Alliance City Council

Council Meetings

July 1, 2025 City Council Meeting

Agenda Materials

Item F - Board Resignation

Alliance Nebraska

Building the Best Hometown in America®

ALLIANCE, NEBRASKA
CITY COUNCIL MEETING
Alliance Learning Center
1750 Sweetwater Avenue
July 1, 2025 – 7:00 p.m.
AGENDA

- **Call to Order**
- **Roll Call**
- **Invocation and Pledge of Allegiance**
- **Open Meetings Act Announcement**

  For the public's reference a copy of the Open Meetings Law has been posted on the northeast corner of this room in the audience area. This posting complies with the requirements of the Nebraska Legislature.

A. Consent Calendar

Approval of Minutes, Payroll, Claims and Council Proceedings
Resolution No. 25-71 – Reallocation of Capital Funds for Picker Cart Purchase
Resolution No. 25-72 – Restated Medical and Dental Plan Document
Resolution No. 25-73 – 2024-2025 Reclassification of Police Lieutenant Pay Grade

B. Public Hearing – Liquor License Manager Application – DPR Wealth Management, LLC

Now is the date, time and place to conduct a Public Hearing on the recommendation approval of Manager Application for Xiomara Smith for DPR Wealth Management, LLC dba Alliance Hotel and Suites, to the Nebraska Liquor Control Commission. Resolution No. 25-70 has been prepared for the Council's consideration and will recommend approval of the Manager Application to the Nebraska Liquor Control Commission.

Resolution No. 25-70 – Manager Application for DPR Wealth Management, LLC

Resolution No. 25-70 will recommend approval of the Manager Application for Xiomara Smith for DPR Wealth Management, LLC dba Alliance Hotel and Suites, to the Nebraska Liquor Control Commission.

C. Resolution No. 25-74 – Engineering Contract for Power Plant Remediation Design

Resolution No. 25-74 will approve entering into agreement with Burns & McDonnell Engineering Company, Inc. in the amount of $103,400.00 for creation of bid documents for the abatement of Asbestos at the decommissioned City of Alliance Power Plant.

D. Resolution No. 25-75 – Interim City Clerk Pay

Resolution No. 25-75 will approve pay for the Interim City Clerk, effective as of June 17, 2025.

E. Resolution No. 25-76 – Nebraska Public Agency Investment Trust (NPAIT) Updates

Resolution No. 25-76 will approve authorized users of the Nebraska Public Agency Investment Trust (NPAIT).

F. Board Resignation

Accept the resignation of Raymond Hielscher from the Planning Commission Board.

G. Executive Session - Personnel Matters

1. Discussion on filling the City Clerk's position.
2. Annual review of City Manager's performance.

- **Motion to Adjourn**

Respectfully submitted,
Ammie L. Bedient
Ammie L. Bedient
Interim City Clerk

† Added by addendum to agenda 24 hours prior to the meeting.
The City Council reserves the right to adjourn into closed session as per Section 84-1410 of the Nebraska Revised Statutes.

CONSENT CALENDAR – July 1, 2025

1. Approval: Minutes of the Regular Meeting, June 17, 2025.

2. Approval: Payroll from June 13, 2025 in the total amount of $429,643.23.

3. Approval: Claims against the following funds: General, General Debt Service, Trust and Agency, Street, Electric, Refuse Collection and Disposal, Sanitary Sewer, Water, Golf Course, Downtown Improvement Districts, R.S.V.P., Keno, and Capital Improvement; $1,173,877.07.

4. Approval: Resolution No. 25-71 which will authorize that $6,200.00 of funds originally allocated for the golf irrigation well design be reallocated for the purchase of a 2021 Yamaha Umax Range Picker Cart in the total amount of $6,200.00 for Sky View Golf Course.

5. Approval: Resolution No. 25-72 which will authorize the Mayor to execute all documents related to finalizing the 2025 Restate Medical and Dental Plans.

6. Approval: Resolution No. 25-73 which will amend the FY24-25 Classification Plan to reclassify the Police Lieutenant position from Grade 104 to Grade 105.

NOTE: City Manager Sorensen and City Treasurer Baker have reviewed these expenditures and to the best of their knowledge confirm that they are within budgeted appropriations to this point in the fiscal year.

Any item listed on the Consent Calendar may, by the request of any single Council Member, be considered as a separate item in the Regular Agenda.

ALLIANCE CITY COUNCIL

REGULAR MEETING, TUESDAY, JUNE 17, 2025

STATE OF NEBRASKA)
)
COUNTY OF BOX BUTTE) §
)
CITY OF ALLIANCE)

The Alliance City Council met in a Regular Meeting, June 17, 2025 at 7:00 p.m. in the Alliance Learning Center Community Meeting Room, 1750 Sweetwater Avenue. A notice of meeting was published in the Alliance Times Herald on June 11, 2025. The notice stated the date, hour and place of the meeting, that the meeting was open to the public, and that an agenda of the meeting, kept continuously current, was available for public inspection at the office of the City Clerk in City Hall; provided the Council could modify the agenda at the meeting if it determined an emergency so required. A similar notice, together with a copy of the agenda, also had been provided to each of the City Council Members. An agenda, kept continuously current, was available for public inspection at the office of the City Clerk during regular business hours from the publication of the notice to the time of the meeting.

Mayor McGhehey opened the June 17, 2025 regular meeting of the Alliance, Nebraska City Council at 7:00 p.m. Present were Mayor McGhehey and Council Members Weisgerber and Turman. Also present were City Manager Sorensen, City Treasurer Baker, City Attorney Selzer and Recording Secretary Bedient.

- First action Mayor McGhehey was to excuse the absence of Vice Mayor Mashburn and to note Councilman Liptack as unexcused.

- Mayor McGhehey read the Open Meetings Act Announcement.

- The first agenda item for Council was to appoint Ammie Bedient as Interim City Clerk.

A motion was made by Councilman Turman, seconded by Councilman Weisgerber to appoint Ammie Bedient as Interim City Clerk.

Roll call vote with the following results:

Voting Aye: Weisgerber, Turman and McGhehey.

Voting Nay: None.

Motion carried.

● The Consent Calendar was the next item on the agenda. A motion was made by Councilman Turman, seconded by Councilman Weisgerber to approve the Consent Calendar as follows:

CONSENT CALENDAR – June 17, 2025

1. Approval: Minutes of the Regular Meeting, June 3, 2025.

2. Approval: Payroll from May 30, 2025 in the total amount of $277,536.46.

3. Approval: Claims against the following funds: General, General Debt Service, Trust and Agency, Street, Electric, Refuse Collection and Disposal, Sanitary Sewer, Water, Golf Course, Downtown Improvement Districts, R.S.V.P., Keno, and Capital Improvement; $533,388.98.

4. Approval: Resolution No. 25-53 which will authorize the Mayor to sign an agreement with Al Vacanti to provide project management assistance and grant writing services with a one-time retainer payment in the amount of $15,000; and payments quarterly of $15,000 in the total amount of $60,000 per each 12-months.

5. Approval: Resolution No. 25-65 which will approve the Plan and Project for Phan Enterprises at 206 Box Butte Avenue which has determined that the Plan meets the requirements of Section 18-2155(2) of the Community Development Law and is consistent with the City's Comprehensive Plan.

6. Approval: Resolution No. 25-66 which will authorize the Mayor to sign the Alliance Urban Area Map as presented.

7. Approval: Resolution No. 25-67 which will approve the closure of 3rd Street, which is a designated State Highway, from Black Hills Avenue east Mississippi Avenue. The event will take place on July 19, 2025 beginning at 9:45 a.m. until completion of the parade for Heritage Days.

NOTE: City Manager Sorensen and City Treasurer Baker have reviewed these expenditures and to the best of their knowledge confirm that they are within budgeted appropriations to this point in the fiscal year.

Any item listed on the Consent Calendar may, by the request of any single Council Member, be considered as a separate item in the Regular Agenda.

Roll call vote with the following results:

Voting Aye: Turman, Weisgerber and McGhehey.

Voting Nay: None.

Motion carried.

● Council next held a Public Hearing on the B & W Gas & Convenience dba YesWay Liquor License Manager Application for Cheyenne Tullier. Following the Public Hearing, Council considered Resolution No. 25-68, which has been prepared to recommend approval of the Manager's Application.

Mayor McGhehey stated, "now is the date, time and place to conduct a Public Hearing to hear support, opposition, criticism, suggestions, or observations of the taxpayers relating to the B & W Gas & Convenience Liquor License Manager Application for Cheyenne Tullier opened the public hearing at 7:06 p.m."

Mayor McGhehey asked Interim City Clerk Bedient if there were any findings. Interim City Clerk Bedient reported that the Alliance Police Department Background Check revealed no concerns or issues.

No additional testimony was offered and the Public Hearing closed at 7:07 p.m.

A motion was made by Councilman Turman, seconded by Councilman Weisgerber to approve Resolution No. 25-68. Which follows in its entirety:

RESOLUTION NO. 25-68

WHEREAS, The City of Alliance has received a notice and copy of a Manager Application for YesWay 1170, 610 East 3rd Street, Alliance, Nebraska submitted by Cheyenne Tullier; and

WHEREAS, City staff has reviewed the application and find no reason why the proposed manager, Cheyenne Tullier, would be disqualified from serving as manager; and

NOW, THEREFORE, BE IT RESOLVED, by the Mayor and Council of the City of Alliance, Nebraska, that the Manager's Application of Cheyenne Tullier, YesWay 1170, 610 East 3rd Street, Alliance, Nebraska is hereby recommended for approval to the Nebraska Liquor Control Commission; and

BE IT FURTHER RESOLVED, that the City shall notify the Nebraska Liquor Control Commission of this Council decision.

Roll call vote with the following results:

Voting Aye: Weisgerber, Turman and McGhehey.

Voting Nay: None.

Motion carried.

● Council next held a Public Hearing on the Class I Liquor License application of DPR Wealth Management, LLC dba Alliance Hotel and Suites. Following the public hearing, Council considered Resolution No. 25-69 which has been prepared to recommend approval of the license. Council was provided the following the information:

[The City is in receipt of a Class I Liquor License application from DPR Wealth Management, LLC dba Alliance Hotel and Suites, 117 Cody Avenue. The license application is included in the packet. No disqualifiers came from a background check conducted by the Alliance Police Department.

HEARING PROCESS -

1. Mayor or council member announces agenda item.
2. Mayor opens public hearing and asks clerk what exhibits she has.
3. Clerk identifies application, checklist for 53-132, Chief's report, and other documents she may have received.
4. Mayor asks for a motion that the exhibits be received into the record, second and vote.
5. Mayor asks for those who are going to give testimony to stand and be sworn.
6. Mayor says "do you swear or affirm to tell the truth so help you God".
7. Individuals respond.
8. Those individuals should include the applicant who must prove to the council's satisfaction the elements on the top part of the checklist. They will also include individuals who may speak either in favor or against the application and police chief who will hit the high points of his report.
9. Mayor calls on applicant to make a presentation.
10. While applicant is still at the podium, the Mayor will call on the City Attorney for any questions and to council and himself for questions.
11. Mayor asks for others who wish to speak in favor of the application and follows the same process for questions.
12. Mayor then calls upon those who wish to speak against and follows the same process for questions.
13. Mayor then calls on the police chief / staff for comments.
14. Mayor asks if there is any other testimony.
15. Mayor closes the public hearing and asks for comment from the City Attorney.
16. Mayor asks for comment from Council and himself.
17. Mayor asks for a motion.
18. The motion is either to make a positive or negative recommendation on the application to the Liquor Control and to reference the elements on the top of the checklist and ask staff to prepare Resolution for the Mayor's signature.
19. After a second, Mayor calls for a vote.**]**

Mayor McGhehey stated, “now is the date, time, and place to conduct a Public Hearing to hear support, opposition, criticism, suggestions, or observations of the taxpayers relating to the

Class I Liquor License Application of DPR Wealth Management, LLC dba Alliance Hotel and Suites and opened the public hearing at 7:08 p.m."

Interim City Clerk Bedient identified the following exhibits for the hearing:

Exhibit 1 – Application of DPR Wealth Management, LLC dba Alliance Hotel and Suites, 117 Cody Avenue, Alliance, NE.
Exhibit 2 – City Council checklist for Section 53-132 R.R.S. (1984)
Exhibit 3 – Written statement from the Alliance Police Department.

A motion was made by Councilman Turman, seconded by Councilman Weisgerber to accept Exhibits 1-3 into the record.

Roll call vote with the following results:

Voting Aye: Turman, Weisgerber and McGhehey.

Voting Nay: None.

Motion carried.

No additional testimony was offered and the Public Hearing closed at 7:11 p.m.

A motion was made by Councilman Weisgerber, seconded by Councilman Turman to approve Resolution No. 25-69. Which follows in its entirety:

RESOLUTION NO. 25-69

BE IT RESOLVED BY THE MAYOR AND CITY COUNCIL OF THE CITY OF ALLIANCE, NEBRASKA:

On June 17, 2025 the matter of the Class I Liquor License Application of DPR Wealth Management, LLC dba Alliance Hotel and Suites, 117 Cody Avenue, Alliance, NE, came on for consideration by the Council.

The following exhibits were offered and received:

Exhibit 1 - Application of DPR Wealth Management, LLC, 117 Cody Avenue
Exhibit 2 - City Council checklist for Section 53-132 R.R.S. (1984)
Exhibit 3 - Written statement from the Alliance Police Department

Witnesses were sworn and testimony was received in support of the Class I Liquor License at the public hearing on this date from DPR Wealth Management, LLC dba Alliance Hotel and Suites.

Upon consideration of the evidence and the criteria to be considered by the City Council pursuant to law, the City Council finds as follows:

Applicant complies with the provisions of Section 53-131.01 R.R.S. (2003).

Applicant has met its burden with regard to the checklist that is provided by Section 53-132 R.R.S. (1984) and demonstrates a willingness and ability to properly manage the liquor license held by DPR Wealth Management, LLC dba Alliance Hotel and Suites in conformance to the rules and regulations of the Nebraska Liquor Control Act.

Based on the above findings, the City Council recommends to the Nebraska Liquor Control Commission that the Class I Liquor License Application of by DPR Wealth Management, LLC dba Alliance Hotel and Suites at the premise described in the application be approved. The City of Alliance shall transmit a copy of this Resolution to the Commission.

Roll call vote with the following results:

Voting Aye: Weisgerber, Turman and McGhehey.

Voting Nay: None.

Motion carried.

- Resolution No. 25-70 which will recommend approval of the Manager Application of Xiomara for DPR Wealth Management, LLC dba Alliance Hotel and Suites, was the next item on the agenda. Which was tabled until July 1st City Council Meeting, for the lack of having a Manager's Background Check completed.

- The next item on the agenda for Council was the third and final reading of Ordinance No. 3002 which will add Section 2-53 to the Municipal Code of Conduct for the City of Alliance City Council.

A motion was made by Councilman Weisgerber, seconded by Councilman Turman to approve the third and final reading of Ordinance No. 3002. Interim City Clerk Bedient read the Ordinance by title which follows in its entirety:

Ordinance No. 3002

AN ORDINANCE OF THE CITY OF ALLIANCE, NEBRASKA ADDING ALLIANCE MUNICIPAL CODE SECTION 2-53 REQUIRING THAT CITY COUNCIL MEMBERS USE THEIR CITY ISSUED EMAIL ADDRESSES WHEN COMMUNICATING WITH ONE ANOTHER; ADDING ALLIANCE MUNICIPAL CODE SECTION 2-54 DEFINING CITY COUNCIL MISCONDUCT AND PROVIDING FOR A PROCESS FOR INVESTIGATING AND DETERMINING WHETHER MISCONDUCT HAS OCCURRED AND THE CONSEQUENCES OF SUCH MISCONDUCT; REPEALING EXISTING PROVISIONS OF THE CITY CODE NOT CONSISTENT WITH THIS ORDINANCE; AND PROVIDING FOR AN EFFECTIVE DATE.

BE IT ORDAINED BY THE MAYOR AND CITY COUNCIL OF THE CITY OF ALLIANCE, NEBRASKA:

SECTION 1. Section 2-53 of the Alliance Municipal Code is added as follows:

2-53-Use of Email by Council Members and City Employees.

City council members will be issued an email address with the City of Alliance domain name. City council members shall use their city issued email addresses when communicating with one another via email or when otherwise conducting city business via email, unless exceptional circumstances make such use impractical.

SECTION 2. Section 2-54 of the Alliance Municipal Code is added as follows:

2-54-City Council Member Official Misconduct.

(a) *Purpose.* The citizens of the City of Alliance are entitled to have a fair, ethical, and accountable local government. The purpose of this ordinance is to ensure that council members act appropriately and to establish a process to determine whether a council member has committed official misconduct.

(b) *Official Misconduct.* Council members shall not commit official misconduct which includes:

(1) Personal attacks or verbal abuse against a City official or employee.

(2) Improper use or disclosure of (i) confidential information, (ii) information that is not intended to be publicly disclosed and not subject to public disclosure by law, or (iii) information discussed or disseminated in a properly called closed session of the City Council.

(3) Making false statements on which the City Council may rely on when establishing an ordinance, passing a resolution, setting the budget, or otherwise establishing policy.

(4) Publicly or privately giving orders to subordinates of the City Manager.

(5) Violation of the Nebraska Political Accountability and Disclosure Act.

(6) Any other violation of City Ordinance, Nebraska law, or Federal law.

(c) *Complaints.* Any council member may make a complaint to the City Attorney if such council member believes another council member has engaged in official misconduct. The complaint must be in writing, dated, and include:

(1) The name of the complaining council member;

(2) The name of the council member alleged to have engaged in official misconduct;

(3) The specific facts and circumstances alleged to constitute official misconduct, including any documentation or evidence;

(4) A statement that the complaining council member swears and affirms, under penalty of perjury, that to the best of the complaining council member's knowledge, all statements in the complaint are true; and

(5) The notarized signature of the complaining council member.

(d) *Investigation.* Upon receipt of the complaint, the City Attorney shall forward the complaint to the City Council. At the next possible City Council meeting, the City Council may (1) direct the City Attorney to investigate the allegations in the complaint and provide their findings to the City Council;(2) if the City Attorney does not feel it is appropriate for the City Attorney to be involved in the investigation, appoint, at the expense of the City, special counsel to investigate the allegations in the complaint and provide their findings to the City Attorney and City Council; or (3) dismiss the complaint without an investigation.

(e) *Initial Action.* If an investigation is ordered, then, within 30 days after receiving the findings, any council member may request that the matter be placed on the agenda at the next possible City Council meeting. At such City Council meeting, the City Council may:

(1) Dismiss the complaint or

(2) Set the complaint for an evidentiary hearing within 30 days.

(f) *Evidentiary Hearing.* Notice of the evidentiary hearing must be given to all council members at least 10 days prior to the hearing. At the evidentiary hearing, the City Attorney or special counsel appointed to investigate shall present the evidence obtained during the investigation to the City Council. At least 7 days prior to the hearing, the City Attorney or special counsel appointed to investigate shall disclose to the accused council member (1) the names and anticipated testimony of each person the City Attorney or special counsel may call to testify at the hearing and (2) a copy of all documents that the City Attorney or special counsel may use at the hearing, except for witnesses and documents solely used for rebuttal purposes. The accused council member may cross examine any witnesses and provide any of its own evidence at the hearing. The accused City Council member may be represented by an attorney at the hearing. If the City Attorney has investigated the complaint according to subsection (d) above, then special counsel shall be hired to represent the City Council at the hearing. The strict rules of evidence shall not apply to the hearing.

(g) *Final Action.* Within 30 days after the evidentiary hearing, the City Council may either dismiss the complaint or find that the accused council member has engaged in official misconduct. If the City Council finds that the accused council member has engaged in official misconduct then the City Council may:

(1) Take no further action;
(2) Provide a written warning to the council member;
(3) Censure the council member; or
(4) Remove the council member from office.

The City Council may only remove a council member from office if the official misconduct was found to be repeated, habitual, or persistent and either willful or a result of gross negligence. Any action to remove a council member from office shall require the unanimous vote of the other council members.

Any action according to subsections 2 through 4 above must be made within 30 day after the hearing. An accused council member may resign from office at any time prior to the City Council taking action

according to this subsection, in which case the complaint shall be deemed moot and the City Council shall take no further action on the complaint.

SECTION 3. All ordinances, parts of ordinances, resolutions, and policies of the City of Alliance in conflict with this ordinance are hereby repealed.

SECTION 4. This ordinance shall be in full force and effect from and after its approval, passage, and publication according to law.

Roll call vote with the following results:

Voting Aye: Weisgerber, Turman, and McGhehey.

Voting Nay: None.

Motion carried.

Mayor McGhehey stated, "the passage and adoption of Ordinance No. 3002 has been concurred by a majority of all members elected to the Council; I declare it passed, adopted and order it published."

- The next item on the agenda for Council was the presentation by Micheal Wallace with Farris Engineering Inc., of the Secondary Power Source Engineering Study. The following information was provided:

[**ALTERNATE FEED FEASIBILITY STUDY**

As a part of the'24-'25 budget, money was allocated for an alternate feed feasibility study. The City's electric system relies on a single source of incoming power, which represents a critical vulnerability. In the event of this one source failing, the entire electric grid would be without power. Current staff have acknowledged that there is weakness in the electrical infrastructure system and there is a need to strengthen the reliability, flexibility, and long- term resilience of the electrical infrastructure.

In October of 2024, an RFP was posted soliciting proposals from qualified engineering firms to conduct a study. The objective of this study is to assess the feasibility of adding an alternate electric feed line, identify potential routes, evaluate technical and environmental considerations, consider other infrastructure "hardening" measures and provide cost estimates and recommendations for implementation. We received one proposal in response to the RFP, submitted by Farris Engineering. This proposal went to Council and was approved in January of 2025.

The study came up with a definite need to establish an alternate feed route to maintain reliability, resilience and operational flexibility of the electric system.

Farris Engineering has come up with the following four options:

1. Build a new 34.5 kV line from an existing transmission source 14 miles North of the City.
2. Build a new 115 kV line from an existing transmission source 14 miles North of the City.
3. Build a new 115 kV line from a source at Hyannis.
4. Install new generation plants at Emerson and Broadwater substations.

After evaluating all the options and taking costs associated with all into consideration, Farris Engineering recommends either option 1 or option 4.]

Micheal Wallace came before the Council giving them an overview.

- The next item on the agenda for Council was the Discussion Item of Public Transit Program Agreement Federal Aid Funds.

Mayor McGhehey gave an overview of the City of Alliance Public Transit grant funding overview.

- The next item on the agenda for Council was to accept the resignation of Maxine Anderson from the Library Board.

A motion was made by Councilman Weisgerber, seconded by Councilman Turman to accept the resignation of Maxine Anderson from the Library Board.

Roll call vote with the following results:

Voting Aye: Weisgerber, Turman and McGhehey.

Voting Nay: None.

Motion carried.

- The next item on the agenda for Council was a Board Appointment.

A motion was made by Councilman Turman, seconded by Councilman Weisgerber to appoint Emily Nelson to the Library Board with a term ending June 30, 2027.

Roll call vote with the following results:

Voting Aye: Turman, Weisgerber and McGhehey.

Voting Nay: None.

Motion carried.

- The last matter before Council was the Discussion and Appointment of the City Clerk.

Mayor McGhehey announced Sean Brenke was the selected candidate for the City Clerk Position.

A motion was made by Mayor McGhehey, seconded by Councilman Turman to appoint Sean Brenke to fill the vacancy and to serve as the City Clerk.

The Alliance City Council adjourned the June 17, 2025 City Council Meeting at 7:39 p.m.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Complete minutes of the Alliance City Council may be viewed by the public during regular work hours at the City Clerk's Office, 324 Laramie Avenue, Alliance, Nebraska

PAYROLL COSTS TO BE REPORTED TO COUNCIL

PAY DATE: **6/13/2025**

GROSS PAYROLL $ 290,348.64
(GET FROM SINGLE LINE SUMMARY REPORT)

EMPLOYER COSTS
(GET FROM BENEFITS REGISTER REPORT)

FICA	$ 16,668.39	
MEDICARE	$ 4,140.27	
POLICE PENSION - PRINCIPAL	$ 2,859.26	
FIRE PENSION - PRINCIPAL	$ 2,266.17	
GENERAL PENSION - PRINCIPAL	$ 8,912.62	
MISSION SQUARE PENSION	$ 327.88	
H S A SANDHILLS STATE BANK	$ 7,520.00	
HEALTH/LIFE INSURANCE - HEALTH FUND	$ 96,600.00	
TOTAL BENEFITS		$ 139,294.59

TOTAL PAYROLL COSTS **$ 429,643.23**

CITY CLERK - SHELBI PITT

$ 304,743.97	Total
-$ 2,266.17	FIRER
-$ 5,196.57	GENER
-$ 3,716.05	OPTER
-$ 2,859.26	POLER
-$ 327.88	CIER
-$ 29.40	VEHIC
$ 290,348.64	

$ 7,520.00	HSA
$ 16,668.39	FICA (SS)
$ 4,140.27	MEDICARE
$ 96,600.00	1ST PAYROLL

Report Criteria:
Invoices with totals above $0 included.
Paid and unpaid invoices included.

