIFICATE NUMBER:

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	ADDITIONAL INSURED	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR	Y	97-CM-6478-9	04/10/2017	04/10/2018	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COM/POP AGG \$ 4,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:					
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB OCCUR CLAIMS-MADE					EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N Y N/A	97-CM-6478-9	04/10/2017	04/10/2018	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
	Fidelity Bond		97-CG-1380-1	03/15/2017	03/15/2015	Bond amount \$200,000

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

Location 1: 9200 Andermatt Dr Ste 8; Lincoln, NE 68526  
Location 2: 2430 S 74th St; Lincoln, NE 68506  
Location 3: 625 S 70th St; Lincoln, NE 68510

## CERTIFICATE HOLDER

## 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

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CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE

CERTIFICATE HOLDER

Star Anesthesia, P.C.  
PO Box 67099  
Lincoln, NE 68506-7099

INSURED

Star Anesthesia, P.C.  
PO Box 67099  
Lincoln, NE 68506-7099

Group Name: Star Anesthesia, P.C.

This Certificate is issued as a matter of information only and confers no rights upon the holder. By its issuance the company does not alter, change, modify or extend the provisions of said policy and does not waive any of its rights thereunder. COPIC extends blanket coverage to an employee or authorized volunteer worker (an "insured") of the named insured while working under the direct supervision of the named insured and within the scope of their assigned duties. However, "employee" or "volunteer worker" does not include:

- |                             |                                  |                                   |
|-----------------------------|----------------------------------|-----------------------------------|
| Acupuncturists              | Emergency Medical Techs          | Pharmacists                       |
| Advanced Practice Nurses    | Endermologists                   | Physician Assistants              |
| Aestheticians               | Laser Technicians                | Physicists                        |
| Anesthesiologist Assistants | Microdermabrasionists            | Physiologists                     |
| Child Health Associates     | Nurse Clinicians                 | Psychologists                     |
| Clinical Nurse-Specialists  | Nurse Midwives                   | Psychotherapists                  |
| CRNA/Nurse Anesthetists     | Nurse Practitioners              | Radiology Practitioner Assistants |
| Cytotechnologists           | Optometrists                     | Surgical Assistants               |
| Electrologists              | Orthopaedic Physician Assistants | Surgical Technicians              |

or any other allied health professional performing highly-skilled health care services or procedures even if they are employees unless the individual or the position is listed on the declaration page(s) and in that event, an employee or volunteer listed on the declaration page(s) shall be treated as an "insured" for coverage purposes. Each "Insured" shall share limits with others, as provided in the Policy. Because we cover certain types of "Insureds" on an automatic and blanket basis, we are unable to verify coverage for an individual who is not in one of the allied health specialties identified above.

POLICY NUMBER: PCN0001070

RETRO DATE: 03/13/2004

POLICY TERM: 01/01/2017 to: 01/01/2018

LIMITS OF LIABILITY:

Per Medical Incident/Peer Review Incident\$ 1,000,000  
Annual Aggregate\$ 3,000,000

SPECIALTY: Entity/Corp Specialty

Dated at: Denver, Colorado

Date: November 07, 2016

Countersigned by Authorized Representative





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CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE

CERTIFICATE HOLDER

Ricky G. Hartwig, M.D.  
9200 Andermatt  
Ste 8  
Lincoln, NE 68526

INSURED

Ricky G. Hartwig, M.D.  
9200 Andermatt  
Ste 8  
Lincoln, NE 68526

Group Name: Star Anesthesia, P.C.

This certificate is issued as a matter of information only and confers no rights upon the holder. By its issuance, the **company** does not alter, change, modify or extend the provisions of said **policy** and does not waive any of its rights thereunder.

POLICY NUMBER: PCN0001070

**RETRO DATE:** 03/13/2004

**POLICY TERM:** 01/01/2017 to: 01/01/2018

LIMITS OF LIABILITY:

Per Medical Incident/Peer Review Incident: \$ 1,000,000  
Annual Aggregate: \$ 3,000,000

SPECIALTY: Anesthesiology - Pain Management I

Dated at: Denver, Colorado

Date: November 07, 2016

Countersigned by Authorized Representative



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CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE

CERTIFICATE HOLDER

Matthew P. Behrens, M.D.  
9200 Andermatt Dr  
Lincoln, NE 68526-9639

INSURED

Matthew P. Behrens, M.D.  
9200 Andermatt Dr  
Lincoln, NE 68526-9639

Group Name: Star Anesthesia, P.C.

This certificate is issued as a matter of information only and confers no rights upon the holder. By its issuance, the **company** does not alter, change, modify or extend the provisions of said **policy** and does not waive any of its rights thereunder.

POLICY NUMBER: PCN0001070

RETRO DATE: 08/01/2009

POLICY TERM: 01/01/2017 to: 01/01/2018

LIMITS OF LIABILITY:

Per Medical Incident/Peer Review Incident: \$ 1,000,000

Annual Aggregate: \$ 3,000,000

SPECIALTY: Anesthesiology - Pain Management I

Dated at: Denver, Colorado

Date: November 07, 2016

Countersigned by Authorized Representative



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CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE

CERTIFICATE HOLDER

Dana R. Lockee, M.D.  
9200 Andermatt  
Ste 8  
Lincoln, NE 68526

INSURED

Dana R. Lockee, M.D.  
9200 Andermatt  
Ste 8  
Lincoln, NE 68526

Group Name: Star Anesthesia, P.C.