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
General Fund					
01-11-11-44-431 Legal, Public Notices	General Fund	City Administration	City Administration		
ALLIANCE TIMES HERALD	LEGAL AD - ORDINANCE 3000	757551	06/18/2025	56.04	
01-11-11-44-431 Legal, Public Notices	General Fund	City Administration	City Administration		
ALLIANCE TIMES HERALD	LEGAL AD - ORDINANCE 2999	757552	06/18/2025	72.92	
01-11-11-44-431 Legal, Public Notices	General Fund	City Administration	City Administration		
ALLIANCE TIMES HERALD	LEGAL AD - ORDINANCE 3001	757553	06/18/2025	24.56	
Total City Administration:				153.52	
Total City Administration:				153.52	
01-31-31-44-441 Electricity	General Fund	Police Administration	Police Department		
COA UTILITIES	ELECTRIC	UTILITIES 06/1	06/17/2025	82.15	06/17/2025
01-31-31-44-442 Water-Sewer	General Fund	Police Administration	Police Department		
COA UTILITIES	WATER / SEWER	UTILITIES 06/1	06/17/2025	5.24	06/17/2025
01-31-31-44-443 Refuse	General Fund	Police Administration	Police Department		
COA UTILITIES	REFUSE	UTILITIES 06/1	06/17/2025	25.36	06/17/2025
01-31-31-44-444 Natural Gas	General Fund	Police Administration	Police Department		
BLACK HILLS ENERGY	8845 9631 60	JUNE 2025	06/04/2025	36.52	
01-31-31-45-511 Office Supplies	General Fund	Police Administration	Police Department		
PRINT EXPRESS	BUSINESS CARDS	84237	06/11/2025	282.24	
Total Police Administration:				431.51	
01-31-32-42-294 Conferences, Cont Education	General Fund	Police Operations	Police Department		
NE LAW ENFORCEMENT TRAINING	LODGING	15337	06/13/2025	75.00	
01-31-32-43-374 Investigators Expense	General Fund	Police Operations	Police Department		
MAGNET FORENSICS LLC	Magnet Axiom Advanced License Ren	SIN080990	05/15/2025	6,720.00	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
ALLIANCE MOTORS UNLIMITED, IN	UNIT #117 REPLACE BAD ALTERNA	71872	06/12/2025	987.69	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
ALLIANCE MOTORS UNLIMITED, IN	UNIT #105 OIL CHANGE	71948	06/19/2025	122.00	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
ALLIANCE MOTORS UNLIMITED, IN	UNIT #103 CHECK OVERHEATING/R	71979	06/23/2025	156.00	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
ALLIANCE MOTORS UNLIMITED, IN	UNIT #114 OIL CHANGE	71997	06/24/2025	80.40	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
ALLIANCE MOTORS UNLIMITED, IN	UNIT #104 OIL CHANGE	71921	06/16/2025	87.00	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
ALLIANCE MOTORS UNLIMITED, IN	UNIT #113 CHECK OIL LEAK/REPAI	71879	06/10/2025	151.50	
01-31-32-44-464 PMCNTSVC-Vehicle Repair	General Fund	Police Operations	Police Department		
RED BEARD GARAGE	TOWING FEE	12215	06/10/2025	175.00	
01-31-32-44-483 NRCNTSVC-Building Public Wrks	General Fund	Police Operations	Police Department		
JACK'S REFRIGERATION INC	JUNE PLANNED MAINT	68337	06/18/2025	360.49	
01-31-32-45-511 Office Supplies	General Fund	Police Operations	Police Department		
NEBRASKA TOTAL OFFICE	BINDER CLIPS/PAPER/PAPER	0128804-001	06/11/2025	63.96	
01-31-32-45-544 Small Tools, Equipment	General Fund	Police Operations	Police Department		
CARTER'S HOME HARDWARE & AP	UNIT #118 KEYS	29337/1	06/19/2025	3.98	
01-31-32-45-563 Cleaning Supplies	General Fund	Police Operations	Police Department		
IDEAL LINEN INC	TOWELS/MOPS	11276004	06/17/2025	36.78	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
Total Police Operations:				9,019.80	
01-31-33-44-451 Telephone Line Expense	General Fund	Police Support Services	Police Department		
AS CENTRAL SERVICES	TELECOMMUNICATIONS CHARGES	1483829	06/18/2025	537.60	
01-31-33-44-451 Telephone Line Expense	General Fund	Police Support Services	Police Department		
AS CENTRAL SERVICES	TELECOMMUNICATIONS CHARGES	1482020	06/11/2025	258.00	
01-31-33-44-452 Long Distance Expense	General Fund	Police Support Services	Police Department		
QWEST - PHOENIX	91388248	740630337	06/16/2025	499.04	
Total Police Support Services:				1,294.64	
Total Police Department:				10,745.95	
01-37-35-44-484 NRCNTSVC-Communication Equi	General Fund	Emergency Management System	Fire Department		
ACTION COMMUNICATION INC	FACTORY RADIO & PAGER	54880	05/28/2025	600.00	
Total Emergency Management Systems:				600.00	
01-37-37-42-238 Vol Firefighter Life Ins	General Fund	Firefighting	Fire Department		
VFIS BENEFITS DIVISION	BASIC COVERAGE	399501130	06/01/2025	380.00	
01-37-37-44-444 Natural Gas	General Fund	Firefighting	Fire Department		
BLACK HILLS ENERGY	2290 8652 37	JUNE 2025	06/04/2025	81.69	
01-37-37-45-561 Bldg Maintenance Material	General Fund	Firefighting	Fire Department		
BERNIES ACE HARDWARE	FIRE HALL LED 2PK #301	319901	06/11/2025	149.95	
Total Firefighting:				611.64	
01-37-38-45-521 Medical Supplies	General Fund	Ambulance	Fire Department		
BOUND TREE MEDICAL, LLC	MEDICAL SUPPLIES	85802853	06/10/2025	365.28	
01-37-38-45-521 Medical Supplies	General Fund	Ambulance	Fire Department		
BOUND TREE MEDICAL, LLC	MEDICAL SUPPLIES	85807741	06/13/2025	142.32	
01-37-38-45-521 Medical Supplies	General Fund	Ambulance	Fire Department		
BOX BUTTE GENERAL HOSPITAL	MEDICAL SUPPLIES	757541	06/13/2025	251.41	
01-37-38-45-521 Medical Supplies	General Fund	Ambulance	Fire Department		
LIFE-ASSIST INC	MEDICAL SUPPLIES	1609487	06/13/2025	87.20	
01-37-38-45-544 Small Tools, Equipment	General Fund	Ambulance	Fire Department		
LIFE-ASSIST INC	RAINBOW SENSOR, PEDI, DCI REU	1609356	06/13/2025	923.00	
Total Ambulance:				1,769.21	
Total Fire Department:				2,980.85	
01-41-44-44-444 Natural Gas - Facility Maint	General Fund	Facility Maintenance	Public Works		
BLACK HILLS ENERGY	8514 7540 93	JUNE 2025	06/04/2025	46.48	
01-41-44-45-544 Small Tools, Equipment	General Fund	Facility Maintenance	Public Works		
FARM PLAN	BIT HAMMER	51453786	06/17/2025	29.99	
Total Facility Maintenance:				76.47	
01-41-46-43-373 Contract Custodial Services	General Fund	Municipal Building	Public Works		
MELISA BRASS	JANITORIAL SERVICES	603216	06/15/2025	3,326.67	
01-41-46-44-444 Natural Gas	General Fund	Municipal Building	Public Works		
BLACK HILLS ENERGY	8314 2036 34	JUNE 2025	06/04/2025	109.43	
01-41-46-45-561 Bldg Maintenance Material	General Fund	Municipal Building	Public Works		
FARM PLAN	MAIN LINE CLEANER	51454586	06/19/2025	9.99	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept	Segment Department / Invoice Number	Invoice Date	Net Invoice Amount	Date Paid
Total Municipal Building:					3,446.09	
Total Public Works:					3,522.56	
01-61-63-45-556 Equip Parts-Veh, Mach, Equip	General Fund	Nuisance Abatement	Community Develop			
WOLF FORD OF ALLIANCE	2013 F150 BRAKE PAD/ROTORS		57995	06/13/2025	155.85	
01-61-63-45-558 Tires-Vehicle, Equipment	General Fund	Nuisance Abatement	Community Develop			
WOLF FORD OF ALLIANCE	2013 FORD F150 BRAKE PADS/ROT		57995	06/13/2025	500.00	
Total Nuisance Abatement:					655.85	
Total Community Development:					655.85	
01-71-71-43-371 Contract Grounds Maintenance	General Fund	Parks	Cultural and Leisure			
ALL SEASONS LANDSCAPING LLC	LANDSCAPE MAINTENANCE		757554	06/23/2025	3,800.00	
01-71-71-44-412 Machine, Equipment Rent	General Fund	Parks	Cultural and Leisure			
TRITLE PLUMBING INC	PORTA JOHN RENTAL		32078	06/16/2025	170.00	
01-71-71-44-441 Electricity	General Fund	Parks	Cultural and Leisure			
COA UTILITIES	ELECTRIC		UTILITIES 06/1	06/17/2025	1,397.70	06/17/2025
01-71-71-44-442 Water-Sewer	General Fund	Parks	Cultural and Leisure			
COA UTILITIES	WATER / SEWER		UTILITIES 06/1	06/17/2025	2,523.48	06/17/2025
01-71-71-44-443 Refuse	General Fund	Parks	Cultural and Leisure			
COA UTILITIES	REFUSE		UTILITIES 06/1	06/17/2025	252.22	06/17/2025
01-71-71-44-444 Natural Gas	General Fund	Parks	Cultural and Leisure			
BLACK HILLS ENERGY	4303 0966 09		JUNE 2025	06/04/2025	67.38	
01-71-71-44-444 Natural Gas	General Fund	Parks	Cultural and Leisure			
BLACK HILLS ENERGY	8316 6747 88		JUNE 2025	06/04/2025	45.37	
01-71-71-44-444 Natural Gas	General Fund	Parks	Cultural and Leisure			
BLACK HILLS ENERGY	8650 1637 80		JUNE 2025	06/04/2025	56.38	
01-71-71-44-444 Natural Gas	General Fund	Parks	Cultural and Leisure			
BLACK HILLS ENERGY	1529 6736 12		JUNE 2025	06/04/2025	45.37	
01-71-71-44-489 NRCNTSVC-Other Mach, Equip	General Fund	Parks	Cultural and Leisure			
SANDBERG IMPLEMENT INC	EQUIPMENT REPAIR		WO04862	06/20/2025	443.00	
01-71-71-44-495 NRCNTSVC-Lawns, Grounds	General Fund	Parks	Cultural and Leisure			
HANSEN'S LOCKSMITHING	BOWER FIELD CONCESSION KEYS		8348	06/05/2025	325.00	
01-71-71-45-542 Parks Furnishings	General Fund	Parks	Cultural and Leisure			
OD SPORTS ACQUISITIONS INC	BALLFIELD NETTING FOR BOWER		INV220564	05/30/2025	3,497.45	
01-71-71-59-970 Capital Outlay-Other Improv	General Fund	Parks	Cultural and Leisure			
TORRINGTON SOD FARMS	SOD, DELIVERY AND INSTALLATIO		23992	06/11/2025	16,046.00	
Total Parks:					28,669.35	
01-71-72-44-441 Electricity	General Fund	Senior Center	Cultural and Leisure			
COA UTILITIES	ELECTRIC		UTILITIES 06/1	06/17/2025	304.58	06/17/2025
01-71-72-44-442 Water-Sewer	General Fund	Senior Center	Cultural and Leisure			
COA UTILITIES	WATER / SEWER		UTILITIES 06/1	06/17/2025	24.11	06/17/2025
01-71-72-44-443 Refuse	General Fund	Senior Center	Cultural and Leisure			
COA UTILITIES	REFUSE		UTILITIES 06/1	06/17/2025	25.36	06/17/2025
01-71-72-44-444 Natural Gas	General Fund	Senior Center	Cultural and Leisure			
BLACK HILLS ENERGY	8177 7736 40		JUNE 2025	06/04/2025	96.81	
Total Senior Center:					450.86	
01-71-74-44-441 Electricity	General Fund	Cemetery	Cultural and Leisure			
COA UTILITIES	ELECTRIC		UTILITIES 06/1	06/17/2025	53.00	06/17/2025

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
01-71-74-45-574 Misc Grounds Maintenance	General Fund	Cemetery	Cultural and Leisure		
TRITLE PLUMBING INC	ONE DOUBLE PORTA JOHN DELIVE	32072	06/11/2025	180.00	
Total Cemetery:				233.00	
01-71-75-44-441 Electricity	General Fund	Swimming Pool	Cultural and Leisure		
COA UTILITIES	ELECTRIC	UTILITIES 06/1	06/17/2025	1,590.30	06/17/2025
01-71-75-44-443 Refuse	General Fund	Swimming Pool	Cultural and Leisure		
COA UTILITIES	REFUSE	UTILITIES 06/1	06/17/2025	126.11	06/17/2025
01-71-75-44-444 Natural Gas	General Fund	Swimming Pool	Cultural and Leisure		
BLACK HILLS ENERGY	4332 1963 21	JUNE 2025	06/04/2025	5,131.69	
01-71-75-45-526 Other Supplies	General Fund	Swimming Pool	Cultural and Leisure		
FARM PLAN	OTHER SUPPLIES	51441653	05/23/2025	47.93	
01-71-75-45-526 Other Supplies	General Fund	Swimming Pool	Cultural and Leisure		
FARM PLAN	OTHER SUPPLIES	51441776	05/24/2025	4.18	
01-71-75-45-526 Other Supplies	General Fund	Swimming Pool	Cultural and Leisure		
FARM PLAN	OTHER SUPPLIES	51441776	05/24/2025	22.52	
01-71-75-45-526 Other Supplies	General Fund	Swimming Pool	Cultural and Leisure		
CARTER'S HOME HARDWARE & AP	OTHER SUPPLIES	29335/1	06/19/2025	39.98	
01-71-75-45-561 Bldg Maintenance Material	General Fund	Swimming Pool	Cultural and Leisure		
BERNIES ACE HARDWARE	BUILDING MAINTENANCE	320217	06/17/2025	22.94	
01-71-75-45-561 Bldg Maintenance Material	General Fund	Swimming Pool	Cultural and Leisure		
BERNIES ACE HARDWARE	BUILDING MAINTENANCE	320264	06/17/2025	15.96	
01-71-75-45-561 Bldg Maintenance Material	General Fund	Swimming Pool	Cultural and Leisure		
BERNIES ACE HARDWARE	BUILDING MAINTENANCE	320223	06/17/2025	8.01	
01-71-75-45-561 Bldg Maintenance Material	General Fund	Swimming Pool	Cultural and Leisure		
BERNIES ACE HARDWARE	BUILDING MAINTENANCE	320308	06/18/2025	17.98	
01-71-75-45-569 Other Replacement Parts	General Fund	Swimming Pool	Cultural and Leisure		
HERITAGE LANDSCAPE SUPPY GR	REPLACEMENT POOL HEATER	0021394493	06/10/2025	51,107.06	06/11/2025
01-71-75-46-624 Other Chemicals	General Fund	Swimming Pool	Cultural and Leisure		
HAWKINS INC	CHEMICALS FOR POOL	7033871	04/10/2025	1,966.75	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
CASH-WA DISTRIBUTING	CONCESSIONS - POOL	14651914	06/12/2025	503.30	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
CASH-WA DISTRIBUTING	CONCESSIONS - POOL	14659459	06/19/2025	447.48	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	9371	06/06/2025	134.10	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	5340	05/29/2025	28.60	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	6635	06/06/2025	81.96	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	5344	05/29/2025	10.00	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	2093B	05/30/2025	113.49	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	5990	06/02/2025	33.34	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	7530	06/12/2025	40.00	
01-71-75-46-625 Concession Supplies	General Fund	Swimming Pool	Cultural and Leisure		
PEPSI COLA OF WESTERN NEBRA	POOL CONCESSIONS	5100165758	06/19/2025	244.95	
Total Swimming Pool:				61,738.63	
01-71-76-44-441 Electricity	General Fund	Knight Museum	Cultural and Leisure		
COA UTILITIES	ELECTRIC	UTILITIES 06/1	06/17/2025	2,796.61	06/17/2025

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
01-71-76-44-442 Water-Sewer	General Fund	Knight Museum	Cultural and Leisure		
COA UTILITIES	WATER / SEWER	UTILITIES 06/1	06/17/2025	14.05	06/17/2025
01-71-76-44-443 Refuse	General Fund	Knight Museum	Cultural and Leisure		
COA UTILITIES	REFUSE	UTILITIES 06/1	06/17/2025	126.11	06/17/2025
01-71-76-45-513 Copy Machine Supplies	General Fund	Knight Museum	Cultural and Leisure		
EAKES INC	B&W AND COLOR COPIES MUSEU	INV658071	06/12/2025	238.07	
Total Knight Museum:				3,174.84	
01-71-77-44-441 Electricity	General Fund	Library	Cultural and Leisure		
COA UTILITIES	ELECTRIC	UTILITIES 06/1	06/17/2025	5,633.64	06/17/2025
01-71-77-44-442 Water-Sewer	General Fund	Library	Cultural and Leisure		
COA UTILITIES	WATER / SEWER	UTILITIES 06/1	06/17/2025	522.75	06/17/2025
01-71-77-44-443 Refuse	General Fund	Library	Cultural and Leisure		
COA UTILITIES	REFUSE	UTILITIES 06/1	06/17/2025	252.22	06/17/2025
01-71-77-44-444 Natural Gas	General Fund	Library	Cultural and Leisure		
BLACK HILLS ENERGY	8075 2560 61	JUNE 2025	06/04/2025	2,083.15	
01-71-77-44-483 NRCNTSVC-Building Public Wrks	General Fund	Library	Cultural and Leisure		
AC ELECTRIC MOTOR SERVICE	MOTOR REPAIR	10018	06/13/2025	119.26	
Total Library:				8,611.02	
01-71-78-44-441 Electricity	General Fund	Sallows Museum	Cultural and Leisure		
COA UTILITIES	ELECTRIC	UTILITIES 06/1	06/17/2025	154.41	06/17/2025
01-71-78-44-442 Water-Sewer	General Fund	Sallows Museum	Cultural and Leisure		
COA UTILITIES	WATER / SEWER	UTILITIES 06/1	06/17/2025	3.52	06/17/2025
01-71-78-45-511 Office Supplies	General Fund	Sallows Museum	Cultural and Leisure		
NEBRASKA TOTAL OFFICE	OFFICE SUPPLIES	0128811-001	06/11/2025	3.93	
01-71-78-45-561 Bldg Maintenance Material	General Fund	Sallows Museum	Cultural and Leisure		
CARTER'S HOME HARDWARE & AP	BUILDING MAINTENANCE	29233/1	06/11/2025	15.63	
01-71-78-45-561 Bldg Maintenance Material	General Fund	Sallows Museum	Cultural and Leisure		
CARTER'S HOME HARDWARE & AP	BUILDING MAINTENANCE	29233/1	06/11/2025	5.33	
Total Sallows Museum:				182.82	
Total Cultural and Leisure Services:				103,060.52	
01-79-79-44-479 CNTSVC Other	General Fund	Marketing	Culture and Leisure		
CROSSROADS MUSIC LLC	SOUND SYSTEM - JULY 11 AND 18	86443	05/20/2025	4,800.00	
Total Marketing:				4,800.00	
01-79-80-44-441 Electricity	General Fund	Carhenge	Culture and Leisure		
PREMA	ELECTRICITY	757546	05/01/2025	147.23	
01-79-80-45-526 Other Supplies	General Fund	Carhenge	Culture and Leisure		
FARM PLAN	POTTING SOIL	51448612	06/07/2025	38.22	
01-79-80-45-526 Other Supplies	General Fund	Carhenge	Culture and Leisure		
CARTER'S HOME HARDWARE & AP	OTHER SUPPLIES	29180/1	06/07/2025	51.96	
01-79-80-46-626 Inventory Costs	General Fund	Carhenge	Culture and Leisure		
PEPSI COLA OF WESTERN NEBRA	CONCESSIONS	5100165753	06/19/2025	328.40	
Total Carhenge:				565.81	
Total Culture and Leisure Services:				5,365.81	
Total General Fund:				126,485.06	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
Electric Fund					
05-0000-07710 Merchandise Inventory	Electric Fund				
CONTRACTORS MATERIALS INC	MIRROR NEMISIS GLASSES/LEATH	259306	06/20/2025	183.60	
05-0000-07710 Merchandise Inventory	Electric Fund				
CRESCENT ELECTRIC SUPPLY CO.	Conduit, PVC 2 1/2 Expansions Coupl	S513331165.00	06/19/2025	170.37	
05-0000-07710 Merchandise Inventory	Electric Fund				
CRESCENT ELECTRIC SUPPLY CO.	Conduit Adptr PVC 2" to M 2" IP	S513320305.0	06/10/2025	65.94	
05-0000-07710 Merchandise Inventory	Electric Fund				
CRESCENT ELECTRIC SUPPLY CO.	Conduit, PVC 2 1/2 Expansions Coupl	S513331165.00	06/17/2025	85.18	
05-0000-07710 Merchandise Inventory	Electric Fund				
CRESCENT ELECTRIC SUPPLY CO.	PVC Glue Cement	S513331165.00	06/12/2025	78.02	
05-0000-07710 Merchandise Inventory	Electric Fund				
CRESCENT ELECTRIC SUPPLY CO.	Conduit, PVC 2 1/2 Expansions Coupl	S513331165.00	06/12/2025	212.96	
05-0000-07710 Merchandise Inventory	Electric Fund				
CRESCENT ELECTRIC SUPPLY CO.	Conduit, PVC 2 1/2 Expansions Coupl	S513331165.00	06/17/2025	596.28	
05-0000-07710 Merchandise Inventory	Electric Fund				
DUTTON-LAINSON COMPANY	Ground Rod 5/8 " x 8'	914424	06/18/2025	671.85	
05-0000-07710 Merchandise Inventory	Electric Fund				
DUTTON-LAINSON COMPANY	Ins Tans Trainer CH9113S	914424-1	06/06/2025	1,521.83	
05-0000-07710 Merchandise Inventory	Electric Fund				
DUTTON-LAINSON COMPANY	WIRE URD 4/0 STR AL	914424-1	06/06/2025	6,034.80	
05-0000-07710 Merchandise Inventory	Electric Fund				
DUTTON-LAINSON COMPANY	Anchor Shackle JOS-2742	914791	06/13/2025	440.15	
05-0000-07710 Merchandise Inventory	Electric Fund				
DUTTON-LAINSON COMPANY	Elbow 1/0 Str 15 KVA ELA-165LR-B-5	914424-1	06/06/2025	1,573.16	
05-0000-07710 Merchandise Inventory	Electric Fund				
IDEAL LINEN INC	TOWELS/LINERS/CLEANING SUPPL	499055	06/13/2025	1,434.66	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	TRANSFORMER BSMTS HL37 X 43	S014277902.0	06/19/2025	2,150.70	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	TAPE, VINYL ELECTRICAL COLORS	S014290572.0	06/13/2025	517.88	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	Twineye Anchor Rod for 12" anchors	S014277902.0	06/06/2025	316.29	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	PEDESTAL- ADPE PFAPI1216WBST	S014277902.0	06/19/2025	1,631.75	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	12" Anchor	S014277902.0	06/06/2025	564.96	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	COMP SLEEVE COVER - C-7	S014291549.0	06/16/2025	197.95	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	TAPE, VINYL ELECTRICAL COLORS	S014290572.0	06/19/2025	517.88	
05-0000-07710 Merchandise Inventory	Electric Fund				
STUART C. IRBY CO	TAPE, VINYL ELECTRICAL COLORS	S014290572.0	06/16/2025	129.47	
05-0000-07710 Merchandise Inventory	Electric Fund				
WESCO DISTRIBUTION INC	CONTAX INHIBITOR	587645	06/17/2025	356.31	
05-0000-07710 Merchandise Inventory	Electric Fund				
RESCO	PDMNT 500 KVA 277/480 3 PH	3076371	06/10/2025	23,227.56	
05-0000-07710 Merchandise Inventory	Electric Fund				
STERLING SECURITY SYSTEMS	Sterling Shackle lock #448	INV068551	06/17/2025	1,284.91	
05-0000-07710 Merchandise Inventory	Electric Fund				
STERLING SECURITY SYSTEMS	LOCK, STERLING SR KEYED/ #438	INV068551	06/17/2025	237.60	
Total :				44,202.06	
Total :				44,202.06	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
05-51-50-44-444 Natural Gas	Electric Fund	Administration	Utility Superintenden		
BLACK HILLS ENERGY	7098 7521 63	JUNE 2025	06/04/2025	335.41	
05-51-50-45-526 Other Supplies	Electric Fund	Administration	Utility Superintenden		
SPECIAL STITCHES	FULL COLOR EMBROIDERY	1888	06/18/2025	20.00	
Total Administration:				355.41	
05-51-51-44-481 NRCNTSVC-Other Mach, Equip	Electric Fund	Generation	Utility Superintenden		
POWERTECH LLC	GEN CALL OUT REF # CITY 110620	83651373	06/12/2025	6,526.00	
Total Generation:				6,526.00	
05-51-52-46-658 Substation-Maintenance	Electric Fund	Transmission	Utility Superintenden		
CROSS CANYON ENGINEERING LL	engineering services	4603	06/06/2025	1,552.50	
05-51-52-46-691 Purchased Power-WAPA	Electric Fund	Transmission	Utility Superintenden		
MEAN	Purchased Power-WAPA	309315	05/01/2025	86,942.83	
05-51-52-46-692 Purchased Power-Mean	Electric Fund	Transmission	Utility Superintenden		
MEAN	Purchased Power-MEAN	309315	05/01/2025	15.82	
05-51-52-46-692 Purchased Power-Mean	Electric Fund	Transmission	Utility Superintenden		
MEAN	Purchased Power-MEAN	309315	05/01/2025	571,703.88	
05-51-52-46-693 Purchased Power-Wind Gen	Electric Fund	Transmission	Utility Superintenden		
MEAN	Purchased Power-WIND	309315	05/01/2025	27,577.55	
Total Transmission:				687,792.58	
05-51-53-44-423 Database Subscriptions	Electric Fund	Urban Distribution	Utility Superintenden		
LANDIS+GYR TECHNOLOGY INC	TECH STUDIO SOFTWARE JUNE 20	90410273	05/19/2025	747.77	
05-51-53-44-423 Database Subscriptions	Electric Fund	Urban Distribution	Utility Superintenden		
LANDIS+GYR TECHNOLOGY INC	TECH STUDIO SOFTWARE JUNE 20	90404709	01/17/2025	726.68	
05-51-53-44-486 NRCNTSVC-Veh, Equip, Tire Rep	Electric Fund	Urban Distribution	Utility Superintenden		
BOLEK-BILT LLC	LENGTHEN DRILL BIT LABOR	4185	06/13/2025	173.75	
05-51-53-44-493 NRCNTSVC-Transformer Rep,Test	Electric Fund	Urban Distribution	Utility Superintenden		
T & R ELECTRICAL SUPPLY CO INC	PCB SAMPLE	183068	06/10/2025	20.00	
05-51-53-45-531 Contracted Service-Uniforms	Electric Fund	Urban Distribution	Utility Superintenden		
SPECIAL STITCHES	Electric Hats	1880	06/03/2025	300.00	
05-51-53-45-532 Protective Gear	Electric Fund	Urban Distribution	Utility Superintenden		
SLATE ROCK FR LLC	UNIFORMS	90629	06/10/2025	2,002.24	
05-51-53-45-534 Safety Commodities	Electric Fund	Urban Distribution	Utility Superintenden		
BORDER STATES ELECTRIC SUPPL	Honeywell 10-4 Glove Dust	930546799	06/11/2025	170.29	
05-51-53-45-534 Safety Commodities	Electric Fund	Urban Distribution	Utility Superintenden		
GRAINGER	GLOVE DUST	9524270759	05/30/2025	55.00	
05-51-53-45-534 Safety Commodities	Electric Fund	Urban Distribution	Utility Superintenden		
STUART C. IRBY CO	Honeywell 10-4 Glove Dust	S014277924.0	06/17/2025	365.94	
05-51-53-45-534 Safety Commodities	Electric Fund	Urban Distribution	Utility Superintenden		
SPECIAL STITCHES	CITY LOGO ON ELECTRIC DEPT	1889	06/18/2025	126.00	
05-51-53-45-544 Small Tools, Equipment	Electric Fund	Urban Distribution	Utility Superintenden		
GRAINGER	SAFE-T-GRIP FUSE PULLERS	9523356344	05/29/2025	193.84	
05-51-53-45-544 Small Tools, Equipment	Electric Fund	Urban Distribution	Utility Superintenden		
CARTER'S HOME HARDWARE & AP	TOOLS	29305/1	06/17/2025	66.45	
05-51-53-45-544 Small Tools, Equipment	Electric Fund	Urban Distribution	Utility Superintenden		
STUART C. IRBY CO	QUICK GRAB CUTOUT DOOR REM	S014229966.0	06/19/2025	92.02	
05-51-53-45-556 Parts-Vehicle, Mach, Equip	Electric Fund	Urban Distribution	Utility Superintenden		
BLOEDORN LUMBER - ALLIANCE	BUILDING MAINTENANCE MATERIA	8826272	06/11/2025	15.12	
05-51-53-45-556 Parts-Vehicle, Mach, Equip	Electric Fund	Urban Distribution	Utility Superintenden		
GRAINGER	CRIMPINGDIE	9518743415	05/27/2025	191.18	
05-51-53-45-561 Bldg Maintenance Material	Electric Fund	Urban Distribution	Utility Superintenden		
BERNIES ACE HARDWARE	BUILDING MAINTENANCE MATERIA	319962	06/12/2025	36.64	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
05-51-53-46-651 Electric Overhead Material	Electric Fund	Urban Distribution	Utility Superintenden		
STUART C. IRBY CO	LINE POST INSULATORS	S013900317.0	10/29/2024	4,429.80-	
05-51-53-46-655 Street Light Mtc	Electric Fund	Urban Distribution	Utility Superintenden		
BORDER STATES ELECTRIC SUPPL	TIMER INT-FF60MC	930546813	06/11/2025	91.21	
05-51-53-46-656 Electric Splicing Tools, Equip	Electric Fund	Urban Distribution	Utility Superintenden		
WESCO DISTRIBUTION INC	HUSKIE COMPACT	584081	06/10/2025	2,140.00-	
05-51-53-46-656 Electric Splicing Tools, Equip	Electric Fund	Urban Distribution	Utility Superintenden		
WESCO DISTRIBUTION INC	HUSKIE COMPACT	584182	06/10/2025	2,140.00	
05-51-53-46-659 Other Electric Commodities	Electric Fund	Urban Distribution	Utility Superintenden		
4IMPRINT INC	Pens for Electric Dept.	29567694	06/03/2025	576.12	
Total Urban Distribution:				1,520.45	
05-51-54-53-948 Rural Rebuilds	Electric Fund	Rural Line Dist and Maint	Utility Superintenden		
CRESCENT ELECTRIC SUPPLY CO.	Burndy KA30U 6STR-00 Dual Rated	S513312656.0	06/10/2025	136.62	
Total Rural Line Dist and Maint:				136.62	
Total Utility Superintendent:				696,331.06	
Total Electric Fund:				740,533.12	
Refuse Fund					
06-41-42-44-482 NRCNTSVC-Vehicle Repair Mtc	Refuse Fund	Refuse Collection	Public Works		
PANHANDLE FAB INC.	REPAIR EYE ON LIFT CYLINDER/SH	48479	06/04/2025	210.75	
06-41-42-44-482 NRCNTSVC-Vehicle Repair Mtc	Refuse Fund	Refuse Collection	Public Works		
PANHANDLE FAB INC.	WELD PLATE ON 10 TRAP PIN	48485	06/12/2025	20.00	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
FARM PLAN	PARTS	51454963	06/20/2025	49.96	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
FARM PLAN	PARTS	51451148	06/12/2025	12.06	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
FARM PLAN	PARTS	51453801	06/17/2025	7.98	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
FARM PLAN	PARTS	51454233	06/18/2025	16.99	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
DARREN'S CARQUEST AUTO PART	PARTS	2723-513386	06/10/2025	39.68	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
DARREN'S CARQUEST AUTO PART	PARTS	2723-513466	06/11/2025	179.90	
06-41-42-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Collection	Public Works		
DARREN'S CARQUEST AUTO PART	PARTS	2723-513466	06/11/2025	200.00	
Total Refuse Collection:				737.32	
Total Public Works:				737.32	
06-51-55-43-331 Professional Engineering Svcs	Refuse Fund	Refuse Disposal	Public Works		
SCS AQUATERRA	2025 GROUNDWATER MONITORIN	0530389	02/28/2025	1,222.50	
06-51-55-43-331 Professional Engineering Svcs	Refuse Fund	Refuse Disposal	Public Works		
SCS AQUATERRA	RATE STUDY AND REVENUE SUFFI	0540060	05/31/2025	2,002.50	
06-51-55-43-331 Professional Engineering Svcs	Refuse Fund	Refuse Disposal	Public Works		
SCS AQUATERRA	ON CALL SUPPORT	0530463	02/28/2025	384.38	
06-51-55-43-331 Professional Engineering Svcs	Refuse Fund	Refuse Disposal	Public Works		
SCS AQUATERRA	ON CALL SUPPORT	0540020	05/31/2025	261.38	
06-51-55-44-444 Natural Gas	Refuse Fund	Refuse Disposal	Public Works		
BLACK HILLS ENERGY	7095 5903 91	JUNE 2025	06/04/2025	153.95	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
06-51-55-44-489 NRCNTSVC-Other Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
PANHANDLE FAB INC.	STRAIGHTEN TOOTH FOR PACKER	43529	06/23/2025	89.75	
06-51-55-44-489 NRCNTSVC-Other Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
SANDBERG IMPLEMENT INC	REPAIR POWER BOBTACH	WO04568	06/13/2025	2,661.26	
06-51-55-44-489 NRCNTSVC-Other Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
MURPHY TRACTOR	LANDFILL DOZER PARTS	2458872	05/28/2025	1,363.13	
06-51-55-45-531 Uniforms	Refuse Fund	Refuse Disposal	Public Works		
IDEAL LINEN INC	Uniforms	11275536	06/12/2025	129.38	
06-51-55-45-553 Refuse-Fuel	Refuse Fund	Refuse Disposal	Public Works		
WESTCO	BULK FUEL	U3325525	06/10/2025	2,491.76	
06-51-55-45-553 Refuse-Fuel	Refuse Fund	Refuse Disposal	Public Works		
WESTCO	BULK FUEL	U3325525	06/10/2025	206.91	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
FARM PLAN	HYDRAULIC HOSE	P48488	06/10/2025	105.66	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
FARM PLAN	PARTS	51451148	06/12/2025	13.20	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
FARM PLAN	5 GAL HYDRAU HYD	P49255	06/19/2025	136.60	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
PANHANDLE BOLT COMPANY	BOLTS FOR TRASH TRUCK	34048	06/23/2025	7.48	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
CARTER'S HOME HARDWARE & AP		29371/1	06/20/2025	4.40	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
CARTER'S HOME HARDWARE & AP	PARTS	29323/1	06/18/2025	33.98	
06-51-55-45-556 Parts-Vehicle, Mach, Equip	Refuse Fund	Refuse Disposal	Public Works		
MURPHY TRACTOR	2018 JOHN DEERE 850K REPAIRS	538769	05/29/2025	1,000.00	06/11/2025
06-51-55-45-569 Other Replacement Parts	Refuse Fund	Refuse Disposal	Public Works		
ALLIANCE TRACTOR & IMPLEMENT	DOZER HOSES/FITTINGS	14747	06/11/2025	65.84	
Total Refuse Disposal:				12,334.06	
Total Public Works:				12,334.06	
06-52-99-58-841 Baler Loan - Principal	Refuse Fund	Debt Services	Public Works		
PLATTE VALLEY BANK	PRINCIPAL	757549	04/15/2025	10,604.02	
06-52-99-58-842 Baler Loan - Interest	Refuse Fund	Debt Services	Public Works		
PLATTE VALLEY BANK	INTEREST	757549	04/15/2025	862.24	
Total Debt Services:				11,466.26	
Total Public Works:				11,466.26	
Total Refuse Fund:				24,537.64	
Sewer Fund					
07-52-58-43-383 Water Testing Services	Sewer Fund	Sewer	Public Works		
ENVIRO SERVICE INC	TESTING	2500588	06/13/2025	141.00	
07-52-58-43-383 Water Testing Services	Sewer Fund	Sewer	Public Works		
ENVIRO SERVICE INC	TESTING	2500588	06/13/2025	355.00	
07-52-58-45-526 Other Supplies	Sewer Fund	Sewer	Public Works		
IDEAL LINEN INC	MATS/MOPS	11275058	06/10/2025	28.18	
07-52-58-45-556 Parts-Vehicle, Mach, Equip	Sewer Fund	Sewer	Public Works		
DARREN'S CARQUEST AUTO PART	PARTS	2723-514064	06/20/2025	11.08	
Total Sewer:				535.26	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
Total Public Works:				535.26	
Total Sewer Fund:				535.26	
Water Fund					
08-0000-07710 Merchandise Inventory	Water Fund				
CORE & MAIN LP	IPERL 3/4 MTR 100 CF 9" LL	W921230	05/06/2025	1,926.73	
08-0000-07710 Merchandise Inventory	Water Fund				
NORTHWEST PIPE FITTINGS INC	CURB BOX LIDS/RUBBER METER F	287602-1	05/30/2025	163.60	
08-0000-07710 Merchandise Inventory	Water Fund				
NORTHWEST PIPE FITTINGS INC	RED RUBBER FULL=FACE GASKET	287959	05/30/2025	72.54	
08-0000-07710 Merchandise Inventory	Water Fund				
NORTHWEST PIPE FITTINGS INC	TOP BOLT COUPLING	288253	06/13/2025	382.49	
Total :				2,545.36	
Total :				2,545.36	
08-52-51-43-383 Water Testing Services	Water Fund	Water Treatment	Public Works		
NE PUBLIC HEALTH ENVIRONMENT	TESTING	592247	06/17/2025	38.00	
08-52-51-43-383 Water Testing Services	Water Fund	Water Treatment	Public Works		
NE PUBLIC HEALTH ENVIRONMENT	TESTING	592372	06/17/2025	91.00	
08-52-51-43-383 Water Testing Services	Water Fund	Water Treatment	Public Works		
NE PUBLIC HEALTH ENVIRONMENT	TESTING	591510	06/17/2025	1,032.00	
08-52-51-44-424 Permits, Licenses	Water Fund	Water Treatment	Public Works		
NIKOLE CROSS - PETTY CASH	CDL LICENSE/TANKER ENDORSEM	757548	05/16/2025	75.00	
08-52-51-44-479 CNTSVC Other	Water Fund	Water Treatment	Public Works		
IDEAL LINEN INC	MATS/MOPS	11275058	06/10/2025	28.18	
08-52-51-45-526 Other Supplies	Water Fund	Water Treatment	Public Works		
FARM PLAN	CHARGERS	51450879	06/11/2025	28.39	
08-52-51-45-556 Parts-Vehicle, Mach, Equip	Water Fund	Water Treatment	Public Works		
BLOEDORN LUMBER - ALLIANCE	PARTS	8841438	06/19/2025	45.72	
08-52-51-45-556 Parts-Vehicle, Mach, Equip	Water Fund	Water Treatment	Public Works		
BLOEDORN LUMBER - ALLIANCE	PARTS	8826272	06/11/2025	16.64	
08-52-51-45-556 Parts-Vehicle, Mach, Equip	Water Fund	Water Treatment	Public Works		
BLOEDORN LUMBER - ALLIANCE	PARTS	8836771	06/17/2025	70.97	
08-52-51-46-629 Other Chemicals	Water Fund	Water Treatment	Public Works		
HAWKINS INC	Chemical	7098956	06/12/2025	2,955.95	
08-52-51-46-629 Other Chemicals	Water Fund	Water Treatment	Public Works		
HAWKINS INC	CHEMICALS	7098956	06/12/2025	2,805.25	
Total Water Treatment:				7,187.10	
08-52-52-44-479 CNTSVC Other	Water Fund	Distribution	Public Works		
SAFELITE AUTOGLASS	#502 SOLAR LIGHT	006494	06/20/2025	308.78	
08-52-52-44-479 CNTSVC Other	Water Fund	Distribution	Public Works		
K. L. WOOD & COMPANY LLC	620 HUDSON--EXCAVATE CURB ST	7089	06/19/2025	3,568.64	
08-52-52-45-556 Parts-Vehicle, Mach, Equip	Water Fund	Distribution	Public Works		
BERNIES ACE HARDWARE	PARTS	320334	06/18/2025	23.53	
08-52-52-45-556 Parts-Vehicle, Mach, Equip	Water Fund	Distribution	Public Works		
CARTER'S HOME HARDWARE & AP	PARTS	29223/1	06/11/2025	38.50	
08-52-52-45-569 Other Replacement Parts	Water Fund	Distribution	Public Works		
CORE & MAIN LP	1.5" Omni +R2 Register	W979451	05/15/2025	552.58	
08-52-52-45-569 Other Replacement Parts	Water Fund	Distribution	Public Works		
CORE & MAIN LP	WIRED RADIOS SUPPLIES	X061959	05/29/2025	406.60-	
08-52-52-45-569 Other Replacement Parts	Water Fund	Distribution	Public Works		
CORE & MAIN LP	WIRED RADIOS SUPPLIES	W759475	04/09/2025	425.23	

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08-52-52-45-569 Other Replacement Parts	Water Fund	Distribution	Public Works		
CORE & MAIN LP	OMNI+ 2R2 REG RETROFIT KIT	X055960	05/28/2025	534.57-	
08-52-52-46-672 Water, Sewer Line Material	Water Fund	Distribution	Public Works		
CORE & MAIN LP	Sensus command link	W967158	05/13/2025	1,126.69	
08-52-52-46-672 Water, Sewer Line Material	Water Fund	Distribution	Public Works		
MUNICIPAL SUPPLY,INC OF NEBR.	GASKET KIT/3-WAY VO 5'BURY 6"	0939397-IN	04/17/2025	65.80	
Total Distribution:				5,168.58	
Total Public Works:				12,355.68	
Total Water Fund:				14,901.04	
Golf Course					
21-71-75-44-444 Natural Gas	Golf Course	Golf Course	Cultural and Leisure		
BLACK HILLS ENERGY	7929 1256 65	JUNE 2025	06/04/2025	67.24	
21-71-75-44-444 Natural Gas	Golf Course	Golf Course	Cultural and Leisure		
BLACK HILLS ENERGY	8588 2648 38	JUNE 2025	06/04/2025	63.97	
21-71-75-44-479 CNTSVC Other	Golf Course	Golf Course	Cultural and Leisure		
MONTY AHRENS	CLEANING OF DEBRIS	757545	06/06/2025	150.00	
21-71-75-44-479 CNTSVC Other	Golf Course	Golf Course	Cultural and Leisure		
ALL SEASONS LANDSCAPING LLC	LANDSCAPE MAINTENANCE	757554	06/23/2025	500.00	
21-71-75-45-576 Herbicides, Pesticides	Golf Course	Golf Course	Cultural and Leisure		
WESTCO	HERBICIDE	70-130544	05/23/2025	52.18	
21-71-75-45-576 Herbicides, Pesticides	Golf Course	Golf Course	Cultural and Leisure		
WESTCO	PESTICIDES	70-130683	05/31/2025	686.85	
21-71-75-46-625 Concession Supplies	Golf Course	Golf Course	Cultural and Leisure		
GROCERY KART INC	CONCESSION SUPPLIES	5894	06/07/2025	14.46	
21-71-75-46-625 Concession Supplies	Golf Course	Golf Course	Cultural and Leisure		
GROCERY KART INC	CONCESSIONS	5894	06/07/2025	90.54	
21-71-75-46-625 Concession Supplies	Golf Course	Golf Course	Cultural and Leisure		
HARRIS SALES COMPANY	CONCESSIONS	1185385	06/05/2025	102.15	
21-71-75-46-625 Concession Supplies	Golf Course	Golf Course	Cultural and Leisure		
HARRIS SALES COMPANY	CONCESSIONS	1185401	06/06/2025	68.00	
21-71-75-46-625 Concession Supplies	Golf Course	Golf Course	Cultural and Leisure		
PEPSI COLA OF WESTERN NEBRA	CONCESSION	5100164821	06/05/2025	276.45	
21-71-75-46-625 Concession Supplies	Golf Course	Golf Course	Cultural and Leisure		
PEPSI COLA OF WESTERN NEBRA	CONCESSION	5100165320	06/12/2025	197.80	
21-71-75-46-626 Inventory Costs	Golf Course	Golf Course	Cultural and Leisure		
VW GOLF INC	FAST TWIST JAR OF 400 SHOE LOC	90809	06/04/2025	224.89	
21-71-75-46-627 Special Order Costs	Golf Course	Golf Course	Cultural and Leisure		
CALLAWAY GOLF SALES CO	SPECIAL ORDER JOSH FLETCHER	940503863	06/04/2025	346.50	
21-71-75-46-627 Special Order Costs	Golf Course	Golf Course	Cultural and Leisure		
CALLAWAY GOLF SALES CO	SPECIAL ORDER BILL KUNZMAN	940521944	06/06/2025	746.10	
Total Golf Course:				3,587.13	
Total Cultural and Leisure Services:				3,587.13	
Total Golf Course:				3,587.13	
Airport					
22-41-43-43-373 Contract Custodial Services	Airport	Airport Operations	Airport		
MELISA BRASS	AIRPORT TERMINAL CLEANING	603217	06/15/2025	1,248.00	
22-41-43-44-444 Natural Gas	Airport	Airport Operations	Airport		
BLACK HILLS ENERGY	9862 2110 07	JUNE 2025	06/04/2025	48.66	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
22-41-43-44-444 Natural Gas	Airport	Airport Operations	Airport		
BLACK HILLS ENERGY	6920 6237 05	JUNE 2025	06/04/2025	92.79	
22-41-43-44-451 Telephone Line Expense	Airport	Airport Operations	Airport		
MOBIUS COMMUNICATIONS CO.	TELEPHONE	757544	06/01/2025	85.82	
22-41-43-44-451 Telephone Line Expense	Airport	Airport Operations	Airport		
MOBIUS COMMUNICATIONS CO.	308-762-1214	757543	06/01/2025	76.45	
22-41-43-44-452 Long Distance Expense	Airport	Airport Operations	Airport		
MOBIUS COMMUNICATIONS CO.	308-762-4512	757544	06/01/2025	4.49	
22-41-43-44-482 NRCNTSVC-Vehicle Repair Mtc	Airport	Airport Operations	Airport		
PRECISION STEREO TECHNOLOG	TIRE REPAIR	53371	06/05/2025	25.00	
22-41-43-45-526 Other Supplies	Airport	Airport Operations	Airport		
CULLIGAN WATER CONDITIONING	SOFTENER RENTAL AND SALT	757542	05/25/2025	23.90	
22-41-43-45-526 Other Supplies	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	UNV MDWT ABS 20X15IN	2723-513367	06/10/2025	148.48	
22-41-43-45-544 Small Tools, Equipment	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	COBALT DRILL BITS	2723-512935	06/04/2025	33.14	
22-41-43-45-544 Small Tools, Equipment	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	DRILL BITS	2723-513367	06/10/2025	36.70	
22-41-43-45-551 Fuel,Oil,Lube-Veh,Mach,Equip	Airport	Airport Operations	Airport		
STURDEVANT'S AUTO PARTS	BERTHA-AIRPORT OIL	834032042	06/05/2025	58.02	
22-41-43-45-551 Fuel,Oil,Lube-Veh,Mach,Equip	Airport	Airport Operations	Airport		
STURDEVANT'S AUTO PARTS	SILVERADO-AIRPORT OIL/FILTERS	834031971	06/04/2025	55.30	
22-41-43-45-551 Fuel,Oil,Lube-Veh,Mach,Equip	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	BRAKE FLUID	2723-513970	06/19/2025	7.43	
22-41-43-45-556 Parts-Vehicle, Mach, Equip	Airport	Airport Operations	Airport		
ACTION COMMUNICATION INC	UNIT #701 ALL AMBER NO TAKE DO	55060	06/12/2025	349.67	
22-41-43-45-556 Parts-Vehicle, Mach, Equip	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	PARTS	2723-513055	06/05/2025	130.46	
22-41-43-45-556 Parts-Vehicle, Mach, Equip	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	PARTS	2723-512935	06/04/2025	21.51	
22-41-43-45-574 Misc Grounds Maintenance	Airport	Airport Operations	Airport		
ACKERMAN AG SERVICE	PRAIRIE DOG AMMO	82673	06/20/2025	462.00	
22-41-43-45-575 AOA Ground Maintenance	Airport	Airport Operations	Airport		
CRESCENT ELECTRIC SUPPLY CO.	RUNWAY BULBS	S513337629	06/12/2025	70.00	
22-41-43-45-575 AOA Ground Maintenance	Airport	Airport Operations	Airport		
CRESCENT ELECTRIC SUPPLY CO.	Candela 300PAR Lamp- Airport Runw	S513337629	06/12/2025	443.48	
22-41-43-45-575 AOA Ground Maintenance	Airport	Airport Operations	Airport		
PANHANDLE BOLT COMPANY	AIRFIELD LIGHT/BOLTS	34025	06/04/2025	11.00	
22-41-43-45-575 AOA Ground Maintenance	Airport	Airport Operations	Airport		
DARREN'S CARQUEST AUTO PART	ANTISEIZE	2723-512935	06/04/2025	9.99	
Total Airport Operations:				3,442.29	
Total Airport:				3,442.29	
Total Airport:				3,442.29	
Public Transit Fund					
23-72-71-45-511 Office Supplies	Public Transit Fund	Transit - Administration	Public Works		
NEBRASKA TOTAL OFFICE	CALCULATOR	0128862-001	06/19/2025	26.99	
23-72-71-45-526 Other Nonoperating Sup/Expense	Public Transit Fund	Transit - Administration	Public Works		
IDEAL LINEN INC	TOWELS	11276005	06/17/2025	55.00	
Total Transit - Administration:				81.99	
Total Public Works:				81.99	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept	Segment Department / Invoice Number	Invoice Date	Net Invoice Amount	Date Paid
Total Public Transit Fund:					81.99	
Street Fund						
24-41-41-44-441 Electricity	Street Fund	Streets		Public Works		
COA UTILITIES	ELECTRIC		UTILITIES 06/1	06/17/2025	157.91	06/17/2025
24-41-41-44-485 NCTCSNV-Sidewalk Rehab	Street Fund	Streets		Public Works		
ERIK HASCALL	CONCRETE		757550	06/18/2025	910.03	
24-41-41-45-526 Other Supplies	Street Fund	Streets		Public Works		
FARM PLAN	CHARGERS		51450879	06/11/2025	28.39	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
CONTRACTORS MATERIALS INC	BROOM/BROOM BUTTON ADAPT		259306	06/20/2025	133.90	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51450921	06/11/2025	17.99	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51447729	06/05/2025	199.98	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51453307	06/16/2025	8.94	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51447729	06/05/2025	300.00	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51453568	06/17/2025	21.99	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51454682	06/19/2025	3.98	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51454045	06/18/2025	26.98	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51454568	06/19/2025	1.78	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51454526	06/19/2025	1.00	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51454540	06/19/2025	1.00-	
24-41-41-45-543 Small Tools, Equipment	Street Fund	Streets		Public Works		
FARM PLAN	Tools		51454490	06/19/2025	7.99	
24-41-41-45-556 Parts-Vehicle, Mach, Equip	Street Fund	Streets		Public Works		
ALLIANCE TRACTOR & IMPLEMENT	ROLL		14938	06/19/2025	3.44	
24-41-41-45-556 Parts-Vehicle, Mach, Equip	Street Fund	Streets		Public Works		
ALLIANCE TRACTOR & IMPLEMENT	PAINT MACHINE HOSES		14714	06/11/2025	72.16	
24-41-41-45-556 Parts-Vehicle, Mach, Equip	Street Fund	Streets		Public Works		
BERNIES ACE HARDWARE	PARTS		320339	06/18/2025	15.18-	
24-41-41-45-556 Parts-Vehicle, Mach, Equip	Street Fund	Streets		Public Works		
BERNIES ACE HARDWARE	PARTS		320332	06/18/2025	15.18	
24-41-41-45-556 Parts-Vehicle, Mach, Equip	Street Fund	Streets		Public Works		
FARM PLAN	WIPER BLADES/WINDEZ/DETAILER		1443565	05/29/2025	75.93	
24-41-41-45-556 Parts-Vehicle, Mach, Equip	Street Fund	Streets		Public Works		
DARREN'S CARQUEST AUTO PART	PARTS		2723-513938	06/18/2025	11.08	
Total Streets:					1,982.47	
Total Public Works:					1,982.47	
Total Street Fund:					1,982.47	
Retired Senior Vol Program						
26-71-70-45-511 Office Supplies	Retired Senior Vol P	Retired Senior Vol Program		Cultural and Leisure		
NEBRASKA TOTAL OFFICE	OFFICE SUPPLIES		0128812-001	06/11/2025	10.76	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
Total Retired Senior Vol Program:				10.76	
Total Cultural and Leisure Services:				10.76	
Total Retired Senior Vol Program:				10.76	
Economic Development Fund					
35-61-64-47-762 Enhanced Employment Area Tax	Economic Develop	Economic Development Support	Community Develop		
DAYSPRING BANK	HEARTLAND FLATS EEAT	04302025	06/18/2025	9,464.38	06/18/2025
Total Economic Development Support:				9,464.38	
Total Community Development:				9,464.38	
Total Economic Development Fund:				9,464.38	
Adminstration Internal Service					
51-13-13-43-381 DOT Testing	Adminstration Intern	Personnel	Personnel		
BOX BUTTE GENERAL HOSPITAL	DRUG TESTING	54	06/04/2025	404.00	
51-13-13-43-381 DOT Testing	Adminstration Intern	Personnel	Personnel		
WPCI	DOT DRUG TESTING	S169205	05/31/2025	162.00	
51-13-13-44-423 Database Subscriptions	Adminstration Intern	Personnel	Personnel		
PAYLOCITY CORPORATION	COMPLETE HCM SOLUTION	INV2907245	06/20/2025	3,697.40	
51-13-13-45-526 Other Supplies	Adminstration Intern	Personnel	Personnel		
DOCU-SHRED LLC	64 GALLON CONTAINER	17852	06/20/2025	60.00	
Total Personnel:				4,323.40	
Total Personnel:				4,323.40	
51-14-16-47-721 Commercial Property Ins	Adminstration Intern	Risk Management	Legal		
LARM	COMMERCIAL PROPERTY	113406	05/29/2025	28,032.44	06/17/2025
51-14-16-47-735 Claim Deductibles, Dividends	Adminstration Intern	Risk Management	Legal		
MURPHY TRACTOR	2018 JOHN DEERE 850K REPAIRS	538769	05/29/2025	73,405.85	06/11/2025
Total Risk Management:				101,438.29	
Total Legal:				101,438.29	
51-17-17-44-457 Internet Operating Expense	Adminstration Intern	MIS	Technology		
MOBIUS COMMUNICATIONS CO.	INTERNET OPERATING EXPENSE	757544	06/01/2025	50.00	
51-17-17-44-469 PMCNTSVC-Other	Adminstration Intern	MIS	Technology		
BYTES COMPUTER		CW41511	06/12/2025	586.24	
51-17-17-59-942 Computer System	Adminstration Intern	MIS	Technology		
BYTES COMPUTER	Replace closet switches in Utility Offic	CW41297	06/09/2025	3,500.00	
51-17-17-59-942 Computer System	Adminstration Intern	MIS	Technology		
BYTES COMPUTER	Security Cameras	CW41515	06/12/2025	2,106.41	
Total MIS:				6,242.65	
Total Technology:				6,242.65	
51-21-21-42-294 Conferences, Cont Education	Adminstration Intern	Accounting	Finance		
CINDY BAKER	MILEAGE	757555	04/24/2025	84.83	
51-21-21-42-294 Conferences, Cont Education	Adminstration Intern	Accounting	Finance		
CINDY BAKER	LODGING	757555	04/24/2025	256.84	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid
51-21-21-42-294 Conferences, Cont Education	Adminstration Intern	Accounting	Finance		
CINDY BAKER	MEALS	757555	04/24/2025	42.92	
51-21-21-44-470 Contractual Services	Adminstration Intern	Accounting	Finance		
EAKES INC	DOCMGT	INV659482	06/16/2025	319.00	
51-21-21-45-511 Office Supplies	Adminstration Intern	Accounting	Finance		
AMY WAGNER	CALCULATOR PAPER	757547	05/19/2025	18.18	
51-21-21-45-526 Other Supplies	Adminstration Intern	Accounting	Finance		
AMY WAGNER	CHAIR SLIPCOVERS	757547	05/19/2025	29.95	
51-21-21-45-541 Office Furniture, Equipment	Adminstration Intern	Accounting	Finance		
AMY WAGNER	DESK RISER	757547	05/19/2025	42.72	
Total Accounting:				794.44	
Total Finance:				794.44	
Total Adminstration Internal Service:				112,798.78	
Enterprise Internal Service					
55-51-56-43-379 Other Contract Operating Svcs	Enterprise Internal S	Warehouse	Utiltiy Superintenden		
IDEAL LINEN INC	MATS	11275058	06/10/2025	56.37	
Total Warehouse:				56.37	
Total Utiltiy Superintendent:				56.37	
Total Enterprise Internal Service:				56.37	
Health Care Internal Service					
57-81-81-42-231 Employee Life Insurance	Health Care Internal	Health Support	Personnel		
UNUM LIFE INSURANCE COMPANY	EMPLOYEE LIFE INSURANCE #091	JUNE-2025	06/01/2025	906.68	06/24/2025
57-81-81-42-281 Specific Premium	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	SPECIFIC PREMIUM	JUNE-25	06/01/2025	43,885.64	06/23/2025
57-81-81-42-285 Transplant Coverage	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	TRANSPLANT COVERAGE	JUNE-25	06/01/2025	1,256.06	06/23/2025
57-81-81-42-286 Aggregate Premium	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	AGGREGATE PREMIUM	JUNE-25	06/01/2025	1,332.39	06/23/2025
57-81-81-42-287 Employee Claims	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	HEALTH CLAIMS	06092025-HC	06/09/2025	8,202.87	06/11/2025
57-81-81-42-287 Employee Claims	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	HEALTH CLAIMS	06162025-HC	06/16/2025	49,620.96	06/18/2025
57-81-81-42-287 Employee Claims	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	HEALTH CLAIMS	06232025-HC	06/23/2025	23,426.72	06/23/2025
57-81-81-42-288 Employee Insurance Admin	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	EMPLOYEE INSURANCE ADMIN	JUNE-25	06/01/2025	2,518.90	06/23/2025
57-81-81-42-289 Vision Premium	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	VISION	JUNE-25	06/01/2025	1,810.56	06/23/2025
57-81-81-43-379 Other Contract Operating Svcs	Health Care Internal	Health Support	Personnel		
REGIONAL CARE, INC.	HAYS PREMIUM	JUNE-25	06/01/2025	2,500.00	06/23/2025
Total Health Support:				135,460.78	
Total Personnel:				135,460.78	
Total Health Care Internal Service:				135,460.78	
Grand Totals:				1,173,877.07	

GL Account and Title / Vendor Name	Segment Fund / Description	Segment Under Dept / Invoice Number	Segment Department / Invoice Date	Net Invoice Amount	Date Paid

Dated: _____

Mayor: _____

City Manager: _____

City Treasurer: _____

Report Criteria:

Invoices with totals above $0 included.