This certificate is issued as a matter of information only and confers no rights upon the holder. By its issuance, the **company** does not alter, change, modify or extend the provisions of said **policy** and does not waive any of its rights thereunder.

POLICY NUMBER: PCN0001070

**RETRO DATE:** 01/01/2012

**POLICY TERM:** 01/01/2017 to: 01/01/2018

LIMITS OF LIABILITY:

Per Medical Incident/Peer Review Incident: \$ 1,000,000  
Annual Aggregate: \$ 3,000,000

SPECIALTY: Anesthesiology - Pain Management I

Dated at: Denver, Colorado

Date: November 07, 2016

  
Countersigned by Authorized Representative



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CERTIFICATE OF PROFESSIONAL LIABILITY INSURANCE

CERTIFICATE HOLDER

Matthew T. Springer  
9200 Andermatt Dr  
Ste 8  
Lincoln, NE 68526-9639

INSURED

Matthew T. Springer  
9200 Andermatt Dr  
Ste 8  
Lincoln, NE 68526-9639

Group Name: Star Anesthesia, P.C.

This certificate is issued as a matter of information only and confers no rights upon the holder. By its issuance, the **company** does not alter, change, modify or extend the provisions of said **policy** and does not waive any of its rights thereunder.

POLICY NUMBER: PCN0001070

RETRO DATE: 09/15/2003

POLICY TERM: 01/01/2017 to: 01/01/2018

LIMITS OF LIABILITY:

Per Medical Incident/Peer Review Incident: \$ 1,000,000  
Annual Aggregate: \$ 3,000,000

SPECIALTY: CRNA/Nurse Anesthetist

Dated at: Denver, Colorado

Date: November 07, 2016

  
Countersigned by Authorized Representative

# STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

Bruce R. Ramage  
Director



Pete Ricketts  
Governor

November 15, 2016

STAR ANESTHESIA PC  
5301 AARON CIRCLE  
LINCOLN NE 68516

RE: Nebraska Hospital-Medical Liability Act  
See Attached List

Dear Healthcare Provider:

On November 14, 2016, we received \$3,503.00, which represents 26% of the premium which you are being charged by COPIC Insurance 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](mailto:stephanie.hobelman@nebraska.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Stephanie Hobelman".

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

**Additional Addressees:**

**STAR ANESTHESIA PC  
MATTHEW BEHRENS, MD  
RICKY G HARTWIG, MD  
DANA LOCKEE, MD  
MATTHEW T SPRINGER, CRNA**



7351 E. Lowry Blvd., Ste. 400, Denver, CO 80230  
P.O. Box 17540, Denver, CO 80217-0540  
P: 720-858-6000 | TF: 800-421-1834 | F: 720-858-6004

callcopic.com

**COPIC Policyholder Services**

November 23, 2016

Hillary Bonin  
PO Box 67099  
Lincoln, NE 68506

Re: PCN0001070

Dear Hillary:

Please accept this letter as confirmation that you have been approved for professional liability coverage with COPIC. Listed below are two tables. The first table reflects the \$500,000/\$1M annual premium amount for your purposes of reporting to the Nebraska Excess Liability Fund only. The second table reflects your policy limits and annual premium amount.

*To avoid a gap in your Fund coverage, payment is due within 30 days of your policy effective date. Please submit a copy of this letter along with your Fund payment to:*

**Nebraska Excess Liability Fund  
Attn: Stephanie Hobelman  
P O Box 82089  
Lincoln, NE 68501**

<b>Table One</b>		<b>Individual</b>	<b>Retro</b>	<b>Fund</b>	<b>Fund</b>
<b>Physician/Employee/Entity</b>	<b>Effective Dates</b>	<b>Premium</b>	<b>Date</b>	<b>Limits</b>	<b>26%</b>
Hillary Bonin	01/01/2017 - 01/01/2018	\$822	12/01/2014	500/1M	\$214

<b>Table Two</b>		<b>Individual</b>	<b>Retro</b>	<b>Policy</b>
<b>Physician/Employee/Entity</b>	<b>Effective Dates</b>	<b>Premium</b>	<b>Date</b>	<b>Limits</b>
Hillary Bonin	01/01/2017 - 01/01/2018	\$979	12/01/2014	1M/3M

We'd like to take this opportunity to thank you for choosing COPIC for your professional liability needs. If you have any questions, please contact me at 1-800-421-1834, extension 6169 or via email at rpanning@copic.com.

Sincerely,

Rachel Panning  
Underwriter  
Underwriting and Policyholder Service

cc: Star Anesthesia

**HOSPITAL/MEDICAL STAFF OFFICE, PLEASE ACCEPT THIS LETTER AS VERIFICATION OF COVERAGE FOR THE ABOVE CAPTIONED PENDING ISSUANCE OF POLICY.**

# STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

Bruce R. Rame  
Director



Pete Ricketts  
Governor

November 30, 2016

STAR ANESTHESIA PC  
5301 AARON CIRCLE  
LINCOLN NE 68516

RE: Nebraska Hospital-Medical Liability Act  
HILLARY M BONIN, CRNA

Dear Healthcare Provider:

On November 30, 2016, we received \$214.00 from you to add coverage as noted in the reference line of this letter. This represents 26% of the \$500,000/\$1,000,000 limits premium you are being charged by COPIC Insurance Company for this coverage from January 1, 2017 to January 1, 2018.

Hillary M Bonin has been added with a qualification date of January 1, 2017.

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, please contact me at (402)471-2201 or [stephanie.hobelman@nebraska.gov](mailto:stephanie.hobelman@nebraska.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Stephanie Hobelman".

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