Paid and unpaid invoices included.

COUNCIL PROCEEDINGS

The Alliance, Nebraska City Council met in a Regular Meeting on Tuesday, June 17, 2025at 7:00 p.m. Present were Council Members McGhehey, Weisgerber and Turman.

Council acted on and/or discussed the following items of business:

1. Appointed Ammie Bedient as Interim City Clerk. Ayes: All. Motion carried.

2. Approved the Consent Calendar. Ayes: All. Motion carried.

3. Conducted a Public Hearing on the recommended approval of Manager Application for Cheyenne Tullier for the B & W Gas and Convenience dba YesWay, to the Nebraska Liquor Control Commission. Following the Public Hearing, Council approved Resolution No. 25-68 recommending approval of the Manager Application for Cheyenne Tullier for B & W Gas Convenience dba YesWay to the Nebraska Liquor Control Commission. Ayes: All. Motion carried.

4. Conducted a Public Hearing on the Class I Liquor License Application of DPR Wealth Management, LLC dba Alliance Hotel and Suites. Following the Public Hearing, Council approved Resolution No. 25-69 recommending approval of the license to the Nebraska Liquor Control Commission. Ayes: All. Motion carried.

5. Tabled Resolution No. 25-70, which will recommend approval of the Manager Application for DPR Wealth Management, LLC dba Alliance Hotel and Suites to the Nebraska Liquor Control Commission.

6. Adopted Ordinance No. 3002, which adds Section 2-53 to the Municipal Code adopting Code of Conduct for the Alliance City Council. Ayes: All. Motion carried.

7. Michael Wallace with Farris Engineering Inc., presented the Secondary Power Source Engineering Study to the Alliance City Council.

8. Discussion Item – Public Transit Program Agreement Federal Aid Funds.

9. Accepted the resignation of Maxine Anderson from the Library Board. Ayes: All. Motion carried.

10. Appointed Emily Nelson, to the Library Board for a term ending June 30, 2027. Ayes: All. Motion carried.

11. Council discussed the appointment of the City Clerk, appointing Sean Brenke to the vacant City Clerk position. Ayes: All. Motion carried.

Meeting adjourned at 7:39 p.m.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Complete minutes of the Alliance City Council may be viewed by the public during regular work hours at the City Clerk's Office, 324 Laramie Avenue, Alliance, Nebraska.

Narrative
July 1, 2025

Picker Cart Replacement:

Staff is recommending that a portion of funds originally allocated for golf irrigation well design be utilized to replace the picker cart at SkyView Golf Course.

Staff has been working on well design, and it has become apparent that the full $20,000 originally allocated for these services will not be necessary. Because irrigation well design for golf courses is an extremely specific process, and the equipment and installation process is standardized, the engineering and specification development less expensive than on other more unique projects.

For that reason, staff is recommending we utilize a portion of those excess funds to replace the picker cart at SkyView Golf Course. This cart is a specialized piece of equipment used to collect golf balls from the driving range. It includes a cage enclosed cab to protect the operator from balls being hit onto the driving range while the balls are picked up. Staff has identified a 2021 Yamaha Umax Range Picker for $6,200 in Colorado to replace the 2011 model currently in use at the course. The existing cart has continually had operational issues and has been worked on by both SkyView staff and taken to the shop for repairs, but a long term solution hasn't been found.

The City of Alliance makes approximately $10,000 in annual revenue from use of the driving range and the ability to pick up balls in a timely manner is vital to this revenue sources.

RECOMMENDATION: REDIRECT CIP FUNDS FOR THE PURCHSE OF A REPLACEMENT PICKER CART FOR THE GOLF COURSE.

RESOLUTION NO. 25-71

WHEREAS, The City of Alliance owns and operates the Sky View Golf Course;

WHEREAS, As part of the 2024-2025 fiscal year, the City Council allocated Twenty Thousand and no/100ths Dollars ($20,000.00) for engineering design services of the golf course irrigation well; and

WHEREAS, The allocated Twenty Thousand and no/100ths Dollars ($20,000.00) for design services are not necessary due to services provided free of charge from the pump vendor; and

WHEREAS, Sky View Golf Course is in need of a newer "range picker"; and

WHEREAS, Staff has located a 2021 Yamaha Umax Range Picker available for the amount of Six Thousand Two Hundred and no/100ths Dollars ($6,200.00); and

WHEREAS, Reallocated funds from the irrigation well project would be sufficient to make this purchase;

WHEREAS, The City Council desires to reallocate funds from the irrigation well project to the purchase of the 2021 Yamaha Umax Range Picker.

NOW, THEREFORE, BE IT RESOLVED by the Mayor and Council of the City of Alliance, Nebraska, that Six Thousand Two Hundred and no/100ths Dollars ($6,200.00) of funds originally allocated for the golf course irrigation well design be reallocated for the purchase of a new Picker Cart in the total amount of Six Thousand Two Hundred and no/100ths Dollars ($6,200.00).

BE IT FURTHER RESOLVED that staff is authorized to carry out all responsibilities in association with this reallocation and associated purchase.

PASSED AND APPROVED this 1st day of July, 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

Simmons Olsen Law Office, Legal Counsel

Narrative
July 1, 2025

RESOLUTION – RESTATED MEDICAL AND DENTAL PLAN DOCUMENT

The City Council is asked to approve the restated Medical and Dental Plan document, which reflects plan changes City Council authorized during recent benefit plan reviews in October 2024. No other changes are being introduced at this time, the restated document incorporates important updates that have already been approved to ensure the plan is current, compliant, and clearly communicated to all stakeholders.

Reason for Delay: The finalization of the restated plan was delayed due to the need to incorporate seven prior amendments, integrate updated federally required language, and conduct a thorough review of all plan revisions to ensure consistency and accuracy. This was a detailed and necessary process to ensure the integrity of the document and compliance with applicable regulations.

Summary of Key Plan Updates Previously Approved:

- **Premiums:** No change to employee or employer contribution levels.
- **Deductibles:**
  - Single: Increase from $3,200 to $3,300
  - Family: Increase from $5,600 to $5,700
  - *No change to maximum out-of-pocket limits.*
- **Co-Insurance:** Enhanced from 80/20 to 90/10, reducing employee cost-sharing.
- **Expanded Medical Coverage:**
  - Added coverage for male reproductive health services
  - Added obesity interventions under medical benefits
- **Dental:**
  - Capped family deductible at $150 (previously $50 per participant)
  - Increased coverage for:
    - Basic services from 80% to 90%
    - Major and Orthodontic services from 50% to 60%

RECOMMENDATION: APPROVAL OF THIS RESTATED DOCUMENT WILL FORMALIZE THESE CHANGES AND ENSURE THAT THE CITY'S SELF-FUNDED HEALTH PLANS REMAIN UP TO DATE, COMPLIANT, AND CLEARLY DOCUMENTED FOR EMPLOYEES AND PLAN ADMINISTRATORS.

RESOLUTION NO. 25-72

WHEREAS, The City of Alliance has engaged in a process with Brown and Brown Corporation, our benefit broker, evaluating its current healthcare benefit plan offered to employees; and

WHEREAS, The Alliance City Council approved Resolution No. 24-106 and Resolution No. 24-107 at their October 15, 2024 Regular Meeting authorizing benefit plan reviews; and

WHEREAS, The restated Medical and Dental Plan document incorporates updates previously approved to ensure plan is current, compliant, and clearly communicated to all stakeholders; and

WHEREAS, The finalization of the restated plan was delayed due to the need to incorporate seven prior amendments, integrate updated federally required language, and conduct a thorough review of all plan revisions to ensure consistency and accuracy; and

WHEREAS, No changes are being introduced at this time, but this restated document ensures that all prior changes are clearly documented and that the Plan remains compliant with applicable laws and transparency for employees, administrators, and stakeholders;

NOW, THEREFORE, BE IT RESOLVED, by the Mayor and Council of the City of Alliance, Nebraska, that the Restated Medical and Dental Plan Document will formalize these changes and ensure that the City's self-funded Health Plans remain up to date, compliant, and clearly documented for the employees and plan administrators.

BE IT FURTHER RESOLVED, that the Mayor is authorized to execute all documents related to finalizing the 2025 Restated Medical and Dental Plan.

PASSED AND APPROVED this 1st day of July, 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

_____
Simmons Olsen Law Office, Legal Counsel

City of Alliance
Medical and Dental Plan

Plan Document and Summary Plan Description

Effective Date: October 01, 2000
Restated Date: January 01, 2025

Produced By:

Regional Care, Inc.
905 West 27th Street
Scottsbluff, NE 69361
(800) 795-7772

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **City of Alliance** (the "Company" or the "Plan Sponsor") as of January 01, 2025, hereby sets forth the provisions of the City of Alliance Medical and Dental Plan (the "Plan"), which was originally adopted by the Company, effective October 01, 2000. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

City of Alliance

By: _____

Name: _____

Date: _____ Title: _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Illness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **City of Alliance** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:
City of Alliance Medical and Dental Plan

Plan Sponsor:
City of Alliance
324 Laramie
Alliance, Nebraska 69301
Phone: 1-308-762-5400

Plan Administrator:
(Named Fiduciary)
City of Alliance
324 Laramie
Alliance, Nebraska 69301
Phone: 1-308-762-5400

Plan Sponsor ID No. (EIN):
47-6006071

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
Federal Law and State of Nebraska

Plan Year:
January 1 through December 31

Plan Type:
Medical
Dental
Prescription

Third-party Administrator:
Regional Care, Inc.
905 West 27th Street
Scottsbluff, Nebraska 69361
Phone: 1-800-795-7772
Fax: 1-308-635-2018
Email/Website: www.regionalcare.com

Participating Employer(s):
City of Alliance
324 Laramie
Alliance, Nebraska 69301
Phone: 1-308-762-5400

Agent for Service of Process:
City of Alliance
324 Laramie
Alliance, Nebraska 69301
Phone: 1-308-762-5400

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice
This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be considered for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective

bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Coverage

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participant's rights in the Plan are governed by the plan documents and applicable State law and regulations.

Discretionary Authority

To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help you to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident, due to a traumatic event, or due to exposure to the elements.

"Actively at Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not totally disabled, provided the covered Employee was Actively at Work on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA (referenced as follows: 29 CFR 2590.702), subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial of benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not have an impact on a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"ADA"
"ADA" shall mean the American Dental Association.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Allowable Expense(s)"
"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for

Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

"Autism Spectrum Disorder"
"Autism Spectrum Disorder" means any of the pervasive developmental disorders or Autism Spectrum Disorder as defined by the Diagnostic and Statistical Manual or Mental Disorders.

"Calendar Year"
"Calendar Year" shall mean the 12-month period from January 1 through December 31 of each year.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

"CDC"
"CDC" shall mean Centers for Disease Control and Prevention.

"Certified IDR Entity"
"Certified IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"Chiropractic Care"
"Chiropractic Care" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column.

"Claim Determination Period"
"Claim Determination Period" shall mean each Calendar Year.

"Claimant"
"Claimant" shall mean any plan Participant, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing and/or to appeal an Adverse Benefit Determination.

"Clean Claim"
A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a Third-party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims' forms, along with any attachments and additional elements or revisions to data elements, attachments, and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

"Clinically Severe Obesity" / "Morbid Obesity"
"Clinically Severe Obesity (Morbid Obesity)" shall mean that an individual has a "body mass index" of 40 or greater with co-morbid conditions that could be improved by weight loss, such as: (1) Diabetes Mellitus; (2) Hypertension; (3) Cholecystitis; (4) Narcolepsy; (5) Pickwickian syndrome or other severe respiratory disease; (6) Hypothalamic disorders; or (7) Severe arthritis of the weight-bearing joints.

"Body Mass Index" equals an individual's weight (measured in kilograms) divided by his or her height (measured in meters squared).

“Copayment” or “Copay”
“Copayment” or “Copay” shall mean a dollar amount per visit, the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

"Cosmetic Surgery”
“Cosmetic Surgery” shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

“Covered Expense(s)”
“Covered Expense(s)” shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatments are subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

“Custodial Care”
“Custodial Care” shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by people without professional skills or training. This care may relieve symptoms or pain but is not expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing, and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

“Deductible”
“Deductible” shall mean an overall amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

“Dentist”
“Dentist” shall mean a professionally trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

“Dependent”
“Dependent” shall mean one or more of the following person(s):

1. An Employee’s present spouse, thereby possessing a valid marriage license, not annulled, or voided in any way. A Dependent spouse shall therefore not be one who is divorced or Legally Separated from the Employee.
2. An Employee’s Child, who is less than 26 years of age. ***NOTE:*** *Coverage of a Dependent Child will continue until the end of the calendar month when he or she turns 26 years of age.*

3. An Employee's Child who is age 26 and older, but less than 30 years of age, subject to the following requirements:

    a. The Child must be unmarried.
    b. The Child must be a resident of Nebraska. If the Child is a resident of another state, then he or she must be a full-time student attending school in his or her state of residency.
    c. The Child must not be covered under any other health benefit plan.

4. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactorily to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The deadline for submission of written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

Active duty members of any armed force shall not be deemed to be "Dependents."

An Employee's spouse who is a resident of a country other than the United States shall not be deemed to be a "Dependent."

"Child" and/or "Children" shall mean the Employee's biological Child, legally adopted Child, or any other Child for whom the Employee has been named legal guardian or legal parent. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

NOTE: Tax treatment for certain dependents*. Federal tax law does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.*

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

"Diagnostic Service"
"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the

identification of an Illness or Injury. A Physician or other professional Provider must order the Diagnostic Service.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements:

1. Can withstand repeated use.
2. It is primarily and customarily used to serve medical purposes.
3. Generally, is not useful to a person in the absence of an Illness or Injury.
4. It is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Employee"
"Employee" shall mean a person who is Employee of the Participating Employer, who is Actively at Work, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. Such person must be scheduled to work an average of at least 30 hours per week in order to be considered an eligible Employee. For Dental Coverage an eligible employee shall also mean designated part-time positions as defined in the Employee Handbook.

"Employer"
"Employer" is City of Alliance.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Exclusion"
"Exclusion" shall mean conditions or services that this Plan does not cover.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug, provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”
“Family Unit” shall mean the Employee and his or her Dependents covered under the Plan.

"FDA"
"FDA" shall mean Food and Drug Administration.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Habilitation/Habilitative Services"
"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or Outpatient settings.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO"
"HMO" shall mean a health maintenance organization.

1. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
2. Meets all of the following requirements.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician.
3. The Home Health Care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

1. It is a Federally certified Home Health Care Agency and approved as such under Medicare.
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
3. Meets all of the following requirements.
    a. It is an agency which holds forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    b. It has a full-time administrator.
    c. It maintains written records of services provided to the patient.
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    e. Its employees are bonded and it provides malpractice insurance.

"Hospital"
"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"HRSA"
"HRSA" shall mean Health Resources and Services Administration.

"Illness"
"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"
A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Independent Freestanding Emergency Department"
"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"
"Inpatient" shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

"Institution"
"Institution" shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Use Disorder Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Intensive Outpatient Services"
"Intensive Outpatient Services" shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family, or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment."

"Leave of Absence"
"Leave of Absence" shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

"Legal Separation" and/or "Legally Separated"
"Legal Separation" and/or "Legally Separated" shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

"Mastectomy"
"Mastectomy" shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

"Maximum Allowable Charge"
The "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate if one exists.

[For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent authority, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will consider accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent authority that meets one of the following requirements:

1. Provides child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

"Medically Necessary"
"Medically Necessary," "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary, must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of a Sickness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed, or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

This Plan shall not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the federal Food and Drug Administration for the treatment of another specific type of cancer if:

1. The drug or combination of drugs is recognized for treatment of the other specific type of cancer in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration; or
2. The drug or combination of drugs is recognized for treatment of the other specific type of cancer in medical literature and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration.

Additionally, this Plan shall not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the federal Food and Drug Administration for the treatment of human immunodeficiency virus or acquired immunodeficiency syndrome if:

1. The drug or combination of drugs is recognized for treatment of human immunodeficiency virus or acquired immunodeficiency syndrome in the United States Pharmacopeia-Drug Information and

the drug or combination of drugs is approved for sale by the federal Food and Drug Administration; or

2. The drug or combination of drugs is recognized for treatment of human immunodeficiency virus or acquired immunodeficiency syndrome in medical literature and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration.

"Medically Necessary Leave of Absence"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that meets all of the following requirements:

1. Commences while such Dependent is suffering from an Illness or Injury.
2. Is Medically Necessary.
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"Medicare"
"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Mental Disorder, Behavioral Disorder or Neurodevelopmental Disorder"
"Mental Disorder," "Behavioral Disorder" or "Neurodevelopmental Disorder" shall mean any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

"Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

"No-Fault Auto Insurance"
"No-Fault Auto Insurance" is the basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

"Non-Network" or "Out-of-Network"
"Non-Network" or "Out-of-Network" shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

"Nurse"
"Nurse" shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

"Open Enrollment Period"
"Open Enrollment Period" shall mean the period specified by the Plan Administrator.

"Out-of-Area"
"Out-of-Area" shall mean services received by a Participant outside of the normal geographic area supported by the Plan's Network, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

"Outpatient"
"Outpatient" shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Partial Hospitalization"
"Partial Hospitalization" shall mean medically directed intensive, or intermediate short-term mental health and Substance Use Disorder treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

"Participant"
"Participant" shall mean any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation, who is eligible for benefits (and enrolled) under the Plan.

"Participating Health Care Facility"
"Participating Health Care Facility" shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

1. The Participant obtains a written order from the Physician.
2. Both the Hospital and the Physician approve of the tests.
3. The tests are performed on an Outpatient basis prior to Hospital admission.
4. The tests are performed at the Hospital in which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage, and/or non-elective abortion. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).

"Privacy Standards"
"Privacy Standards" shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.

"Provider"
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital," the Institution must ensure every patient is under the care of a Physician and their

staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital."

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

"Qualifying Payment Amount"
"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third-party Administrator (if calculated by the Third-party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount"
"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

"Rehabilitation"
"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Residential Treatment Facility"
"Residential Treatment Facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Use Disorders or mental illness.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service includes all meals, special diets, therapeutic diets, required nourishment, dietary supplements and dietary consultation.
3. All general nursing services include but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy are Medically Necessary.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time that must pass before an Employee is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time, however for purposes of satisfying a Service Waiting Period an Employee shall be considered an Active Employee for the duration of any absence from work due to a health factor as defined by HIPAA.

"Skilled Nursing Facility"
"Skilled Nursing Facility" shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, Custodial Care, educational care.
7. It is approved and licensed by Medicare.

"Specialty Drug(s)"
"Specialty Drug(s)" shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to, cancer, rheumatoid arthritis, and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

"Substance Use Disorder"
"Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

"Substance Use Disorder Treatment Center"

"Substance Use Disorder Treatment Center" shall mean an Institution whose facility is licensed, certified, or approved as a Substance Use Disorder Treatment Center by a Federal, State, or other agency having legal authority to so license. This treatment center must be affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Third-party Administrator"
"Third-party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third-party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third-party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage
Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 30 days provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Reinstatement of Coverage
A covered Employee who is terminated and rehired will be treated as a new Employee upon rehire only if the Employee was not credited with an hour of service, as defined under the ACA, with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding period of employment.

Upon return, coverage will be reinstated on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Eligibility Dates for Dependent Coverage
Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for the Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan.

Effective Dates of Coverage; Conditions
The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 31 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after reviewing the form, and upon the subsequent date that such employees or dependents are eligible.

2. Coverage as Both Employee and Dependent. An eligible Participant may enroll in this Plan either as an Employee or as a Dependent, but not both.

   If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

3. Birth of Dependent Child. If a Dependent Child is born to an Employee on a date subsequent to the date their coverage goes into effect (and the Employee currently has coverage for Dependents), coverage shall be deemed to be in effect for said Child at and after the moment of birth, and any Plan limitations applicable to congenital defects shall not apply to such Child. The coverage shall continue for 31 days as it applies to the aforementioned Child, but shall subsequently terminate unless Employee submits a written application to the Plan, to enroll the Child. The application must also be accompanied by any required contribution, ongoing, as the case may be. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

   If a covered Employee does not currently have coverage for Dependents, a newborn Child will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, newborn care and Preventive Care **if written notification to add the Child is received by the Plan Administrator within 31 days following the Child's date of birth.** Newborn children will not automatically enroll. If written notification to add a newborn Child is received by the Plan Administrator AFTER the 31-day period immediately following the Child's date of birth, the Child is not eligible for the Plan until the next Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

4. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents and written application is made within 31 days. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 31 days of the date of the newly acquired Dependent's initial eligibility, and any required contributions must be made if the Plan Administrator otherwise approves enrollment.

5. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.

6. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only and not both.

7. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be considered by the Plan in determining that individual's eligibility under the Plan.

8. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: *It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent's status.*

Special and Open Enrollment

Federal law requires and the Plan provides so-called "special enrollment periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:

    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available.
    d. The Plan is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered and no substitute is available.
    f. The employer contributions under the other coverage were terminated.

Special enrollment rights will not be available to an Employee or Dependent if either of the following occurs:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within 31 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, legal

guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the special enrollment period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a Dependent's birth, as of the date of birth.
4. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e., CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

Open Enrollment
Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage."

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator, and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the period specified by the Plan Administrator.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions, and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient are covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan.
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
    a. Be in writing.
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individuals.

3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain extremely limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums, or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The date of the expiration of the last period for which the Employee has contributed, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
3. The last day of the month in which Employee is no longer eligible for such coverage under the Plan.
4. The last day of the month in which the termination of employment occurs.
5. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has contributed, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. The last day of the month in which such person is no longer a Dependent, except for Dependent Children, as defined herein, except as may be provided for in other areas of this section.
6. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
7. In the case of a Dependent Child who is older than age 26, the date that the Child marries.
8. In the case of a Dependent Child who is older than age 26, the date that the Child is no longer a resident of Nebraska. This termination of coverage does not apply to Dependent Children who are full-time students attending school in their state of residency.
9. In the case of a Dependent Child who is older than age 26, the date that the Child becomes covered under any other health benefit plan.
10. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

CONTINUATION OF COVERAGE

Employer Continuation Coverage
Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

1. Layoff; coverage will continue until the Employer ends the continuance.
2. Americans with Disabilities Act (ADA) Leave: A non-FMLA leave granted by the Employer in accordance with the ADA; coverage will continue until the Employer ends the continuance.
3. Leave of Absence (not meeting the definition of a FMLA Leave); coverage will continue for coverage until the Employer ends the continuance.
4. Pregnant Workers Fairness Act Leave; A non-FMLA leave granted by the Employer in accordance with the Pregnant Workers Fairness Act; coverage will continue until the employer ends the continuance.

The above noted leave(s) run concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence. At the end of the period(s) listed above, the Participant's coverage will be deemed to have been terminated for purposes of Continuation of Coverage under COBRA.

Continuation Coverage for Dependents
A Dependent Child who meets the limiting age as defined by this Plan will be given the option to continue coverage at his or her own expense (Nebraska Legislative Bill 551) provided the Child is unmarried, a resident of Nebraska (unless he or she is a full-time student) and is not enrolled in coverage under another health plan. The Dependent Child will be required to submit an election form requesting this coverage within 31 days after losing coverage. Once enrolled coverage will end at the end of the month in which the Child: (1) marries; (2) ceases to be a resident of Nebraska (unless the child is a full-time student); (3) enrolls in coverage under another health benefit plan; or (4) attains 30 years of age. If at any time during this continuation of coverage the Dependent Child becomes ineligible for coverage for any of the reasons, as described above, he or she will be ineligible for re-enrollment.

Continuation During Family and Medical Leave Act (FMLA) Leave
Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

Leave Entitlements
Eligible employees who work for a covered employer can accept 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care with the eligible employee(s).
- To bond with a child (leave must be taken within 1 year of the child's birth or placement) with the eligible employee(s).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.

- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

Spouses employed by the same employer are jointly entitled to a combined total of 12 workweeks of FMLA leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care or placement for adoption or foster care must conclude within 12 months of the birth or placement.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also accept 26 weeks of FMLA leave in a single 12-month period to care for the service member with an acute injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, to use accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must meet all of the following requirements:

- Have worked for the employer for at least 12 months.
- Have at least 1,250 hours of service in the 12 months before taking leave.*
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave
Employees must give 30 days' advance notice of the need for FMLA leave. If it is not possible to give 30 days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is

necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify their employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd
U.S. Department of Labor Wage and Hour Division
WH1420a - REV 04/23

Continuation During USERRA
Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction
The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise

would lose their group health coverage. Under the Plan, certain Participants, and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan doesn't accept late enrollees.

COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. Employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced or Legally Separated from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parents-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or Legally Separated.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events
In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation**: Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse.
2. **Notice of Child's Loss of Dependent Status**: Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event**: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. **Notice Regarding Disability**: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. **Notice Regarding End of Disability**: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Contents of Employee Notice of Qualifying Events
When applicable, the Employee or Qualified Beneficiary must provide the COBRA Administrator the following substantiating documentation related to a Qualifying Event:

1. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
2. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
3. In the case of a Qualifying Event, that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
4. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
5. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
6. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Notification must be provided to the COBRA Administrator. The COBRA Administrator is:

Regional Care, Inc.
905 West 27th Street
Scottsbluff, Nebraska 69361
Phone: 1-800-795-7772
Fax: 1-308-635-2018
Email/Website: COBRA@regionalcare.com

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline For Providing the Notice
For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.

3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. Continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement on the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement says that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not

ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage lasts for only up to a total of 18 months. There are two ways in which this eighteen-month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage

Disability can extend the 18-month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the COBRA Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18-month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Administrator or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or Legal Separation, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

Shorter Duration of COBRA Continuation Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage for a maximum of 18 months after Qualifying Events arise due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying

Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage will terminate immediately, unless otherwise noted, upon the occurrence of any of the following events:

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage (except as stated under COBRA's special bankruptcy rules),
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or
- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

If COBRA Continuation Coverage is terminated early, the Plan will provide the Qualified Beneficiary with an early termination notice.

Employee Notice of Other Enrollment
If the Qualified Beneficiary becomes enrolled in Medicare or under another group health plan after electing COBRA Continuation Coverage, the Qualified Beneficiary must notify the COBRA Administrator in writing immediately.

Contribution and/or Premium Requirements
The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30-day grace period during which a delinquent payment may still be made without the loss of COBRA Continuation Coverage.

Additional Information
Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

Regional Care, Inc.
905 West 27th Street
Scottsbluff, Nebraska 69361
Phone: 1-800-795-7772
Fax: 1-308-635-2018
Email/Website: COBRA@regionalcare.com

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contacts identified above. For more information about a Participant's rights under COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the

U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

Essential information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations, and provisions. All coverage figures, if applicable, are after the out-of-pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians, and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides distinct levels of benefits based on whether the Participants use a Network or non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are lower than those payable when a Network Provider is used. The following exceptions apply:

    a. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the non-Network Provider will be paid as though a Network Provider provided the services.
    b. In the event a Plan Participant has no choice of a Network Provider in the specialty he or she is seeking within the Network service area, then charges of the Non-Network Provider will be paid as though a Network Provider provided the services.

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third-party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balanced billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third-party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,

3. is scheduled to undergo non-elective Surgery from a specific Provider, including receipt of postoperative care with respect to the Surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

Summary of Benefits – Medical

	MIDLANDS CHOICE PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	Unlimited	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Plan Participant	$3,300	$3,600
Per Family Unit	$5,700	$6,720
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (including deductible)		
Per Plan Participant	$4,000	$8,000
Per Family Unit	$8,000	$16,000
The Plan will pay the designated percentage of Covered Expenses until out-of-pocket amounts are reached; at time the Plan will pay 100% of the remainder of Covered Expenses for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid 100%. Cost containment penalties		
COVERED SERVICES		
Hospital Services		
Room and Board	90% after deductible the semiprivate room rate (private room if Medically Necessary)	60% after deductible the semiprivate room rate (private room if Medically Necessary)
Intensive Care Unit	90% after deductible Hospital's ICU Charge	60% after deductible Hospital's ICU Charge
Nursery	90% after deductible	60% after deductible
Ancillary Charges	90% after deductible	60% after deductible
Outpatient Hospital Services		
Surgery	90% after deductible	60% after deductible
Radiology/Lab	90% after deductible	60% after deductible
Chemotherapy/Radiation	90% after deductible	60% after deductible
Pre-Admission Testing	90% after deductible	60% after deductible
Emergency Services		
Hospital	90% after deductible	90% after deductible
Physician	90% after deductible	90% after deductible
Urgent Care Center	90% after deductible	60% after deductible
Skilled Nursing Facility (Including Ancillary Services)	90% after deductible 60 days Calendar Year maximum	60% after deductible 60 days Calendar Year maximum
Physician Services		
Inpatient Visits	90% after deductible	60% after deductible
Office Visits	90% after deductible	60% after deductible
Surgery	90% after deductible	60% after deductible
Office Surgery	90% after deductible	60% after deductible
Office X-Ray/Lab	90% after deductible	60% after deductible
Radiology	90% after deductible	60% after deductible
Pathology	90% after deductible	60% after deductible
Anesthesiology	90% after deductible	60% after deductible

	MIDLANDS CHOICE PROVIDERS	NON-NETWORK PROVIDERS
Misc. Office Procedures	90% after deductible	60% after deductible
Home Health Care	90% after deductible	60% after deductible
Hospice Care	90% after deductible	60% after deductible
Bereavement Counseling	90% after deductible 5 visits Lifetime maximum	60% after deductible 5 visits Lifetime maximum
Ambulance Service	90% after deductible	90% after deductible
Covid Testing and Diagnosis	90% after deductible	60% after deductible
Children's Hearing Aids *$3,000 maximum per 48 months*	90% after deductible	60% after deductible
Jaw Joint/TMJ (Non-Surgical Treatment Surgical Treatment)	90% after deductible	60% after deductible
Wig After Chemotherapy	90% after deductible $150 Lifetime maximum	60% after deductible $150 Lifetime maximum
Autism Spectrum Disorders/ABA Therapy/Treatment	90% after deductible	60% after deductible
Occupational Therapy (Outpatient)	90% after deductible 60 visits Calendar Year maximum	60% after deductible 60 visits Calendar Year maximum
Note: The Calendar Year maximums for Therapy do not apply to Autism Spectrum Disorders for Plan Participants under the age of 21.		
Speech Therapy (Outpatient)	90% after deductible	60% after deductible
Physical Therapy (Outpatient)	90% after deductible	60% after deductible
Durable Medical Equipment	90% after deductible	60% after deductible
Prosthetics	90% after deductible	60% after deductible
Orthotics	90% after deductible	60% after deductible
Spinal Manipulation Chiropractic	90% after deductible 30 visits Calendar Year maximum	60% after deductible 30 visits Calendar Year maximum
Mental Disorders		
Inpatient	90% after deductible	60% after deductible
Outpatient – Office Visits	90% after deductible	60% after deductible
Outpatient – Other Services	90% after deductible	60% after deductible
Substance Abuse		
Inpatient	90% after deductible	60% after deductible
Outpatient – Office Visits	90% after deductible	60% after deductible
Outpatient – Other Services	90% after deductible	60% after deductible
Preventive Care		
Routine Well Care (Child and Adult)	No Charge	60% after deductible

	MIDLANDS CHOICE PROVIDERS	NON-NETWORK PROVIDERS
Covered Expenses include items and services rated A or B in the United States Preventive Services Task Force recommendations and services set forth in comprehensive guidelines supported by the Health Resources and Services Administration including but not limited to: office visits, pap smear, mammogram and prostate screening will be covered every two years starting at age 40 and annually beginning at age 50, gynecological exam, routine physical examination, x-rays, laboratory blood tests, immunizations, well child care and other preventive care services required by applicable law. For any service that does not have a Network provider available, coverage will be provided at the In-Network level of benefits. All covered services are subject to age and frequency limitations. The complete list of recommendations and guidelines that are required to be covered can be found at: http://www.hhs.gov/healthcare/about-the-law/preventive-care/index.html.		
Newborn Care (Initial Hospitalization and Physician Care)	90% after deductible	60% after deductible
Organ Transplants	90% after deductible	60% after deductible
Note: This Plan contains a separate Organ & Tissue Transplant policy. The benefits listed above apply to Covered Expenses not reimbursable under the Transplant Policy and for Covered Expenses incurred after the Policy has been exhausted. Refer to the Organ & Tissue Transplant Policy for Full Transplant Benefit.		
Pregnancy	90% after deductible	60% after deductible

Summary of Benefits - Pharmacy

DEDUCTIBLE, PER CALENDAR YEAR	
Retail Prescription Drug Benefits (90 Day Supply)	90% after Medical Plan deductible
Mail Order Prescription Drug Options (90 Day Supply)	90% after Medical Plan deductible
Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, as required by the Affordable Care Act are covered at 100% not subject to any copayment, coinsurance, or deductible. Certain contraceptives and certain smoking cessation products, as required by the Affordable Care Act are covered at 100% not subject to any copayment, coinsurance, or deductible, when purchased from a network pharmacy. A written prescription is required. This Plan requires the pharmacist to fill prescriptions with a generic whenever it is available. If the the member request a Brand Name medication over a Generic, the drug will not be covered under this Plan. If the member's Physician has specified "Dispense as Written" and there is a Generic available, an additional copayment will be applied based on the difference in cost between the Brand Name drug and the Generic equivalent.	

Summary of Benefits - Dental

DEDUCTIBLE, PER CALENDAR TEAR	
Per Plan Participant	$50
Per Family Unit	$150
MAXIMUM BENEFIT AMOUNT, PER PERSON	
Class A, B and C Services	$2,000 per Calendar Year
Class D Services	$2,000 per Lifetime
Note: The Maximum Benefit Amount does not apply to Pediatric Services for Dependent children up to the age of 18.	
Note: Class A, B, C, and D services have a waiting period of 30 days.	
DENTAL PERCENTAGE PAYABLE	
Class A – Preventive	100% after deductible
Class B – Basic	90% after deductible
Class C – Major	60% after deductible
Class D - Orthodontia	60% after deductible
Charges are limited to Usual and Customary Fees.	

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction results. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Use Disorder treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Cosmetic Surgery. That are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness, or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health or are provided as a rest cure or for maintenance care, unless specifically mentioned otherwise.

Excess. That exceed Plan limits, set forth herein and includes (but not limited to) the Maximum Allowable Charge, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Foreign Travel. That are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Hospital Employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Illegal Acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this Exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction results, or that a sentence of imprisonment for a term in excess of one year be imposed for this Exclusion to apply. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, or of any Schedule I substance, even if administered on the advice of a Physician and/or legal under the law of the state where the Participant lives. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Immediate Family Member. That are rendered by a member of the immediate Family Unit or person regularly residing in the same household; whether the relationship is by blood or exists in law.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this

coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

Non-Compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

Non-Emergency Hospital Admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if Surgery is performed within 24 hours of admission.

Non-Prescription Drugs. That are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over the counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act, as amended.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Specified As Covered. That are not specified as covered under any provision of this Plan.

Occupational. Care and treatment of an injury or sickness that is occupational – that is, arises from work for wage or profit including self–employment, unless occupation is exempt and/or waived from the applicable State Workers Compensation Law or act.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prohibited by Law. That are themselves prohibited by applicable law, in general or within the context of the course of treatment, or to the extent that payment under this Plan is prohibited by applicable law.

Provider Error. That are required as a result of unreasonable Provider error.

Subrogation, Reimbursement, and/or Third-party Responsibility. That are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or Third-party responsibility provisions.

Unreasonable. That are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection, or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave

rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

War/Riot. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury or Illness which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury or Illness if the Injury or Illness results from being the victim of an act of domestic violence or a documented medical condition, even if the condition is not diagnosed before the Illness or Injury. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

MEDICAL BENEFITS

Medical Benefits

Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

Advanced Imaging. Charges for advanced imaging including Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

Air Ambulance (Emergency Only).
Covered Expenses will be payable at the most appropriate of the following:

1. A negotiated, contracted amount as mutually agreed upon with a Provider or other discounting contract.
2. of the allowable charge established by application of the Medicare Ambulance Fee Schedule.
3. The billed charge if less than 1 or 2 above.

Benefits are provided for air ambulance transportation only if the Plan Administrator determines that the Participant's condition, the type of service required for the treatment of the Participant's condition, and the type of facility required to treat the Participant's condition justify the use of air ambulance instead of another means of transport. This Plan will only cover air ambulance transportation when no other method of transportation is appropriate (including emergency ground transport).

This Plan will cover rotary and/or fixed wing aircraft, excluding all fixed wing charter flights, for ambulance services.

Only charges Incurred for the first trip to a Hospital, or from one Hospital to another Hospital shall be included.

The determination of whether air ambulance transport for a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Ambulance (Emergency Only). Covered Expenses for professional ambulance, including approved available water and rail transportation to a local Hospital, or transfer to the nearest facility having the capability to treat the condition if the transportation is connected with Inpatient confinement.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

Autism Spectrum Disorders. Coverage for the screening, diagnosis, and treatment of Autism Spectrum Disorder in a Plan Participant under 21 years of age.

"Diagnosis" means a Medically Necessary assessment, evaluation, or test to diagnose if an individual has an Autism Spectrum Disorder;

"Treatment" means evidence-based care, including related equipment, that is prescribed or ordered for a Participant diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist, including:

1. Behavioral Health Treatment
2. Pharmacy Care
3. Psychiatric Care
4. Psychological Care; and
5. Therapeutic Care

Coverage for Behavioral Health Treatment, including Applied Behavior Analysis, shall be subject to a maximum benefit of 25 hours per week until the Plan participant reaches 21 years of age. Payments made by the Plan for treatment other than Behavioral Health Treatment, including Applied Behavior Analysis, shall not be applied to any maximum benefit.

Except in the case of Inpatient service, if a Plan Participant is receiving treatment for an Autism Spectrum Disorder, the Plan Administrator shall have the right to request a review of that treatment not more than once every 6 months unless the Plan Administrator and the Participant's licensed Physician or licensed psychologist execute an agreement that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently should apply only to a particular individual being treated for an Autism Spectrum Disorder and should not apply to all individuals being treated for Autism Spectrum Disorder by a licensed Physician or licensed psychologist. The cost of obtaining a review shall be paid for by the Plan.

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be expected to require blood.

Breast Pumps. Breast pumps will be covered under the preventive care benefit and subject to the following limitations:

1. The Plan considers purchase of a standard electric breast pump Medically Necessary Durable Medical Equipment (DME) for initiation of breastfeeding in the postpartum period (within the first two months (60 days) following delivery).
2. The Plan considered purchase of a manual breast pump Medically Necessary DME for continuation of breastfeeding within the first 12 months (365 days) following delivery.
3. The Plan considers rental of a heavy duty electrical (hospital grade) breast pump Medically Necessary for the period of time that a newborn is detained in the hospital.
4. For women using a breast pump from a prior pregnancy, a new set of breast pump supplies is considered Medically Necessary with each subsequent pregnancy for initiation or continuation of breastfeeding within the first 12 months following delivery.
5. A replacement manual breast pump is considered Medically Necessary for subsequent pregnancies, who have not received either a standard electric breast pump within the previous three years.
6. A replacement standard electrical breast pump is considered Medically Necessary for subsequent pregnancies, for initiation of breastfeeding the postpartum period (within the first 60 days following

delivery), for Plan Participants who have not received a standard electric breast pump within the previous three years.

7. The Plan considers purchase of heavy duty electrical (hospital grade) breast pumps not Medically Necessary.

Cardiac Rehabilitation. Cardiac Rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, or coronary bypass Surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Hospital as defined by this Plan.

Chemotherapy. Charges for chemotherapy, including materials and services of technicians.

Chiropractic Care. Spinal adjustment and manipulation x-rays for manipulation and adjustment, and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits, as applicable.

Clinically Severe Obesity (Morbid Obesity). Surgical treatment of Clinically Severe Obesity is covered under this Plan only if all of the following criteria are satisfied:

Weight Loss Medications (Anorexiants):
GLP-1 receptor agonists and prescription appetite suppressants will be covered for the treatment of obesity under the following conditions:

- Coverage is provided for individuals meeting the eligibility criteria outlined in the "Medical Benefits for Obesity" section.
- On-going weight loss must be documented every 6 months for continued approval, with an expected minimum weight loss of 4 pounds per month.
- Coverage will continue until an appropriate weight goal is achieved, as determined by the treating physician and consistent with medical guidelines.

Medical Benefits for Obesity (GLP-1 Drug Use)

Eligibility Criteria for GLP-1 Prescription Coverage. GLP-1 receptor agonists will be covered under the following conditions, when prescribed by a physician:

1. For Adults (Age 18 and Older):
    - Class III Obesity (BMI ≥ 40): Eligible regardless of co-morbid conditions.
    - Class II Obesity (BMI 35.0 to 39.9): Eligible with at least one diagnosed obesity-related co-morbid condition.
    - Class I Obesity (BMI 30.0 to 34.9): Eligible *only* if the individual has documented Type 2 Diabetes Mellitus.
2. Additional Requirements:
    - Documented participation in a physician-supervised, clinically appropriate weight loss program for at least 6 consecutive months within the past 12 months.
    - No contraindications to GLP-1 therapy based on current clinical guidelines. This means the individual should not have any medical conditions or factors that would make GLP-1 therapy unsafe or inappropriate including, but are not limited to a personal or family history of Medullary Thyroid Carcinoma (MTC), Multiple endocrine neoplasia syndrome type 2 (MEN 2), Severe gastrointestinal disorders, such as gastroparesis, or Hypersensitivity to any components of the medication.

B. Continuation of Therapy
To maintain GLP-1 coverage, the following must be met:

- Documentation of weight loss of at least 4 pounds per month.
- Evidence of ongoing adherence to a comprehensive weight management program, including lifestyle modifications.
- Re-evaluation by the prescribing physician every 6 months to assess progress and potential side effects.

C. Discontinuation Criteria
Coverage for GLP-1 drugs will be discontinued if:

- The individual fails to achieve a weight loss of at least 5% of their initial body weight after 6 months of therapy.
- The individual experiences adverse effects that outweigh the benefits of continued use.
- Non-compliance with medical and lifestyle recommendations is documented by the provider.

Non-Covered Situations:
GLP-1 receptor agonists and similar weight loss medications will not be covered:

- For cosmetic weight loss purposes.
- For individuals without documented medical necessity as outlined above.
- When prescribed outside of evidence-based clinical guidelines.

"CMS"
"CMS" shall mean Centers for Medicare and Medicaid Services.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Coinsurance"
"Coinsurance" shall mean a cost sharing feature of many plans which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

Contact Lenses. Initial contact lenses or glasses required following cataract Surgery.

Contraceptives. The charges for all Food and Drug Administration (FDA)-approved, -granted, or -cleared contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines.

COVID-19 Testing. Expenses related to testing for COVID-19.

Dental. Injury to or care of mouth, teeth, and gums. Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Expenses under Medical Benefits only if that care is for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

2. Emergency repair due to Injury to sound natural teeth.
3. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.
4. Excision of benign bony growths of the jaw and hard palate.
5. External incision and drainage of cellulitis.
6. Incision of sensory sinuses, salivary glands, or ducts.
7. Removal of impacted teeth, unless covered under a separate dental plan.
8. Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diabetes. Coverage for the equipment, supplies, medication, and Outpatient self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by a health care professional legally authorized by law to prescribe such items.

Dialysis. Charges for dialysis.

Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:

1. Any purchase without its advance written approval.
2. Replacements or repairs. ***NOTE:*** *The Plan covers repair and replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item or the existing equipment is damaged and cannot be made serviceable.*
3. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."

The purchase price limitation for rentals will not apply to life sustaining equipment including, but not limited to, oxygen concentrators, home ventilators, and iron lungs.

Children's Hearing Aids (ages 18 and younger). For each ear affected, the evaluation, fitting (including ear molds), programming, adjustments, repair of hearing aids and auditory rehabilitation and training. Items and services shall be covered on a continual basis to the extent that benefits paid for such items and services during the immediately preceding forty-eight-month period have not exceeded three thousand dollars ($3,000).

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic, or outpatient department.

5. Services, Drugs, and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: *Transportation services are not covered under this benefit.*

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein include rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse, or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care is furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists, or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.
10. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's Family Unit after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable if the following requirements are met:

    a. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan.
    b. Charges for such services are Incurred by the Participants within six months of the terminally ill person's death.

The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment
    1. Daily semiprivate Room and Board charges. Room charges made by a Hospital having only private rooms or room charges made by a Hospital having the same room rate for semi-private and private rooms will be paid at the semi-private room rate.
    2. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
    3. General nursing services.
    4. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.

2. Outpatient Treatment
    1. Emergency room.
    2. Treatment for chronic conditions.
    3. Physical therapy treatments.
    4. Hemodialysis.
    5. X ray, laboratory, and linear therapy.

Infertility Diagnosis. Charges for infertility diagnosis only.

Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

Mammogram. Mammograms, subject to the following guidelines:

1. Mammograms will be covered every two years starting at age 40
2. Annually beginning at age 50,

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided with this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician.

Medical Supplies. Dressings, casts, splints, trusses, braces, and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

Mental Health and Substance Use Disorder Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Use Disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Benefits are available for, but not limited to, Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Newborn Care. Routine Hospital and routine Physician nursery care for newborns who are Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. Physician services for well-baby care during the newborn's initial Hospital confinement at birth.

NOTE: *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.*

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

Pregnancy Expenses. Expenses are attributable to a Pregnancy. Pregnancy expenses of Dependent Children are not covered. Benefits for Pregnancy expenses are paid the same as any other Sickness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.

Prescription Drugs. Charges for prescription Drugs (as defined). Drugs purchased by a Participant at an on-line pharmacy outside of the United States will not be covered.

Preventive Care. Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

See the following websites for more details:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved, -granted, or -cleared contraception methods and contraceptive counseling.
7. Breastfeeding support supplies and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

Private Duty Nursing. Private duty nursing (Outpatient only).

Prosthetics and Orthotics. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet.

Radiation Therapy. Charges for radiation therapy and treatment.

Rehabilitative Services and Therapies. Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

1. **Autism Spectrum Disorders Treatment.** Charges for treatment of Autism Spectrum Disorder (ASD).
2. **Cardiac Therapy.** Charges for cardiac therapy.
3. **Cognitive Therapy.** Charges for cognitive therapy.
4. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
5. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
6. **Respiration Therapy.** Respiration therapy services.
7. **Speech Therapy.** Charges for speech therapy.

See the Summary of Benefits for treatment and/or frequency limitations.

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:

    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

2. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Covered Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Second Surgical Opinions. Charges for second surgical opinions.

Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility as defined in the Plan, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury for which the Participant is confined. For information on Inpatient medical benefits for mental health or Substance Use Disorders, please refer to the "Mental Health and Substance Use Disorder Benefits" in the Medical Benefits section above.

Sterilization. Charges for male and female sterilization procedures are covered. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA). Additionally, coverage is provided for male vasectomy procedures, including all associated costs such as pre-operative consultations, the procedure itself, and necessary follow-up care.

Supplemental Accident Benefit. Benefits are payable for eligible medical expenses incurred as a result of an Accidental Injury. Expenses must be incurred within 90 days of the date of the Accident. Eligible expenses include charges incurred upon the recommendation and approval of a duly qualified Physician and include:

1. Medical or surgical treatment rendered or prescribed by a Physician;
2. Hospital room and board, services, supplies and;
3. X-ray or laboratory examinations.

Benefits payable under this provision shall not exceed the maximum amount shown in the Summary of Benefits. Any expenses incurred in excess of the maximum amount shall be payable under the benefits other wise provided by this Plan.

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

1. Multiple procedures adding significant time or complexity will be allowed at:
    a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
    b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
    c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge for the secondary or lesser procedure.
2. Charges made for services rendered by an assistant surgeon will be allowed at twenty percent (20%) of the Maximum Allowable Charge for the type of Surgery performed.

No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

Temporomandibular Joint Disorder. Medically Necessary services for the care and treatment of jaw joint conditions, including Temporomandibular Joint Syndrome (TMJ).

Tobacco Use Disorder and/or Nicotine Dependency. Tobacco and nicotine dependence screening, counseling, nicotine withdrawal programs, facilities, Drugs, or supplies.

Transplants. This Plan includes a special attachment regarding human organ and tissue benefits, as explained in full in the Organ & Tissue Transplant Policy. All eligible Employees and their Dependents requiring human organ and tissue transplant services will have transplant – related charges covered under this separate policy, according to its terms and conditions, from the time of their evaluation through 365 days post-transplant operation. After this specified benefit period has elapsed, all transplant-related medical benefits will revert to the terms and conditions of health coverage under this health plan document. A transplant case manager will be assigned to assist and coordinate the Employee or Dependent's continuing transplant related needs.

Benefits available for Human Organ and Tissue Transplants are subject to the following:

1. The Employee and Dependent(s) are eligible for medical benefits under the group's plan document;

2. The Employee and Dependent(s) meet all the terms and conditions outlined in the Organ and Tissue Policy/Certificate; and
3. The Employee and their Dependent(s) do not have a pre-existing condition as defined in the Organ & Tissue Transplant Policy/Certificate.

Those Employees and their Dependents who are initially excluded, (at the time the Organ & Tissue Transplant Policy was first issued to the group) from human organ and tissue transplant coverage under the Organ & Tissue Transplant policy (due to a pre-existing condition) will continue to receive health care benefits as they relate to the transplantation according to the terms and conditions of the Plan (as defined in the Schedule of Benefits) and until eligible for benefits under the separate policy. This Organ & Tissue Transplant coverage does not include corneal transplants.

For coverage excluded or exhausted under the Organ & Tissue Transplant Policy, the following limitations will apply:

The transplant must be performed to replace an organ or tissue.

Benefit payments for donor charges are subject to the separate Donor Maximum Benefit limit as shown in the Schedule of Benefits.

If the organ or tissue donor is a Plan Participant and the recipient is not, then the Plan will cover donor organ or tissue charge for:

1. Evaluating the organ or tissue;
2. Removing the organ or tissue from the donor.

No transportation charges will be considered. The Plan will always pay secondary to any other coverage.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Abortion. For or related to an abortion, except where the life of the mother is endangered by the continued Pregnancy, for medical complications that arise from an abortion, or if the Pregnancy is the result of rape or incest.

Acupuncture. Relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy as specifically provided herein.

Foot Disorders. Treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses, or toenails (unless needed in treatment of a metabolic or peripheral vascular disease).

Gene [and Cellular] Therapy. Expenses related to gene [and cellular] therapy unless otherwise stated as covered.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness. ***NOTE:*** *This Exclusion does not apply to hair pieces and wigs that are covered under the Plan for patients who are undergoing chemotherapy or radiation.*

Adult Hearing Aids (ages 19 and older). For hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids.

Hypnosis. Related to the use of hypnosis.

Impotence. Care, treatment, services, supplies, or medication in connection with treatment for impotence.

Impregnation and Infertility Treatment. Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), in-vitro fertilization, surrogate mother (unless the surrogate is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions) donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos or any type of artificial impregnation procedure, or any type of artificial impregnation procedure, whether or not such procedure is successful.

Marital or Pre-Marital Counseling. Care and treatment for marital or pre-marital counseling.

Non-Compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

Non-Emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

Organ Transplants. Related to donation of a human organ or tissue, except as specifically provided.

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers, and exercise equipment, whether or not recommended by a Physician.

Pregnancy of a Dependent Child. Incurred by an eligible Dependent Child, including, but not limited to, pre-natal, delivery and post-natal care, treatment of miscarriage and complications due to Pregnancy, unless specifically provided as a covered benefit elsewhere in this Plan. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Replacement Braces. For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

Routine Patient Costs for Participation in an Approved Clinical Trial. For routine patient costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits.

Sexual Dysfunction. For any treatment of a sexual dysfunction. This Exclusion includes medications, implants, hormone therapy, Surgery, or gender dysphoria, unless otherwise specified by the Plan.

Sleep Disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

Sterilization Reversal. For sterilization procedure reversal.

Travel and Accommodations. For travel accommodation, whether or not recommended by a Physician, except as specifically provided herein.

Vision Care. Expenses for the following:

1. For eye refractions or the vision examination for prescribing or fitting eyeglasses or contact lenses.
2. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Vitamins. For vitamins, except as specified under Preventive Care.

UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. "The scope of the program" includes Hospital pre-admission certification, continued stay review, length of stay determination discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

Services that Require Pre-Certification
The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

1. Inpatient hospitalization.
2. Skilled Nursing Facility stays.

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification if there is a need to have a longer stay.

Pre-certification process is limited to determining the medical necessity of the procedure. This does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Pre-Certification Procedures and Contact Information
The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is located on the back of the employee identification card. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant, or an individual acting on behalf of the Participant should follow the Physician's instructions carefully and contact the pre-certification department within 72 hours of the first business day after the admission date.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Non-Emergency Admissions:
For services requiring pre-certification that are scheduled in advance, a call to the pre-certification department should be completed 48 hours before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the provision entitled "Pre-Certification Procedures and Contact Information," allowed charges will be reduced by $500. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: *If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.*

Alternate Course of Treatment
Certain types of conditions, such as spinal cord Injuries, cancer, AIDS, or premature births, may require long term, or lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Participant or their attending Physician may not be deemed to be Medically Necessary or within Maximum Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Maximum Allowable Charge, been pursued.

Pre-Admission Testing
If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven days prior to such Hospital admission will be paid according to the Summary of Benefits as outlined in the Summary of Benefit, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.

3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Second Surgical Opinion
If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary Bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer Toe repair.
8. Hemorrhoidectomy.
9. Herniorrhaphy.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone, or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).
17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

Case Management
The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family, and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

NOTE: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PRESCRIPTION DRUG BENEFITS

Pharmacy Options	
Retail Prescription Drug Benefits (90 Day Supply)	90% after Medical Plan deductible
Mail Order Prescription Drug Options (90 Day Supply)	90% after Medical Plan deductible
Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, as required by the Affordable Care Act are covered at 100% not subject to any copayment, coinsurance, or deductible. Certain contraceptives and certain smoking cessation products, as required by the Affordable Care Act are covered at 100% not subject to any copayment, coinsurance, or deductible, when purchased from a network pharmacy. A written prescription is required. This Plan requires the pharmacist to fill prescriptions with a generic whenever it is available. If the the member request a Brand Name medication over a Generic, the drug will not be covered under this Plan. If the member's Physician has specified "Dispense as Written" and there is a Generic available, an additional copayment will be applied based on the difference in cost between the Brand Name drug and the Generic equivalent.	

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. The administrator of the prescription drug plan is shown on the back of the employee identification card. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage.

The Mail Order Option is available for maintenance medications (those that are taken for extended periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of the volume buying the mail order pharmacy is able to offer Participants significant savings on their prescriptions. The mail order pharmacy is shown on the back of the employee identification card.

Covered Expenses

The following are covered under the Plan:

Anorexiants. Anorexiants (weight loss Drugs) will be covered in the case of Clinically Severe Morbid Obesity and throughout a continuum of treatment until an appropriate weight goal is achieved. On-going weight loss must be documented every six months for continued approval and weight loss must be a minimum of four pounds per month.

Compounded Prescriptions. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

Contraceptives. All Food and Drug Administration (FDA)-approved, -granted, or -cleared contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *All other contraceptive methods are covered under the Preventive Care benefit in the medical plan.*

Diabetes. Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over the counter, and glucose test strips, when prescribed by a Physician.

GLP-1 Drugs. (Glucagon-like peptide-1 receptor agonists) – to help manage blood sugar for people with Type-2 diabetes and/or treat obesity.

- Class I Obesity (Moderate Obesity): shall mean that an individual has a Body Mass Index (BMI) between 30.0 and 34.9. This level of obesity may be associated with an increased risk of developing obesity-related health conditions, such as Type 2 Diabetes Mellitus, hypertension, dyslipidemia, and cardiovascular disease.
- Class II Obesity (Severe Obesity): shall mean that an individual has a Body Mass Index (BMI) between 35.0 and 39.9. This classification is associated with a higher risk of obesity-related co-morbid conditions, including Type 2 Diabetes Mellitus, hypertension, obstructive sleep apnea, dyslipidemia, and cardiovascular disease.
- Class III Obesity (Clinically Severe/Morbid Obesity): BMI of 40.0 or greater, as previously defined in the Plan.

BMI is calculated as an individual's weight (in kilograms) divided by the square of their height (in meters).

Medical Devices and Supplies. Charges for legend and over-the-counter medical devices and supplies.

Preventive Drugs. All legend and non-legend Drugs required to be covered in accordance with the Affordable Care Act (ACA). More information can be found by visiting http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/coverage/preventive-care-benefits/.

Required by Law. All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below.

Smoking Deterrents. A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches.

Limitations

The benefits set forth in this section will be limited to:

Dosages.

1. With respect to the Pharmacy Option, any one prescription is limited to a 90-day supply.
2. With respect to the Mail Order Option, any one prescription is limited to a 90-day supply.
3. With respect to the Specialty Drug Option, any one prescription is limited to a 30-day supply.

Refills.

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

Exclusions

In addition to the General Limitations and Exclusions section, the following are not covered by the Plan:

Administration. Any charge for the administration of a covered Drug, except for administration fees that may be charged for covered immunizations received at a retail pharmacy.

Blood and Blood Plasma. Charges for blood and blood plasma.

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed.

Cosmetic Anti-Aging.

Devices and Supplies. Legend and over-the-counter devices and supplies of any type, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device.

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant.

FDA. Any drug not approved by the Food and Drug Administration.

Fertility Agents. Charges for fertility agents.

Immunizations. Immunization agents, biological sera, and immunologicals (vaccines), except as required under applicable law.

Impotency. A charge for impotency medication, including Viagra.

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises.

Investigational Use Drugs. A Drug or medicine labeled "Caution – limited by Federal law to Investigational use."

No Charge. A charge for Drugs which may be properly received without charge under local, State or Federal programs.

Non-Prescription Drug or Medicine. A Drug or medicine that can legally be bought without a prescription, except for injectable insulin.

Occupational. Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law.

Steroids. Anabolic steroids.

Vitamins. Vitamins, except pre-natal vitamins and any other vitamins required by the Affordable Care Act (ACA) are to be covered.

DENTAL BENEFITS

DEDUCTIBLE, PER CALENDAR	
Per Plan Participant	$50
Per Family Unit	$150
MAXIMUM BENEFIT AMOUNT, PER PERSON	
Class A, B and C Services	$2,000 per Calendar Year
Class D Services	$2,000 per Lifetime
Note: The Maximum Benefit Amount does not apply to Pediatric Services for Dependent children up to the age of 18.	
Note: Class A, B, C, and D services have a waiting period of 30 days.	
DENTAL PERCENTAGE PAYABLE	
Class A – Preventive	100% after deductible
Class B – Basic	90% after deductible
Class C – Major	60% after deductible
Class D - Orthodontia	60% after deductible
Charges are limited to Usual and Customary Fees.	

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and Exclusions set forth in this section.

Dental and Orthodontic expense benefits are separate from and in addition to the Medical Benefits of this Plan. These benefits are available only if elected by an Employee for himself/herself and eligible Dependents.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Maximum Allowable Charge for an amalgam filling. The patient will pay the difference in cost.

Pre-determination of Dental Benefits

If a planned dental service or Participant's proposed course of treatment can be expected to involve dental charges of $100 or more, a Participant may submit a description of the procedures to be performed and an estimate of the charges to the Plan Administrator or Third-party Administrator prior to the commencement of the course of treatment.

If requested, the Plan Administrator or Third-party Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination**

is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.

Dental Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to the Maximum Allowable Charge. The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

Class A Services (Preventive Care)

1. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two (2) per Plan Participant every Calendar Year.
2. One bitewing x-ray series every two (2) Calendar Years.
3. One full mouth x-ray every five (5) Calendar Years.
4. One fluoride treatment for covered Dependent children under age 19 each Calendar Year.
5. Space maintainers for covered Dependent children under age 19 to replace primary teeth.
6. Emergency palliative treatment for pain.
7. Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 14, once per tooth in any thirty-six (36) consecutive month period.

Class B Services (Repair and Restoration)

1. Dental x-rays not included in Class A.
2. Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
3. Periodontics (gum treatments).
4. Endodontics (root canals).
5. Extractions. This service includes local anesthesia and routine post-operative care, including removal of impacted teeth when performed in the provider's office.
6. Recementing bridges, crowns, or inlays.
7. Fillings, other than gold.
8. General anesthetics, upon demonstration of Medical Necessity.
9. Antibiotic drugs.

Class C Services (Major Dental Repair)

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Installation of crowns.
3. Installing precision attachments for removable dentures.
4. Installing partial, full, or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during six (6) following the installation.
5. Addition of clasp or rest to existing partial removable dentures.
6. Initial installation of fixed bridgework to replace one or more natural teeth.
7. Repair of crowns, bridgework, and removable dentures.
8. Rebasing or relining of removable dentures.

9. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth.

   However, this item will apply only if one of these tests is met:

   a. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable; or
   b. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within twelve (12) from the date the temporary denture was installed;

Class D Services (Orthodontics)

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments, and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

Dental Exclusions and Limitations

The following Exclusions and limitations are in addition to those set forth in the sections entitled "General Limitations and Exclusions," and "Summary of Benefits."

Administrative Costs. For administrative costs of completing claim forms or reports or for providing dental records.

Anesthetic. Local infiltration anesthetic when billed separately by a Dentist.

Crowns. For crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.

Hygiene. For oral hygiene, plaque control programs or dietary instructions.

Implants. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants, except first-time non-cosmetic dental implants.

Medical Benefits. For charges covered under the "Medical Benefits" section of the Plan.

Orthognathic Surgery. For Surgery to correct malpositions in the bones of the jaw.

Personalization. For expenses for services or supplies that are cosmetics in nature, including charges for personalization or characterization of dentures.

Replacements. Charges for replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge, made within five years after the last placement, exclusive of replacement necessitated by damages caused by an Accidental Injury sustained by the Participant, resulting in damages that are beyond repair.

Splinting. For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, and applicable law. To receive consideration, claims for benefits and questions regarding said claims should be directed to the Third-party Administrator. The Plan Administrator may delegate to the Third-party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third-party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third-party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submit claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations, and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the people involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third-party Administrator within 365 days of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third-party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third-party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third-party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third-party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following periods:

1. Pre-service Urgent Care Claims:

    a. If the Claimant has provided all of the necessary information, as soon as possible, considering the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, considering the medical exigencies, after the earliest of:
        i. The end of the period allowed the Claimant to provide the information.
        ii. The Plan's receipt of the specified information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, considering the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request within less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
    c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
    d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

        i. Notification to Claimant 30 days
        ii. Notification of Adverse Benefit Determination on appeal 30 days

4. Post-service Claims:

    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
    c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

5. Exclusions:

    a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
    b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day processing period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
    c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.

5. A description of the Plan's review procedures and the time limits applicable to the procedures.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol, or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180-day time following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180-day period.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that considers all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.

9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third-party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal

The Claimant must file the appeal an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

Pre-service Claims. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Regional Care, Inc.
905 West 27th Street
Scottsbluff, Nebraska 69361
Phone: 1-800-795-7772
Fax: 1-308-635-2018
Email/Website: www.regionalcare.com

Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Regional Care, Inc.
905 West 27th Street
Scottsbluff, Nebraska 69361
Phone: 1-800-795-7772
Fax: 1-308-635-2018
Website/Email: www.regionalcare.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.

6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, consider the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile, or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol, or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be

provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.

11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

The decision by the Plan Administrator or other appropriately named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the external review program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the external review program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the external reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The Claimant has exhausted the Plan's internal appeal process (unless the Claimant is not required to exhaust the internal appeals process under the final regulations) and rendered the appeal available for standard external review.
    d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan will act against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third-party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.
    b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review.

4. Notice of final external review decision. The Plan's (or Third-party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in

accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third-Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to function as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion of a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Autopsy

Upon receipt of a claim for a deceased Claimant for any condition, Sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Non-U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non-U.S. Provider." Claims for Emergency medical care, supplies, or services provided by a Non-U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non-U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non-U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non-U.S. Provider must satisfy all applicable credentialing and licensing requirements; and claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days

of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimant and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third-party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

Medicaid Coverage

A Claimant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A Claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within three years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans
Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

Standard Coordination of Benefits
The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due to 100% of the total allowable charges.

Benefits Subject to This Provision
The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance
Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Sickness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. The party is responsible, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible Third-party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles, or classifications.

Effect on Benefits

Application to Benefit Determinations
The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance

due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered secondary regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination between the Plan and an Other Plan are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses a claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.
3. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or Retired Employee. The benefits of a plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
4. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
5. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When both parents have the same birthday, the benefits of the plan which has covered the parent for the longer time are determined before those of the plan which covered the other parent.
    b. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    c. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be

determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

d. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separate of divorced.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

6. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for a shorter period of time.
7. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish the Plan Administrator with such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Covered Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Covered Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elect's coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third-party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third-party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency, and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entity's part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status, and coverage under the Plan.
3. To interpret the Plan, including the authority to construe ambiguities, inconsistencies, omissions and disputed terms.

4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third-party Administrator to pay claims.
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
10. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of the date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Material Modification by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: *The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.*

Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes made shall be binding on each Participant. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

THIRD-PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a Third-party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, Third-party assets, Third-party insurance, and/or guarantor(s) of a Third-party, any medical, applicable disability, or other benefit payments and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and Third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or Third-party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
If the Participant(s) fails to file a claim or pursue damages against:

1. The party responsible, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible Third-party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance companies.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all

funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Participant understands that he/she is required to:

1. Notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
2. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any Third-party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability
The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable Third-party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance
Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The party responsible, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible Third-party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance companies.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds
Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a Third-party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations
It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any Third-party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status
In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite

court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical errors will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of any other applicable law.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Pronouns
Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage
Wherever any words are used in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

No Waiver or Estoppel
All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the narrowest fashion possible.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowed under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so action, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish the Plan Administrator with such information as requested and as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has authority over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements
All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors
To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

HIPAA PRIVACY

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses the Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling the Plan Administrator.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI without individual authorization in the minimum necessary amount only if the use or disclosure is for a Treatment, Payment, or Health Care Operations purpose as defined by HIPAA. For example, the Plan may use or disclose the Participant's PHI in the following ways:

1. To help manage the health care treatment the Participant receives: The Plan can use the Participant's PHI and share it with professionals who are treating the Participant. **Example:** A

doctor sends the Plan information about your Diagnosis and treatment plan so the Plan can arrange additional services.
2. For health care operations: The Plan can use and disclose the Participant's PHI to run the Plan and may contact the Participant when necessary. **Example:** The Plan uses PHI about the Participant to develop better services for the Participant.
3. To conduct payment of benefits. **Example:** The Plan discloses PHI to other payers to coordinate benefits.
4. To administer the Plan. **Example:** The Plan discloses PHI to the Plan Sponsor to perform administrative functions and make coverage decisions.
5. If the use or disclosure falls within one of the other limited circumstances described in the rules. **Example:** The Plan makes a disclosure which is required by law or for public health activities.

Reproductive Health Information
Pursuant to federal law (29 FR 32976), unless required by law, the Plan will **not** use or disclose PHI which is requested to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for either purpose.

If the Plan receives a request for PHI which is potentially related to reproductive health care for one of these impermissible purposes, the Plan will not use or disclose PHI without first obtaining a signed attestation from the requesting party that the request is not for an impermissible purpose.

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to conduct Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.

6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make PHI available in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights
The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to request this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

City of Alliance
324 Laramie
Alliance, Nebraska 69301
Phone: 1-308-762-5400

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality, and availability of protected health information that creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

i. City Manager, City Clerk, Administrative Assistant: The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliances to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to an extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damage.
5. Training Employees in privacy protection requirements and appointing a Privacy Officer responsible for such protections.

6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Narrative
July 1, 2025

Alliance Nebraska

RESOLUTION - RECLASSIFICATION OF POLICE LIEUTENANT POSITION

The Police Department is requesting a reclassification of the Police Lieutenant position from its current Exempt designation of Pay Grade 104 to Pay Grade 105.

This request is driven by internal equity considerations. Currently, the department has a highly qualified individual on the Lieutenant eligibility list who is serving as a Police Sergeant at the top of the pay scale. The Sergeant classification is non-exempt, based on an 84-hour pay period, and eligible for overtime. In contrast, the Lieutenant role is classified as an exempt, administrative position based on an 80-hour pay period, with no overtime eligibility.

Under the current pay structure, the top hourly rate for the Lieutenant position is *less per hour* than the Sergeant's current rate. As a result, promoting this individual would unintentionally lead to a decrease in hourly compensation despite the increased responsibilities, leadership expectations, and exemption from overtime. To address this disparity, the Police Chief is recommending that the Lieutenant position be reclassified to Pay Grade 105. This change would raise the top hourly wage for the position by 4.37%. This adjustment would ensure that the promotional pathway offers appropriate compensation for the increased scope of duties and reinforces our commitment to valuing internal advancement.

While the Lieutenant classification remains within acceptable external compensation benchmarks, this reclassification is proposed to resolve a matter of internal fairness, support employee engagement, and maintain the integrity of our promotional system.

Staff respectfully request the City Council's approval of this reclassification.

RECOMMENDATION: APPROVE RESOLUTION AUTHORIZING THE RECLASSIFICATION OF THE POLICE LIEUTENANT POSITION.

RESOLUTION NO. 25-73

WHEREAS, The City of Alliance desires to maintain internal equity of pay while encouraging promotion of qualified internal candidates; and

WHEREAS, The City's pay structure currently has compression between the sergeant and lieutenant positions, making it difficult for employees to advance without a loss in pay; and

WHEREAS, The City desires to promote from within and remedy the compression in order to promote a current candidate without the need for retesting and re-advertising the lieutenant position.

NOW, THEREFORE, BE IT RESOLVED by the Mayor and Council of the City of Alliance, Nebraska, that the FY24-25 Classification Plan is hereby amended to reclassify the Police Lieutenant position from Grade 104 to Grade 105.

PASSED AND APPROVED this 1st day of July 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

_____
Simmons Olsen Law Office, Legal Counsel

City of Alliance
Classification Plan

Effective: July 1, 2025

Job Title	Grade	Minimum	Maximum
Exempt Classifications			
Golf Course Administrator	101	$51,563.20	$69,804.80
Airport Director	102	$54,059.20	$73,153.60
Library Director	103	$56,680.00	$76,731.20
~~Police Lieutenant~~	~~104~~	~~$59,384.00~~	~~$80,475.20~~
Assistant Fire Chief	104	$59,384.00	$80,475.20
Community Development Director	104	$59,384.00	$80,475.20
Police Lieutenant	105	$62,233.60	$84,406.40
City Treasurer	105	$62,233.60	$84,406.40
Cultural & Leisure Services Director	106	$65,249.60	$88,504.00
Human Resource Director	106	$65,249.60	$88,504.00
Police Captain	106	$65,249.60	$88,504.00
City Clerk	107	$68,390.40	$92,872.00
Finance Director	109	$75,192.00	$102,086.40
Fire Chief	109	$75,192.00	$102,086.40
Police Chief	109	$75,192.00	$102,086.40
Public Works Director	109	$75,192.00	$102,086.40
Electric Superintendent	110	$78,832.00	$107,078.40
Non-Exempt Classifications			
Library Page	201	$12.00	$14.15
Museum Support Clerk	202	$12.00	$14.73
Nutrition Delivery Driver	202	$12.00	$14.73
Nutrition Aide	204	$12.00	$16.00
Cook	206	$13.68	$17.36
RSVP Clerk	206	$13.68	$17.36
Library Clerk	207	$14.25	$18.08
Museum Clerk	207	$14.25	$18.08
Public Transit Driver/Dispatcher	209	$15.46	$19.67
Account Clerk I	211	$16.79	$21.36
Grounds Maintenance Worker I	211	$16.79	$21.36
Golf Course Maintenance Worker I	212	$17.50	$22.27
Secretary	212	$17.50	$22.27
Meter Reader	212	$17.50	$22.27
Account Clerk II	213	$18.21	$23.23
Airport Maintenance Worker I	213	$18.21	$23.23
Streets Maintenance Worker I	213	$18.21	$23.23
Water Maintenance Worker I	214	$18.99	$24.21
Refuse Collection Driver	214	$18.99	$24.21
Landfill Transfer Station Operator	214	$18.99	$24.21
Facilities Maintenance Worker	214	$18.99	$24.21
Assistant Museum Director	214	$18.99	$24.21
Librarians	214	$18.99	$24.21
Children's/Youth Services			
Outreach/Adult Services			
Outreach/Technical Services			
Grounds Maintenance Worker II	214	$18.99	$24.21
Administrative Secretary	214	$18.99	$24.21
Administration			
Culture and Leisure Services			
Warehouse Manager	214	$18.99	$24.21

Animal Control Officer	215	$19.80	$25.25
Code Enforcement Officer	215	$19.80	$25.25
Account Clerk III	215	$19.80	$25.25
Golf Course Assistant Superintendent	215	$19.80	$25.25
Streets Maintenance Worker II	215	$19.80	$25.25
Airport Maintenance Worker II	216	$20.64	$26.35
Landfill Heavy Equipment Operator	216	$20.64	$26.35
Purchasing Manager	216	$20.64	$26.35
Deputy City Clerk	216	$20.64	$26.35
Permit Technician I	216	$20.64	$26.35
Personnel Technician I	216	$20.64	$26.35
RSVP Director	216	$20.64	$26.35
Public Transit Director	216	$20.64	$26.35
Museum Director	217	$21.53	$27.51
Water Maintenance Worker II	217	$21.53	$27.51
Electric Apprentice Line Worker			
Apprentice I	220/1	$24.44	
Apprentice II	220/5	$27.58	
Apprentice III	223/6	$32.33	
Apprentice IV	223/9	$35.47	
Utility Services Office Manager	220	$24.44	$31.21
Landfill Foreman	220	$24.44	$31.21
Grounds Maintenance Foreman	220	$24.44	$31.21
Golf Course Superintendent	220	$24.44	$31.21
Street Foreman	220	$24.44	$31.21
Airport Maintenance Foreman	221	$25.46	$32.57
Building & Code Inspector	221	$25.46	$32.57
Water Foreman	221	$25.46	$32.57
Electric Journey Line Worker	227	$32.82	$42.13
Metering & Load Control Technician	228	$34.26	$43.94
Electric Foreman	229	$35.75	$45.86
Fire Classifications			
Fire Apparatus Engineer/EMT	520	$18.72	$23.85
Police Classification			
Police Officer Trainee	90% of Grade 1 of Police Officer Wages		

Narrative
July 1, 2025

RESOLUTION– MANAGER'S APPLICATION FOR DPR WEALTH MANAGEMENT, LLC DBA ALLIANCE HOTEL AND SUITES CLASS I LIQUOR LICENSE MANAGER

The City of Alliance is in receipt of a new liquor license application from DPR Wealth Management, LLC dba Alliance Hotel and Suites located at 117 Cody Avenue. The applicant has designated Xiomara Smith as the on-site Manager of the Liquor License. The Police Department has completed a background check and has found no reason to deny the application.

RECOMMENDATION: APPROVE RESOLUTION RECOMMENDING THE MANAGER LICENSE OF XIOMARA SMITH TO THE LIQUOR CONTROL COMMISSION.

RESOLUTION NO. 25-70

WHEREAS, The City of Alliance has received a notice and copy of a Manager Application for DPR Wealth Management, LLC dba Alliance Hotel and Suites, 117 Cody Avenue, Alliance, Nebraska submitted by Xiomara Smith; and

WHEREAS, City staff has reviewed the application and finds no reason why the proposed manager, Xiomara Smith, would be disqualified from serving as manager.

NOW, THEREFORE, BE IT RESOLVED, by the Mayor and Council of the City of Alliance, Nebraska, that the Manager's Application of Xiomara Smith for DPR Wealth Management, LLC dba Alliance Hotel and Suites, 117 Cody Avenue, Alliance, Nebraska is hereby recommended for approval to the Nebraska Liquor Control Commission.

BE IT FURTHER RESOLVED, that the City shall notify the Nebraska Liquor Control Commission of this Council decision.

PASSED AND APPROVED this 1st day of July, 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

_____
Simmons Olsen Law Office, Legal Counsel

MANAGER APPLICATION
FORM 103

NEBRASKA LIQUOR CONTROL COMMISSION
301 CENTENNIAL MALL SOUTH
PO BOX 95046
LINCOLN, NE 68509-5046
PHONE: (402) 471-2571
FAX: (402) 471-2814
EMAIL: lcc.frontdesk@nebraska.gov
WEBSITE: www.lcc.nebraska.gov

License Class:_____

License Number:

MANAGER MUST:

- Be at least 21-years of age
- Complete all sections of the application.
- Form must be signed by a **member or corporate officer**
- Include Form 147 –Fingerprints are required
- Provide a copy of one of the following: US birth certificate, US Passport, naturalization papers OR legal resident documentation
- Be a resident of the state of Nebraska and if an US citizen be a registered voter in the State of Nebraska
- Spouse who **will** participate in the business, the spouse must meet the same requirements as the manager applicant:

Spouse who **will not** participate in the business

- Complete the Spousal Affidavit of Non Participation (Form 116). **Be sure to complete both halves of this form.**

CORPORATION/LLC INFORMATION

Name of Corporation/LLC: DPR Wealth Management LLC

PREMISES INFORMATION

Premises Trade Name/DBA: Alliance Hotel and Suites

Premises Street Address: 117 Cody Avenue

City: Alliance County: Box Butte Zip Code: 69301

Premises Phone Number: 3087628000

Premises Email address: thealliancehotels@gmail.com

SIGNATURE REQUIRED BY CORPORATE OFFICER / MANAGING MEMBER

The individual whose name is listed as a corporate officer or managing member as reported or listed with the Commission.

MANAGER INFORMATION

Last Name: Smith First Name: Xiomara MI:

Home Address: 412 Cheyenne Avenue

City: Alliance County: Box Butte Zip Code: 69301

Home Phone Number: [redacted]

Email address: xiomarasmith396@gmail.com

Are you married? If yes, complete spouse's information (Even if a spousal affidavit has been submitted)

☑ YES ☐ NO

Spouse's information

Spouses Last Name: Smith First Name: Jack MI: W

[redacted]

APPLICANT & SPOUSE MUST LIST RESIDENCE(S) FOR THE PAST TEN (10) YEARS

APPLICANT **SPOUSE**

CITY & STATE	YEAR FROM	YEAR TO	CITY & STATE	YEAR FROM	YEAR TO
Alliance, Nebraska	2012	Current	Alliance, Nebraska	2012	Current

MANAGER'S LAST TWO EMPLOYERS

YEAR FROM	YEAR TO	NAME OF EMPLOYER	NAME OF SUPERVISOR	TELEPHONE NUMBER
2015	2017	Dollar General	Angela Moore	4023183454
2017	2019	Holiday Inn Xpress - Alliance	Alice Hellwig	(308) 761-0970

1. **READ CAREFULLY. ANSWER COMPLETELY AND ACCURATELY.**
Must be completed by both applicant and spouse, unless spouse has filed an affidavit of non-participation.

Has anyone who is a party to this application, or their spouse, EVER been convicted of or plead guilty to any charge. Charge means any charge alleging a felony, misdemeanor, violation of a federal or state law; a violation of a local law, ordinance or resolution. List the nature of the charge, where the charge occurred and the year and month of the conviction or plea, include traffic violations. Also list any charges pending at the time of this application. If more than one party, please list charges by each individual's name. Commission must be notified of any arrests and/or convictions that may occur after the date of signing this application.

☐ YES ☒ NO

If yes, please explain below or attach a separate page.

Name of Applicant	Date of Conviction (mm/yyyy)	Where Convicted (City & State)	Description of Charge	Disposition

2. Have you or your spouse ever been approved or made application for a liquor license in Nebraska or any other state?

☐YES ■NO

IF YES, list the name of the premise(s):

_____

3. Do you, as a manager, qualify under Nebraska Liquor Control Act (§53-131.01) and do you intend to supervise, in person, the management of the business?

■YES ☐NO

4. List the alcohol related training and/or experience (when and where) of the person making application.

Applicant Name	Date (mm/yyyy)	Name of program (attach copy of course completion certificate)

*For list of NLCC Certified Training Programs see training

Experience:

Applicant Name / Job Title	Date of Employment:	Name & Location of Business:

5. Have you enclosed Form 147 regarding fingerprints?

☒YES ☐NO

PERSONAL OATH AND CONSENT OF INVESTIGATION
SIGNATURE PAGE – PLEASE READ CAREFULLY

The undersigned applicant(s) hereby consent(s) to an investigation of his/her background and release present and future records of every kind and description including police records, tax records (State and Federal), and bank or lending institution records, and said applicant(s) and spouse(s) waive(s) any right or causes of action that said applicant(s) or spouse(s) may have against the Nebraska Liquor Control Commission, the Nebraska State Patrol, and any other individual disclosing or releasing said information. Any documents or records for the proposed business or for any partner or stockholder that are needed in furtherance of the application investigation of any other investigation shall be supplied immediately upon demand to the Nebraska Liquor Control Commission or the Nebraska State Patrol. The undersigned understand and acknowledge that any license issued, based on the information submitted in this application, is subject to cancellation if the information contained herein is incomplete, inaccurate or fraudulent.

Applicant Notification and Record Challenge: *Your fingerprints will be used to check the criminal history records of the* FBI. *You have the opportunity to complete or challenge the accuracy of the information contained in* FBI *identification record. The procedures for obtaining a change, correction, or updating an* FBI *identification record are set forth in Title 28, CFR, 16.34.*

Must be signed by applicant and spouse.

Signature of **APPLICANT**

Printed Name of **APPLICANT**

Signature of **SPOUSE**

Printed Name of **SPOUSE**

SPOUSAL AFFIDAVIT OF NON-PARTICIPATION

NEBRASKA LIQUOR CONTROL COMMISSION
301 CENTENNIAL MALL SOUTH
PO BOX 95046
LINCOLN, NE 68509-5046
PHONE: (402) 471-2571
FAX: (402) 471-2814
Website: www.lcc.nebraska.gov

☑ I acknowledge that I am the non-participating spouse of a liquor license holder. My signature below confirms that I will not have any interest, directly or indirectly in the operation of the business (§53-125(13)) of the Liquor Control Act. I will not tend bar, make sales, serve patrons, stock shelves, write checks, sign invoices, represent myself as the owner or **in any way participate in the day to day operations of this business in any capacity**. The penalty guideline for violation of this affidavit is cancellation of the liquor license.

☑ I acknowledge that I am the applicant of the non-participating spouse. I understand that my spouse and I are responsible for compliance with the conditions set out above. If, it is determined that my spouse has violated (§53-125(13)) the commission may cancel or revoke the liquor license.

Jack Wayne Smith
Jack Wayne Smith
Signature of **NON-PARTICIPATING SPOUSE**

Jack Wayne Smith
Print Name

Leonard Smith
Signature of **APPLICANT**

Leonard Smith
Print Name

State of Nebraska, County of Box Butte

The foregoing instrument was acknowledged before me

this April 17, 2025 (date)

by _____
Name of person acknowledged
(Individual signing document)

Natalie Torres
Notary Public Signature

GENERAL NOTARY - State of Nebraska
Affix Seal NATALY TORRES
My Comm. Exp. February 7, 2027

State of Nebraska, County of Box Butte

The foregoing instrument was acknowledged before me

this April 17, 2025 (date)

by _____
Name of person acknowledged
(Individual signing document)

Natalie Torres
Notary Public Signature

GENERAL NOTARY - State of Nebraska
Affix Seal NATALY TORRES
My Comm. Exp. February 7, 2027

ALLIANCE POLICE DEPARTMENT
MEMORANDUM

To: Ammie Bedient

From: Communications Supervisor Gerth

Subject: Background check on Xiomara Smith

To whom it may concern:

On June 16, 2025 I conducted a background check on the person of Xiomara Smith. An interview was also conducted VIA phone and was in reference to her liquor license application for Alliance Hotel & Suites.

Xiomara Smith has indicated that she knows the rules of liquor sales and has had some previous exposure to it at a previous time.

Xiomara Smith resides in Alliance fulltime.

Xiomara Smith advised that Alliance Hotel & Suites has and will continue to establish protocols for dealing with fake ID's, selling alcohol to minors, disturbances, etc. She stated that the hotel has signs indicating the sale of liquor, and that she knows if they don't get alcohol from them they will get it elsewhere. I asked her how she would ensure no sale violations occurred, she advised they would be checking IDs.

After reviewing Xiomara Smith's background, I did not see anything that would be a concern for approving the request. Xiomara Smith advised she does not have any current civil suits or judgements and has not filed for bankruptcy.

Overall, I do not have any concerns with Xiomara Smith receiving her liquor license within the City of Alliance.

Respectfully,
Hannah Gerth, Dispatch Supervisor #C4
Alliance Police Department
308-762-4955

Narrative
July 1, 2025

PASSAGE OF RESOLUTION APPROVING ENTERING INTO AN AGREEMENT WITH BURNS & MCDONNELL ENGINEERING COMPANY, INC. IN THE AMOUNT OF $103,400 FOR CREATION OF BID DOCUMENTS FOR THE ABATEMENT OF ASBESTOS AT THE DECOMMISIONED CITY OF ALLIANCE POWER PLANT

The City decommissioned its power plant located at 2nd and Big Horn Avenue approximately 40 years ago. The city desires to have the property redeveloped in efforts to lead the way as an example as the property is vacant and located in a blighted and substandard area. Before the property can be redeveloped, asbestos and any other environmental concerns need to be remediated.

City Staff advertised seeking requests for qualifications and reached out to approximately 30 firms directly as well. In response the city received qualifications from four engineering firms. All four firms demonstrated competence in this area, however scoring amongst the review committee showed Burns & McDonald as the preferred firm. Staff approached Burns & McDonald requesting that they put together a final scope and contract amount which is now before Council for consideration.

Work will include identifying areas for remediation along with the requirements and specifications for removal, creation of bid documents, and assistance with the bidding process. Upon completion, it is anticipated that the City will seek the services of 1) a contractor to perform the remediation, 2) an engineering firm to oversee the remediation, and 3) services to monitor air quality, testing, etc. during removal.

Recommendation: Staff recommends approval

RESOLUTION NO. 25-74

WHEREAS, The City of Alliance desires to obtain the services of a professional firm to prepare remediation specifications and bid documents for the decommissioned power plant still owned by the City; and

WHEREAS, Four firms submitted qualifications to perform such work; and

WHEREAS, Burns & McDonnell Engineering Company, Inc. was determined by a review committee to be the most qualified to perform this work; and

WHEREAS, Burns & McDonnell Engineering Company, Inc. has submitted a scope of work in compliance with the services requested in the Request for Qualifications (RFQ) and provided a quote in the amount of $103,400.00 to perform said service; and

WHEREAS, The City desires to retain the services of Burns & McDonnell Engineering Company, Inc. to perform this work.

NOW, THEREFORE, BE IT RESOLVED by the Mayor and Council of the City of Alliance, Nebraska, that the Mayor is authorized to approve this work and sign an Agreement with Burns & McDonnell Engineering Company, Inc. on behalf of the City in an amount not to exceed One Hundred Three Thousand, Four Hundred dollars ($103,400.00).

PASSED AND APPROVED this 1st day of July 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

_____
Simmons Olsen Law Office, Legal Counsel

June 25, 2025

Mr. Seth Sorensen
City Manager
City of Alliance
324 Laramie Avenue
Alliance, NE 69301

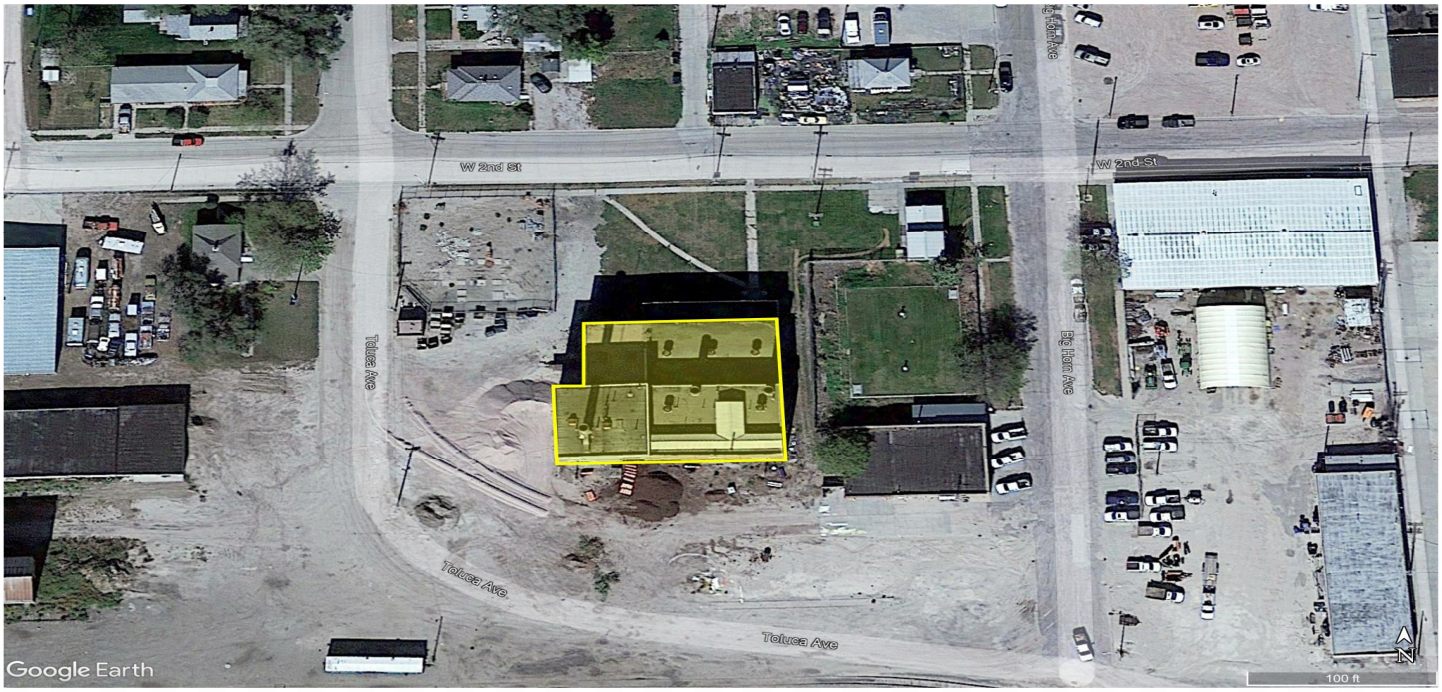
RE: Cost Proposal
Engineering Services - Power Plant Asbestos Abatement Bid Package Development

Dear Mr. Sorensen,

Burns & McDonnell Engineering Company, Inc. (Burns & McDonnell) is pleased to submit our cost proposal to the City of Alliance to provide engineering services for Power Plant Asbestos Abatement Bid Package Development in accordance with the Request for Qualifications (RFQ) dated April 2, 2025.

SCOPE OF WORK

Burns & McDonnell Engineering Company, Inc. (Burns & McDonnell) understands that City of Alliance is interested in conducting an abatement of the decommissioned coal-fired power plant in Alliance, Nebraska which has known asbestos-containing materials (ACMs). The following sections describe the scope of work to be accomplished as part of this cost proposal.



TASK 1 – PROJECT KICKOFF MEETING

Initial steps for this task will involve Burns & McDonnell scheduling a virtual kickoff meeting with City of Alliance to discuss the scope, schedule, and any details necessary to begin developing the bid documents. Burns & McDonnell personnel will make one (1) initial site visit to the former plant following the kickoff meeting to observe and document current conditions and begin data gathering for the bid documents development.

Items to be discussed during this kickoff meeting for the project include:

- Roles and responsibilities
- Project communications
- City of Alliance's expectations for a successful project
- Details regarding the end state for the property at project completion
- Expected decommissioning and abatement activities for the site
- Review outline for bid documents
- Discuss anticipated project schedule

Prior to the kickoff meeting, we will request the City of Alliance provide plant construction drawings, environmental reports, etc., required to complete the scope of work. These may include:

- → Construction or as-built drawings for structures and underground utilities
- → Environmental reports (spills, underground tanks, ACM reports, Phase I and II reports, etc.)
- → Information on PCB concentrations in retrofilled transformers and other equipment

TASK 2 – REGULATED MATERIALS ASSESSMENT (RMA)

Our onsite assessment team will conduct a thorough inspection of the facility to document the current condition and estimated quantities of regulated materials present at the plant requiring abatement. A combination of the previous studies as well as any new information collected will be used to prepare a comprehensive study that will include the quantification of all regulated materials (including asbestos) that will need to be removed and transported offsite for disposal.

Information that is important for these assessments includes: a complete characterization of all identified regulated materials (i.e., potential waste removal); list of materials sampled, locations where samples were taken, noting equipment and/or buildings, building elements, elevations, etc. in order to match precisely the sample result to the location the sample was collected in the facility; type of equipment and survey method utilized by the contractor; laboratory analytical results; and estimated quantities of each regulated material. The information generated during the RMA will assist in developing the estimate of probable costs more accurate for the abatement of these materials. It will also be used as the basis for the abatement bid documents.

A typical regulated materials assessment includes a thorough visual inspection of the plant as well as collection of appropriate samples (asbestos, lead based paint, PCBs) to identify the presence or absence of the following regulated materials:

- Asbestos-containing materials (ACM's)
- Polychlorinated Biphenyls (PCBs) in waste and building materials (oil, lighting ballasts, concrete, caulk, paint, etc.)
- Fuels (gasoline, diesel, No. 2, No. 6)
- Hydraulic fluids, lubricating oils, etc.
- Halon or other fire protection chemicals

- Batteries
- Universal wastes (mercury and other fluorescent, halogen, sodium-vapor, and high-intensity discharge lights; mercury-containing gauges, pressure meters thermostats and thermometers; batteries; aerosols)
- Chemicals (maintenance, water treatment, etc.)
- Lead-based paint
- Devices with a nuclear source (flow meters, exit signs, smoke detectors, etc.)
- Industrial gases used for such purposes as generator cooling, fire protection, welding/cutting and refrigeration among others
- Ozone-depleting substances (ODSs) in heating, cooling, and refrigeration equipment
- Polychlorinated biphenyl (PCB) or PCB-replacement chemical containing electrical components (starters, capacitors, light ballasts)
- PCB-containing electrical equipment and associated PCB-contaminated surfaces (transformer oil and concrete pedestals)
- PCB-containing building materials and associated PCB-contaminated surfaces (paint, caulk, Galbestos siding, concrete, CMU, other porous materials)

Burns & McDonnell has developed a data collection system that uses hand-held tablets in the field to collect information on the type of material, analytical results (if sampled), location, and photos. This information is linked together in a database along with the GPS location that is used to prepare a comprehensive regulated materials summary spreadsheet along with a photo log.

Our database of information is then exported to a spreadsheet to create an inventory/removal tracking list. Photos that are associated with each material / location are exported in a photolog that indicates the location, type of material, and any sampling results (if sampled). We anticipate that it will require up to 3 days to complete the onsite sampling and inventory work.

Asbestos Sampling

The asbestos inspection and sampling will be conducted to satisfy the United States Environmental Protection Agency (US EPA) National Emission Standard for Hazardous Air Pollutants Act (NESHAP) as amended November 20, 1990. The USEPA NESHAP final rule requires the identification and removal of all regulated ACM in a building prior to decommissioning/removal.

Sample locations will generally include thermal system insulation (TSI), tank insulation, flooring, ceiling tiles, and other materials that, upon visual inspection, are suspected of containing asbestos. All sample collection will be performed by a State-Licensed Asbestos Inspector in accordance with Asbestos Hazard Emergency Response Act (AHERA) standards for all suspected or Presumed Asbestos-Containing Materials (PACM). The inspection process will involve semi-destructive testing methods, including cutting through multiple layers of flooring, roofing, refractory, and similar materials to identify and collect samples from individual suspect asbestos-containing layers.

During the inspection, suspect materials will be located, sampled, quantified, and the friability of the material determined. Friable materials are those materials that hand pressure can crumble, pulverize, or reduce to powder when dry. An estimated quantity of identified ACM is provided for positive materials only. The materials are quantified in linear or square feet, depending on the nature of the material. If the measurement is in linear feet, the nominal diameter of the piping will be included in the description for the sample.

Sample locations will be left such that there is no friable PACM exposure to others, which may include tape, caulk, or other temporary measures that may limit exposure. Suspect building materials that are inaccessible for inspection and sampling will be presumed to be ACM for the report. These suspect materials may be located in operational equipment, behind rigid walls and ceilings, below rubber roof membranes or otherwise concealed areas of the building, including below grade materials. PACM that cannot be sampled (e.g., gaskets, boiler refractory, boiler insulation, wiring etc.) will be

photographed where possible and noted in field notes. Materials currently marked as "non-asbestos" will be sampled and analyzed to confirm that they do not contain asbestos.

Sample Analysis

PACM samples collected at the site will be shipped to an accredited National Voluntary Laboratory Accreditation Program (NVLAP) laboratory for testing. Each sample will be analyzed for asbestos using Polarized Light Microscopy (PLM). The laboratory will provide test results to Burns & McDonnell for inclusion in the final report. We have assumed that a total of up to 100 samples will be collected for analysis.

Field Marking and Sample Labeling

Burns & McDonnell will mark the location for each sample collected via permanent marker, painting, or tagging. Each sample location will have a unique identification number to correlate with the laboratory results, summary table, and photo log. Burns & McDonnell will coordinate with City of Alliance at the beginning of the Regulated Materials Assessment to confirm and finalize the unique sample identification numbering system.

Lead-Based Paint Survey

A lead-based paint survey will be conducted at the facility focused on painted surfaces. This general assessment will test paint on major components, walls, mechanicals, railings, etc. throughout the facility. Sampling will be conducted collecting paint chips for analysis from various painted surfaces in the facility. The samples will be sent to an accredited NVLAP laboratory for analysis. We have assumed a total of 8 samples will be collected for analysis.

Other Regulated Materials Inventory

In addition to the sampling efforts described above, an inventory of other universal and other wastes will be conducted during the onsite activities. This effort will consist primarily of identifying the number / volume and location of these materials throughout the plant. Photos of each typical regulated material and location will be taken and included in the final report along with a summary table with the type, quantity, and location of these other regulated materials.

PCB Sampling

Building Materials

Samples of various building materials (if present) will be collected throughout each structure for PCB analysis. Materials to be sampled may include:

- Window/building caulk
- Paint
- Expansion joint sealant
- Suspect galbestos siding (if present)

Representative samples of window and building caulk, expansion joint sealants, galbestos coating, etc. will be collected from the building for analysis. This information will be used to identify the potential contractors the requirements for the proper handling and disposal of these materials during decommissioning/removal.

In addition to the lead-based paint survey, representative paint samples will be collected to evaluate distinct types of painted components to identify on a broad scale the impact of PCB paint as it relates to the disposal of PCB paint contaminated debris and potential worker exposure issues. A paint chip sample will be collected to represent an assortment of colors observed within the building. Generally, wall surfaces, structural steel components, painted steel railings, and painted process equipment and piping will be tested. A total of 8 samples have been assumed for this project.

Concrete Surfaces

Concrete beneath liquid filled transformers or other equipment that may have contained PCBs in the past will be sampled for the presence of PCBs. It is important to determine whether the concrete can be removed, crushed, and reused for

backfill or if it will require offsite transportation and disposal. Sample locations will be determined in the field and will be biased toward stained surfaces (if present). If no visible staining is observed, then samples will be in a representative area beneath or next to the equipment.

Discrete samples will be comprised of drill cuttings collected by drilling into the concrete. Each sample location will be a composite from several closely spaced shallow drill holes. An equal amount from each drill hole will be added to the composite jar, to acquire a target sample mass of 30 to 40 grams. The drill bit will not exceed 1-inch in diameter and drill holes will not exceed 0.5-inch in depth. The minimum volume/weight of each composite sample to be analyzed will be governed by the laboratory requirements.

Drill bits will be decontaminated with Alconox and distilled water, rinsed with distilled water and dried prior to use at a different discrete location. All other items (spoons, gloves, equipment, etc.) that may come in contact with the sample will be either decontaminated using a similar approach or disposed of and replaced with new materials between each location. We have assumed a total of 5 samples will be collected for analysis.

Analytical Methods

Samples of concrete and building materials will be submitted, under chain-of-custody protocols, to a laboratory certified in the state of Iowa. Samples will be analyzed using one of the approved extraction and analytical methods listed in 40 CFR Part 761, as amended on August 29, 2023.

Regulated Materials Assessment Report

A final report will be generated that identifies the type, location and quantity of regulated materials that must be removed from the site as part of the decommissioning project. This report will be used to provide the necessary information to provide to prospective contractors during the bid process. The RMA report for the site will summarize the visual inspection / inventory as well as any sampling results (asbestos, lead-based paints, PCBs, universal wastes, etc.). The report will include the following:

- Type of equipment and survey method utilized by the contractor including a complete characterization of all identified regulated materials (for potential waste removal)
- Date, location, name of inspector(s) that conducted the survey along with any required credentials (e.g., licensed state asbestos inspector)
- List of materials sampled, locations where samples were taken noting equipment and / or buildings, building elements, etc., and estimated quantities of each regulated material
- All like materials will be grouped in the results table with a separate line for each sample. If one or more of the samples was classified as ACM, then all three will be bolded and colored to indicate ACM.
- Estimates of the volume of each material sampled (linear feet, square feet) will be included in the table reporting all the material sampled at the Site. If linear feet are used as the unit of measure, an estimate of the diameter size of the piping will be included in the description.
- Table noting locations per elevation, equipment type, building, vessel, etc. to precisely match the sample (result) location with the actual field location.
- All analytical results from the laboratory.

Copies of previous Regulated Materials Assessments or other pertinent information will also be included in this report so that all the available information is in one document that could be shared with the potential contractors in the future.

TASK 3 – ESTIMATE OF PROBABLE COSTS

Burns & McDonnell has decommissioning, abatement, and demolition estimating specialists on staff with previous contractor experience that allow us to develop real world cost estimates that closely resemble the actual costs that City of Alliance will incur at the time of decommissioning of the plant. The as-built drawings, City of Alliance's knowledge of the environmental issues, and the RMA will be used to develop the estimate of probable costs.

The estimate of probable costs will be an Association for the Advancement of Cost Engineering (AACE) Class 4 planning level estimate that will be presented in a report that outlines the study methodologies, assumed abatement approach, general assumptions, and site-specific assumptions.

TASK 4 - BID DOCUMENT DEVELOPMENT

Burns & McDonnell will develop a comprehensive bid package for City of Alliance to solicit bids from potential abatement contractors for the abatement of the former steam plant. Our approach is tailored such that the bid package serves both as a tool for soliciting accurate bids and as a guide during project implementation.

Our technical bid documents focus on:

- **Minimizing Unknowns**: We aim to eliminate as many unknowns as possible to reduce the potential for inflated base estimates due to excessive contingency allowances in lump sum bids.
- **Consistency and Comparability**: We provide a consistent set of project expectations, constraints, and bid line items to facilitate easy comparison of all bidders.
- **Reducing Change Orders**: By providing comprehensive information during the bid process, we aim to minimize the potential for future change orders due to unknowns.
- **Including Alternates and Unit Prices**: We include potential items as alternates and unit prices (including labor and equipment rates) to control and reduce the magnitude of change orders if they become necessary.

To manage the risk of excessive change orders during project implementation, our bid form requires both unit pricing and/or lump sum add/deduct costs for alternative or potential items/services. This approach helps lower project costs by obtaining competitive pricing in the bid environment rather than through change orders after contractor mobilization.

Burns & McDonnell will issue a draft technical bid package to City of Alliance for review and comment prior to the final submittal date. The package will include specifications, reference drawings, and associated exhibits (regulated materials assessment, asbestos survey, etc.). We will conduct a teleconference with City of Alliance to review the bid documents and obtain final comments and changes required to complete the bid package. These final comments and changes will be incorporated into the specifications, and the final bid package will be provided to City of Alliance, ready for issuance to potential bidders.

Bid Specifications

Burns & McDonnell will use the Construction Specification Institute (CSI) format for developing specifications in the bid package. This format, which we have successfully employed in numerous abatement and demolition projects, is the industry standard for presenting project expectations. It provides clear organization of contractor requirements and facilitates the resolution of potential disputes.

The bid package specifications will be divided into distinct sections for ease of review and will include, at a minimum, the following information:

- Instructions to Bidders: Bid requirements, bid form with schedule of values, date for mandatory onsite pre-bid meeting, and bid due date.
- Minimum Contractor and Subcontractor Qualifications
- Information on Regulated Materials: Details on asbestos, PCBs, universal waste, mercury, fuel oil, other chemicals, lead paint, and nuclear sources.
- Waste Management Requirements
- Request for Contractor Project Approach:
  - → Detailed preliminary sequencing and execution plan, along with a schedule, to confirm the bidder's understanding of contract requirements and approach to the work.
  - → Identification of key project staff with resumes detailing relevant experience.

- List of subcontractors, including safety records (past three years), experience, and licensing. If subcontractors are not provided, bidders must ensure subcontractors meet minimum safety and experience requirements before approval.

- Acceptable Work Hours
- City of Alliance Safety and Security Requirements
- Schedule Constraints, if any
- Air Monitoring Requirements for Asbestos Abatement
- Permitting Requirements of the Contractor
- Reporting and Communication Requirements
- Mobilization and Demobilization Requirements
- Burns & McDonnell Developed Bid Form: For both bid comparison and contract schedule of values.

City of Alliance will be responsible for providing the administrative "front-end" documents (e.g., agreement, insurance requirements, bonding requirements), combining them with the bid package, and sending them to bidders.

Contract Drawings

Burns & McDonnell recognizes the value of visual representation in project documentation. To illustrate the scope of work, we will develop contract drawings by marking up existing as-built drawings or site photos. These drawings will include:

- Identification of structures to be abated/demolished
- Temporary utility hookup locations (if any)
- Locations of acceptable staging areas
- Acceptable traffic routes at the Facility

Reference Drawings

All available drawings will be reviewed for inclusion in the bid package as reference drawings. While some will be used to develop contract drawings, many will serve as reference information for potential contractors. Our goal is to provide comprehensive information regarding the construction and layout of the site. These drawings assist contractors in planning site settings, accessibility, and work limits.

Burns & McDonnell will collaborate with City of Alliance to identify the necessary reference drawings for the bid documents. We require these drawings in electronic format (preferably PDF).

Final Bid Documents

Burns & McDonnell will develop bid specifications and drawings to address the identified scope of work. We assume no additional site visits will be necessary after the site visit during the RMA. A draft submittal will be provided to City of Alliance for review before issuing the final set for the bid process. The final submittal will include a full set of contract drawings, specifications, reference drawings, and associated exhibits (e.g., regulated materials assessment). We anticipate meeting with City of Alliance via teleconference to review the bid documents and incorporate final comments and changes.

TASK 5 - BID PROCESS ASSISTANCE AND EVALUATION

Burns & McDonnell understands that City of Alliance has a list of pre-qualified bidders, eliminating the need for pre-qualification. Our proposed tasks to support the bid process include:

Contractor Pre-Qualification

Contractor pre-qualification is an important step in the process of awarding an abatement contract. Burns & McDonnell has assumed that this will be done prior to soliciting bids. It is important to verify that each bidder is technically qualified, has an acceptable safety record, and has experience safely and effectively demolishing facilities of similar size and scope. Information to be requested, at a minimum, will include:

- Identification of key project staff along with resumes describing their relevant experience for similar projects
- Description of at least three (3) similar projects conducted within the last five (5) years with references that can be contacted
- Copies of appropriate licenses for the prime contractor to conduct the work expected at the site
- Safety, insurance, and legal statistics (i.e., Experience Modification Rate [EMR], Total Recordable Incident Rate [TRIR] rates, Days Away, Restricted or Transferred [DART] rates) for the last three (3) years including any incidents, claims, violations, lawsuits, etc. the prime contractor as follows:
  - → Meet City of Alliance's safety requirements
  - → EMR for the past 3 years (abatement contractor and all subcontractors)
  - → TRIR for the past 3 years (abatement contractor and all subcontractors)
  - → DART for the past 3 years (abatement contractor and all subcontractors)
  - → OSHA Citation history and details for the past three (3) years (abatement contractor and all subcontractors)
  - → OSHA 300 logs to back-up the safety statistics reported (prime and subcontractors)
  - → Insurance coverage and claims history
- Bonding capacity of the abatement contractor (total, per project and available)

Once this information is received, an evaluation of the information will be conducted with a weighted scoring system used to determine if the potential bidders are qualified and capable of doing the work prior to being allowed to provide a bid. This information will be discussed with City of Alliance to make a final determination of the bidders to be included on project bid list.

Pre-Bid Site Walk

We will participate in a mandatory pre-bid site walkdown for the bidders along with the City of Alliance. We will lead a guided tour of the site, highlighting key areas/items included in the scope of work. Participation by key City of Alliance personnel is beneficial for answering bidder questions regarding the site setting and current conditions.

Questions raised by bidders will be recorded and included in an addendum sent to all bidders. Our costs assume one (1) Burns & McDonnell personnel on-site for one (1) day (including travel) for the pre-bid meeting.

Addendums & RFP Clarifications

After the pre-bid conference and site walkdown, Burns & McDonnell will assist City of Alliance in addressing bidder questions. If necessary, we will prepare addenda and/or modify the bid package to facilitate the bid process. It is crucial that all bidders receive the same clarifying information. Our fee estimate assumes minimal revisions to drawings or specifications and includes costs for a reasonable number of clarifications presented in addenda.

Bid Evaluation

Burns & McDonnell will assist City of Alliance with technical bid evaluation upon receipt of bids. We will develop a technical bid evaluation spreadsheet to numerically rank each aspect of the contractors' proposals based on criteria established collaboratively with City of Alliance. The Technical Evaluation will confirm each contractor's understanding of the project scope and requirements, evaluating:

- Subcontractor license compliance (if applicable)

- Experience of proposed contractor and subcontractor project staff
- Overall project approach (execution plan)
- Proposed project schedule

We will also develop a spreadsheet summarizing cost estimates for each line item, unit price item, alternate item, and the overall base cost. This information, along with the technical evaluation, will be provided to City of Alliance for cost evaluation. Burns & McDonnell anticipates conducting a teleconference to review the evaluation summary and assist City of Alliance in selecting an abatement contractor.

TASK 6 – PERIODIC MEETINGS

Burns & McDonnell will coordinate bi-weekly meetings via teleconference with the City of Alliance to go over progress and discuss any data needs. There will be two (2) staff from Burns & McDonnell that will participate and we have assumed the meetings will take no longer than one (1) hour for a total of 8 meetings.

PRELIMINARY SCHEDULE

The following is a preliminary schedule to complete the project scope. Burns & McDonnell will review with the City of Alliance the proposed schedule and adjust, as necessary.

Name	Duration	Start	Finish
Notice of Award	0 wks	7-Jul-25	7-Jul-25
Project Kickoff and Scope Workshop	**0.2 wks**	**14-Jul-25**	**14-Jul-25**
Project Kickoff	0.2 wks	14-Jul-25	14-Jul-25
Regulated Materials Assessment	**6 wks**	**11-Aug-25**	**19-Sep-25**
Site Visit & Sampling	1 wk	11-Aug-25	15-Aug-25
Prepare Draft RMA Report	3 wks	20-Aug-25	9-Sep-25
Submit Draft RMA Report to City of Alliance for Review	0 wks	9-Sep-25	9-Sep-25
City of Alliance Review of Draft RMA Report	1 wk	10-Sep-25	16-Sep-25
Finalize RMA Report	0.6 wks	17-Sep-25	19-Sep-25
Abatement Bid Document Development	**11 wks**	**21-Jul-25**	**3-Oct-25**
Prepare Draft Abatement Bid Documents	9 wks	21-Jul-25	19-Sep-25
Submit Draft Bid Documents to City of Alliance for Revie	0 wks	19-Sep-25	19-Sep-25
City of Alliance Review of Draft Bid Documents	1 wk	22-Sep-25	26-Sep-25
Finalize Abatement Bid Documents	1 wk	29-Sep-25	3-Oct-25
Abatement & Demolition Bid Process Administration	**15.2 wks**	**4-Aug-25**	**17-Nov-25**
Bidder Pre-Qualification	2 wks	4-Aug-25	15-Aug-25
Recommended Bid List Finalized	2 wks	18-Aug-25	29-Aug-25
Send Bid Packages to Prospective Subcontractors	0 wks	3-Oct-25	3-Oct-25
Mandatory Pre-Bid Site Walkdown	0.2 wks	13-Oct-25	13-Oct-25
Bid Period	4 wks	6-Oct-25	31-Oct-25
Receive Contractor Bids	0 wks	31-Oct-25	31-Oct-25
Conduct Bid Evaluation	2 wks	3-Nov-25	14-Nov-25
Review of Bid Evaluation with City of Alliance	0.2 wks	17-Nov-25	17-Nov-25

COMMERCIAL

Burns & McDonnell will complete the scope of work presented in this proposal on a lump sum basis in accordance with the attached terms and conditions. Our proposal pricing is valid for 60 days from the proposal date. The breakdown of cost is as follows:

Task No.	Task Description	TOTAL
1	Project Kickoff	$ 2,500
2	Regulated Materials Assessment	$ 40,700
3	Estimate of Probable Costs	$ 17,700
4	Abatement Bid Document Development	$ 24,300
5	Bid Process Assistance	$ 13,800
6	Period Progress Meetings	$ 4,400
	TOTAL	**$ 103,400**

Burns & McDonnell proposes to invoice according to the following milestone payment schedule:

Payment Milestone No.	Milestone Description	Payment Milestone Percentage	Payment Amount ($)
1	Project Kickoff	5%	$ 5,170
2	Final RMA Report	40%	$ 41,360
3	Bid Documents & Cost Estimate Completion	45%	$ 46,530
4	Bid Administration Completion	10%	$ 10,340

ASSUMPTIONS AND CLARIFICATIONS

1. City of Alliance will give prompt notice to Burns & McDonnell whenever City of Alliance observes or otherwise becomes aware of any development that affects the scope or timing of Burns & McDonnell's services.

2. Project deliverables will be provided in electronic format (e.g., PDF). One draft copy of each deliverable will be provided to City of Alliance for review and comment. The draft will be revised based on one round of City of Alliance comments and one (1) final copy of each deliverable will be provided to City of Alliance.

3. City of Alliance will provide Burns & McDonnell with all applicable reports, proposals, environmental reports, and figures for the Facility necessary to understand and manage the scope of work. It is assumed that these documents will be delivered to Burns & McDonnell in electronic format. Drawings and reports will be provided in native pdf format, and we can rely on them for completion of our work. It is assumed that drawings are accurate and represent current plant condition. No independent verification, separate surveying, or mapping of the underground utilities and other structures are included in the costs.

4. City of Alliance will provide adequate and safe access for the site visit. It is assumed that the equipment (e.g., transformers, wiring, etc.) or structures requiring sampling can be conducted safely at the time of the field activities.

5. No lifts or scaffolding will be required to collect samples as part of the Regulated Materials Assessment

6. No sampling of waste, soil, groundwater, or surface water other than the sampling identified in the Regulated Materials Assessment.

7. Burns & McDonnell assumes facility-knowledgeable personnel will be made available to provide construction documents, identify equipment and systems, and answer Burns & McDonnell questions.

8. Permits required for the abatement activities will be identified and made the responsibility of the Contractor, therefore no costs have been included for the development of permits required for the Work.

9. No costs for detailed engineering design for utility / service isolation and/or reroutes have been included.

10. No costs for support during abatement or asbestos air monitoring have been included in this proposal. A separate proposal can be provided once the asbestos contract is awarded should the City of Alliance be interested in our support.

11. In no event will Burn & McDonnell be responsible for abatement contractors' means, methods, techniques, sequences, or procedures, or for safety precautions or programs, or for abatement contractor's failure to perform abatement work in accordance with the contract documents and applicable law.

12. Burns & McDonnell shall not be responsible for the implementation or management of site safety programs for the contractor contracted by City of Alliance. Burns & McDonnell shall not have the authority to direct City of Alliance's contractors, nor shall Burns & McDonnell have the authority to bind City of Alliance by its actions.

13. Estimates and projections prepared by Burns & McDonnell relating to schedules, performance, construction costs, recovery costs, and operating and maintenance costs are based on our experience, qualifications, and judgment as a professional consultant. Since Burns & McDonnell has no control over weather, cost and availability of labor, material and equipment, labor productivity, contractor's procedures and methods, unavoidable delays, contractor's method of determining prices, economic conditions, government regulations and laws (including interpretation thereof), competitive bidding and market conditions or other factors affecting such estimates or projections, Burns & McDonnell does not guarantee that actual rates, costs, performance, schedules, etc., will not vary from the estimates and projections prepared by Burns & McDonnell. To the fullest extent permitted by law, Burns & McDonnell shall have no liability whatsoever to any reader or any other third party, and any third party hereby waives and releases any rights and claims it may have at any time against Burns & McDonnell, Burns & McDonnell Engineering Company, Inc., and any Burns & McDonnell affiliated company, with regard to this material, including but not limited to the accuracy or completeness thereof.

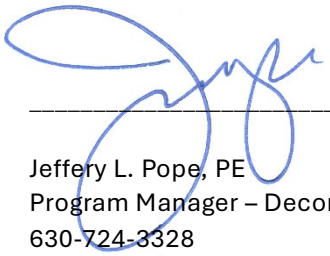
14. Estimates and projections prepared by Burns & McDonnell relating to schedules, performance, construction costs, recovery costs, and operating and maintenance costs are based on our experience, qualifications, and judgment as a professional consultant. Any entity in possession of, or that reads or otherwise utilizes information herein, is assumed to have executed or otherwise be responsible and obligated to comply with the contents of any Confidentiality Agreement and shall hold and protect its contents, information, forecasts, and opinions contained herein in confidence and not share with others without prior written authorization.

15. City of Alliance will indicate to the successful contractor that they will be required to indemnify Burns & McDonnell for their safety, means and methods. In addition, Burns & McDonnell will be included as an additional insured on the contractor insurance policies.

We look forward to continuing our support to City of Alliance for this project. If you have any questions, please contact me at (630) 724-3328 or jpope@burnsmcd.com

Sincerely,

Burns & McDonnell Engineering Co., Inc.



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Jeffery L. Pope, PE
Program Manager – Decommissioning/Demolition
630-724-3328
jpope@burnsmcd.com

Attachment A

Terms and Conditions

BURNS McDONNELL

TERMS AND CONDITIONS FOR PROFESSIONAL SERVICES

Project:	**Date of Letter, Proposal, or Agreement:**
Power Plant Abatement Bid Documents	**6/25/2025**
Client:	**Client Signature:**
City of Alliance, Nebraska	

1. SCOPE OF SERVICES

For the above-referenced Project, Burns & McDonnell Engineering Company, Inc. (BMcD) will perform the services set forth in the above-referenced Letter, Proposal, or Agreement in accordance with these Terms and Conditions. BMcD has relied upon the information provided by Client in the preparation of the Proposal and shall rely on the information provided by or through Client during the execution of this Project as complete and accurate without independent verification.

2. PAYMENTS TO BMCD

A. Compensation will be as stated in the above-referenced Letter, Proposal, or Agreement. Statements will be in BMcD's standard format and are payable upon receipt. Time is of the essence in payment of statements, and timely payment is a material part of the consideration of this Agreement. A late payment charge will be added to all amounts not paid within 30 days of statement date and shall be calculated at 1.5 percent per month from statement date. Client shall reimburse any costs incurred by BMcD in collecting any delinquent amount, including reasonable attorney's fees. If a portion of BMcD's statement is disputed, Client shall pay the undisputed portion by the due date. Client shall advise BMcD in writing of the basis for any disputed portion of any statement. BMcD shall have the right, in its sole discretion, to suspend services if any invoiced amount due and owing is not paid within 30 days of the statement date.

B. Taxes as may be imposed on professional consulting services by state or local authorities shall be in addition to the payment stated in the above-referenced Letter, Proposal, or Agreement.

3. INSURANCE

A. During the course of performance of its services, BMcD will maintain Worker's Compensation insurance with limits as required by statute, Employer's Liability insurance with limits of $1,000,000, Commercial General Liability with limits of $1,000,000 per occurrence and $2,000,000 general aggregate, and Automobile Liability insurance with combined single limit of $1,000,000 per accident.

B. If the Project involves on-site construction, construction contractors shall be required to provide (or Client may provide) Owner's Protective Liability Insurance naming Client as a Named Insured and BMcD as an Additional Insured or to endorse Client and BMcD using ISO forms CG 20 10 0704 & CG 20 37 0704 endorsements or their equivalents as Additional Insureds on all construction contractor's liability insurance policies covering claims for personal injuries and property damage in at least the amounts required of BMcD in 3A above. Construction contractors shall be required to provide certificates evidencing such insurance to Client and BMcD. Contractor's compensation shall include the cost of such insurance including coverage for contractual and indemnification obligations herein.

C. Client and BMcD release each other and waive all rights of subrogation against each other and their officers, directors, agents, or employees for damage covered by property insurance and self- insurance during and after the completion of BMcD's services. A provision similar to this shall be incorporated into all construction contracts entered into by Client, and all construction contractors shall be required to provide additional insured coverage and waivers of subrogation in favor of Client and BMcD for damage covered by any construction contractor's policies of insurance.

4. INDEMNIFICATION

A. To the extent allowed by law, Client will require all construction contractors to indemnify, defend, and hold harmless Client and BMcD from any and all loss where loss is caused or alleged to be caused in whole or in part by the construction contractors, their employees, agents, subcontractors or suppliers.

B. If this Project involves construction and BMcD does not provide consulting services during construction including, but not limited to, on-site monitoring, site visits, site observation, shop drawing review, and/or design clarifications, Client agrees to indemnify and hold harmless BMcD from any liability arising from this Project or Agreement, except to the extent caused by BMcD's negligence.

5. PROFESSIONAL RESPONSIBILITY– LIMITATION OF REMEDIES

A. BMcD will exercise reasonable skill, care, and diligence in the performance of its services and will carry out its responsibilities in accordance with customarily accepted professional practices. If BMcD fails to meet the foregoing standard, BMcD will perform at its own cost, the professional services necessary to correct errors and omissions reported to BMcD in writing within one year from the completion of BMcD's services for the Project. No warranty, express or implied, is included in this Agreement or regarding any drawing, specification, or other work product or instrument of service.

B. In no event will BMcD be liable for any special, indirect, or consequential damages including, without limitation, damages or losses in the nature of increased Project costs, loss of revenue or profit, lost production, claims by customers of Client, and/or governmental fines or penalties.

C. BMcD's aggregate liability for all damages connected with its services for the Project not excluded by the preceding subparagraph, whether or not covered by BMcD's insurance, will not exceed $100,000.

D. These mutually negotiated obligations and remedies stated in this Paragraph 5, Professional Responsibility – Limitation of Remedies, are the sole and exclusive obligations of BMcD and remedies of Client, whether liability of BMcD is based on contract, warranty, strict liability, tort (including negligence), indemnity, or otherwise.

6. PERIOD OF SERVICE AND SCHEDULE

The provisions of this Agreement have been agreed to in anticipation of the orderly and continuous progress of the Project through completion of the services stated in the Proposal. BMcD's obligation to render services hereunder will extend for a period that may reasonably be required for the completion of said services. BMcD shall make reasonable efforts to comply with deliverable schedules (if any) and consistent with BMcD's professional responsibility.

7. COMPUTER PROGRAMS OR MODELS

Any use, development, modification, or integration by BMcD of computer models or programs does not constitute ownership or a license to Client to use or modify such computer models or programs.

8. ELECTRONIC MEDIA AND DATA TRANSMISSIONS

A. Any electronic media (computer disks, tapes, etc.) or data transmissions furnished (including Project Web Sites or CAD file transmissions) are for Client information and convenience only. Such media or transmissions are not to be considered part of BMcD's instruments of service. BMcD, at its option, may remove all indicia of its ownership and involvement from each electronic display.

B. BMcD shall not be liable for loss or damage directly or indirectly, arising out of Client's use of electronic media or data transmissions.

9. DOCUMENTS

A. All documents prepared by BMcD pursuant to this Agreement are instruments of service in respect of the Project specified herein. They are not intended or represented to be suitable for reuse by Client or others in extensions of the Project beyond that now contemplated or on any other Project. Any reuse, extension, or completion by Client or others without written verification, adaptation, and permission by BMcD for the specific purpose intended will be at Client's sole risk and without liability or legal exposure to BMcD.

B. In the event that BMcD is to reuse, copy or adapt all or portions of reports, plans, or specifications prepared by others, Client represents that Client either possesses or will obtain permission and necessary rights in copyright, patents, or other proprietary rights and will be responsible for any infringement claims by others. Client warrants the completeness, accuracy, and efficacy of the information, data, and design provided by or through Client (including prepared for Client by others), for which BMcD shall rely on to perform and complete its services.

10. ESTIMATES, SCHEDULES, FORECASTS, AND PROJECTIONS

A. Estimates, schedules, forecasts, and projections prepared by BMcD relating to loads, interest rates and other financial analysis parameters, construction costs and schedules, operation and maintenance costs, equipment characteristics and performance, and operating results are opinions based on BMcD's experience, qualifications, and judgment as a professional. Since BMcD has no control over weather, cost and availability of labor, cost and availability of material and equipment, cost of fuel or other utilities, labor productivity, construction contractor's procedures and methods, unavoidable delays, construction contractor's methods of determining prices, economic conditions, government regulations and laws (including the interpretation thereof), competitive bidding or market conditions, and other factors affecting such estimates or projections, BMcD does not guarantee that actual rates, costs, quantities, performance, schedules, etc., will not vary significantly from estimates and projections prepared by BMcD.

11. POLLUTION

In view of the uncertainty involved in investigating and recommending solutions to environmental problems and the abnormal degree of risk of claims imposed upon BMcD in performing such services, notwithstanding the responsibility of BMcD set forth in Paragraph 5A to the maximum extent allowed by law, Client agrees to release, defend, indemnify and hold harmless BMcD and its officers, directors, employees, agents, consultants and subcontractors from all liability, claims, demands, damages, losses, and expenses including, but not limited to, claims of Client and other persons and organizations, reasonable fees and expenses of attorneys and consultants, and court costs, except where there has been a final adjudication that the damages were caused by BMcD's willful disregard of its obligations under this Agreement. Such indemnification includes claims arising out of, or in any way relating to, the actual, alleged, or threatened dispersal, escape, or release of, or failure to detect or contain, chemicals, wastes, liquids, gases, or any other material, irritant, contaminant, or pollutant.

Hazardous Substances: Any substances, chemicals, pollutants, explosive ordinances, or other materials, in whatever form or state, including, without limitation, product, waste, contaminant, smoke, vapors, soot, fumes, acids, alkalis, minerals, liquids, gases, or any other material, irritant, contaminant, or pollutant, that is known or suspected to adversely affect the health and safety of humans or of animal or plant organisms, or which are known or suspected to impair the environment in any way whatsoever including, without limitation, those substances defined, designated, or listed in the Clean Water Act (33 U.S.C. §1251 et seq.), Clean Air Act (42 U.S.C. §7401 et seq.), Emergency Planning & Community Right-to-Know Act (42 U.S.C. §11001 et seq.), Resource Conservation and Recovery Act ("RCRA") (42 U.S.C. §6901 et seq.), Toxic Substances Control Act (15 U.S.C. §2601 et seq.), Comprehensive Environmental Response, Compensation and Liability Act ("CERCLA") (42 U.S.C. §9601 et seq.), or as defined, designated, or listed under any other federal, state, or local law, regulation, or ordinance concerning hazardous substances, toxic or dangerous substances, chemicals, wastes, pollutants, contaminants, or explosive ordinances.

Client and BMcD acknowledge and understand that Client shall retain ownership of and title to any Hazardous Substances originating at, found on, brought to, removed from, or generated from the project site or operations on the premises. The parties agree that such Hazardous Substances, including substances designated as waste, were not caused by and are not the responsibility of BMcD; and that this Agreement, or any documents associated with this Agreement, do not attempt to nor do they actually transfer responsibility, liability, or ownership for Hazardous Substances to BMcD. Under no circumstances shall BMcD assume ownership of or legal liability for such Hazardous Substances under any law, rule, order, or regulation pertaining to Hazardous Substances, or assume the status of generator, transporter, storer, treater, or disposal facility, or arranger of transport, storage, or disposal, for Hazardous Substances. Client further acknowledges and agrees that the evaluation, management, and other decisions, conclusions, recommendations, or other actions involving Hazardous Substances that may be undertaken as part of BMcD's services, entail uncertainty and risk of injury or damage to property, including that to third-parties, which cannot be always avoided even with compliance of generally accepted Standard Industry Practice.

12. ON-SITE SERVICES

A. Project site visits by BMcD during investigation, observation, construction or equipment installation, or the furnishing of Project representatives shall not make BMcD responsible for construction means, methods, techniques, sequences, or procedures; for construction safety precautions or programs; or for any construction contractor(s') failure to perform its work in accordance with the contract documents.

B. Client shall disclose to BMcD the location and types of any known or suspected toxic, hazardous, or chemical materials or wastes existing on or near the premises upon which work is to be performed by BMcD's employees or subcontractors. If any hazardous wastes not identified by Client are discovered after a Project is undertaken, Client and BMcD agree that the scope of services, schedule, and compensation may be adjusted accordingly. Client agrees to release BMcD from all damages related to any pre-existing pollutant, contaminant, toxic, or hazardous substance at the site.

13. CHANGES

Client shall have the right to make changes within the general scope of BMcD's services, with an appropriate change in compensation and schedule, upon execution of a mutually acceptable amendment or change order signed by authorized representatives of Client and BMcD.

14. TERMINATION

Services may be terminated by Client or BMcD by seven (7) days' written notice in the event of substantial failure to perform in accordance with the terms hereof by the other party through no fault of the terminating party. If so terminated, Client shall pay BMcD all amounts due BMcD for all services properly rendered and expenses incurred to the date of receipt of notice of termination, plus reasonable costs incurred by BMcD in terminating the services. In addition, Client may terminate the services for Client's convenience upon payment of twenty percent of the yet unearned and unpaid estimated, lump sum, or not-to-exceed fee, as applicable.

15. DISPUTES, NEGOTIATIONS, MEDIATION

A. If a dispute arises relating to the performance of the services to be provided and, should that dispute result in litigation, it is agreed that the substantially prevailing party (as determined in equity by the court) shall be entitled to recover all reasonable costs of litigation, including staff time, court costs, attorney's fees and other related expenses.

B. The parties shall participate in good faith negotiations to resolve any and all disputes. Should negotiations fail, the parties agree to submit to and participate in a third party-facilitated mediation as a condition precedent to resolution by litigation. Unless otherwise agreed to, mediation shall be conducted under the rules of the American Arbitration Association and shall be held in Kansas City, Missouri.

C. The parties agree that any dispute between them, including any action against an officer, director or employee of a party, arising out of or related to this Agreement, whether in contract or tort, not resolved through direct negotiation and mediation, shall be resolved by litigation in the state or federal courts located in Jackson County, Missouri, and each party expressly consents to jurisdiction therein. Any litigation to compel or enforce, or otherwise affect the mediation shall be in state or federal courts located in Jackson County, Missouri, and each party expressly

consents to jurisdiction therein.

D. Causes of action between the parties shall accrue, and applicable statutes of limitation shall commence to run the date BMcD's services are substantially complete.

16. WITNESS FEES

A. BMcD's employees shall not be retained as expert witnesses, except by separate written agreement.

B. Client agrees to pay BMcD pursuant to BMcD's then current schedule of hourly labor billing rates for time spent by any employee of BMcD responding to any subpoena by any party in any dispute as an occurrence witness or to assemble and produce documents resulting from BMcD's services under this Agreement.

17. CONTROLLING LAW

This Agreement shall be subject to, interpreted and enforced according to the laws of the State of Missouri without regard to any conflicts of law provisions.

18. RIGHTS AND BENEFITS – NO ASSIGNMENT

BMcD's services will be performed solely for the benefit of Client and not for the benefit of any other persons or entities. Neither Client nor BMcD shall assign or transfer interest in this Agreement without the written consent of the other.

19. ENTIRE CONTRACT

These Terms and Conditions and the above-referenced Letter, Proposal, or Agreement contain the entire agreement between BMcD and Client relative to BMcD's services for the Project herein. All previous or contemporaneous agreements, representations, promises, and conditions relating to BMcD's services for the Project are superseded. Since terms contained in purchase orders do not generally apply to professional services, in the event Client issues to BMcD a purchase order, no preprinted terms thereon shall become part of this Agreement. Said purchase order documents, whether or not signed by BMcD, shall be considered only as an internal document of Client to facilitate administrative requirements of Client's operations.

20. SEVERABILITY

Any unenforceable provision herein shall be amended to the extent necessary to make it enforceable; if not possible, it shall be deleted and all other provisions shall remain in full force and affect.

21. REPORTING

A. BMcD will provide Client with a written report ("Report") if required as part of the scope of services. The Report will present such findings and conclusions respecting the Site as BMcD may reasonably make with the information gathered in accordance with this Agreement. The Report shall be based only upon BMcD 's observations made in the performance of the scope of services agreed upon in writing.

B. In preparing the Report, BMcD may review and interpret certain information provided by subconsultants and others, including government authorities, title companies, testing laboratories and other entities. BMcD will not independently evaluate the accuracy or completeness of such information, and shall not be responsible for any errors or omissions contained in such information.

C. BMcD 's Report is intended for the exclusive use of Client. There may be no further distribution of the Report, in whole or in part, or summaries or abstracts thereof, without the written consent of an officer of the BMcD. Any reuse, transmittal, or use of without written verification, approval, or adaptation by BMcD for the specific purpose intended is prohibited and will be at Client's sole risk and without liability or legal exposure to BMcD or to BMcD's subcontractors, and Client shall waive, release, and otherwise defend, indemnify, and hold harmless BMcD and BMcD's subcontractors from and against all claims, damages, losses, and expenses, including attorneys' fees arising out of or resulting therefrom, to the fullest extent permissible by law. Any such verification or adaptation will entitle BMcD to further compensation at rates to be agreed upon by Client and BMcD.

22. SITE INFORMATION

In addition to providing the information relating to the site listed in the Proposal, Client shall provide the following:

A. The location of utilities, underground tanks, and other structures and the routing thereof at the site;

B. A description of activities conducted at the site at any time by the Client or by any other person or entity; and

C. Identification, by name, quantity, location, and date, of any storage, release or handling of any substance Client either knows or suspects is hazardous.

23. CONTROL OF SITE

By providing services under this Agreement, BMcD does not assume control of or responsibility for the site or become the person in charge of the site or undertake responsibility for reporting to any federal, state or local public agency respecting conditions at the site that may present a potential danger to public health, safety or the environment. Further, nothing contained within this Agreement or the services to be rendered thereunder shall be construed or interpreted as requiring BMcD to assume the status of a generator, storer, transporter, treater, operator or disposal facility as those terms may appear within federal, state or local laws, statutes, ordinances, or regulations concerning the generation, transportation, treatment, storage and disposal of waste. Client assumes full responsibility for compliance with all federal, state or local laws, statutes, ordinances and regulations governing the handling, treatment, storage and disposal of such waste.

24. SITE ACCESS

Client shall obtain for BMcD access to the site and all buildings thereon at reasonable times throughout performance of this Agreement. BMcD will take reasonable precautions to minimize damage to the site from use of equipment, but unavoidable damage or alteration may occur.
Client agrees to assume responsibility for such unavoidable damage or alteration.

25. CERTIFICATION

Certification by BMcD of test results or reports constitute a statement of the professional judgment of BMcD based on the facts and data known to BMcD. Certification or other "assurances" are not guarantees or warranties concerning current or future considerations or performance of the facilities surveyed, or that Client or others will be entitled to any innocent landowner or purchaser defenses which may be available under applicable environmental laws including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended.

26. LABOR SOURCES

BMcD may engage temporary staffing agencies or obtain assistance from its affiliates and subsidiaries including, without limitation, Burns & McDonnell Canada Ltd., Burns & McDonnell Global, Inc., Burns & McDonnell Europe (UK) Limited, and Burns & McDonnell India Pvt. Ltd. ("Labor Sources") to fulfill BMcD's performance obligations under this Agreement. The parties agree that contracts, purchase orders, or similar agreements between BMcD and any Labor Sources are not subcontracts as that term is used in this Agreement, and personnel from such Labor Sources shall not be considered a subcontractor and shall be billed according to the applicable rate sheet for the scope of work as if such personnel is a direct hire employee. Personnel from Labor Sources shall be considered agents of BMcD and able to act on behalf of BMcD within the scope of the authority granted to such personnel according to job function and billing classification. BMcD remains fully responsible for the work and services performed by all Labor Sources.

- END -

RESOLUTION NO. 25-75

WHEREAS, The City of Alliance is in need of an Interim City Clerk to serve until a new City Clerk is hired and available to work; and

WHEREAS, The City Council appointed Ammie Bedient to serve in the Interim City Clerk capacity at its meeting of June 17, 2025; and

WHEREAS, It has been customary to pay employees for work conducted outside of normal classification, as is the case with Ammie Bedient, who is currently classified as a Secretary.

NOW, THEREFORE, BE IT RESOLVED by the Mayor and Council of the City of Alliance, Nebraska, that Ammie Bedient shall receive payment in the amount of $_____ per month to serve as Interim City Clerk.

BE IT FURTHER RESOLVED that City Staff is authorized to make all changes necessary for out of classification pay retroactive to June 17, 2025 and payable until such time that a new City Clerk is hired and available to work.

PASSED AND APPROVED this 1st day of July 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

_____
Simmons Olsen Law Office, Legal Counsel

RESOLUTION NO. 25-76

WHEREAS, Nebraska law expressly allows municipalities to invest surplus or excess funds; and

WHEREAS, The Interlocal Cooperative Act, Neb. Rev. Stat. §13-801 et. seq. provides that two or more governmental units may jointly cooperate in the exercise or in the performance of their respective governmental functions, powers or responsibilities, may enter into joint agreements as may be deemed appropriate for such purposes when such agreements have been adopted by appropriate action by the governing bodies of the participating governmental units; and

WHEREAS, The Declaration of Trust (Interlocal Agreement) and the Information Statement relating to the Nebraska Public Agency Investment Trust have been presented to the City Council of the City of Alliance, Nebraska; and

WHEREAS, The Declaration of Trust authorizes governmental units to adopt and enter into the Declaration of Trust and become participants of such trust; and

WHEREAS, The City Council of the City of Alliance, Nebraska, deems it advisable to adopt and enter into the Declaration of Trust and become a participant of the Nebraska Public Agency Investment Trust for the purpose of the joint investment of the City of Alliance's money with those other governmental units so as to enhance the investment earnings accruing to each such governmental unit.

NOW, THEREFORE, BE IT RESOLVED by the Mayor and City Council of the City of Alliance, Nebraska:

1. The City of Alliance shall and does hereby join with other Nebraska governmental units in accordance with the provisions of Nebraska law and in accordance with the Interlocal Cooperative Act, as applicable, by becoming a participant of the Nebraska Public Agency Investment Trust, and the Declaration of Trust and Interlocal Agreement is hereby adopted by this reference with the same effect as if it had been set out verbatim in this resolution. A copy of the Declaration of Trust is attached hereto and incorporated herein by this reference and shall be filed with the minutes of the meeting at which this resolution was adopted.

2. The City of Alliance hereby delegates all authority and duties which the law otherwise authorizes it to delegate in accordance with the Declaration of Trust. The following officers of the city and their respective successors in office each are hereby designated as "Authorized Officials" and are authorized to take action and execute any and all such documents as they deem necessary and appropriate to effectuate the entry by the City of Alliance into the Declaration of Trust and to effectuate the investment and withdrawal of monies of the City of Alliance from time to time in accordance with the Declaration of Trust.

John McGhehey, Mayor
Ammie L. Bedient, Interim City Clerk

Cindy Baker, City Treasurer

3. An Authorized Official of the City of Alliance shall advise the Nebraska Public Agency Investment Trust of any changes in the authorized signors in accordance with the procedures established by the trust.

4. The Trustees of the Nebraska Public Agency Investment Trust are hereby designated as having official custody of the City of Alliance's monies which are invested in accordance with the Declaration of Trust.

5. Authorization is hereby given for members of the City Council and officials of the City of Alliance to serve as Trustees of the Nebraska Public Agency Investment Trust from time to time if elected as such pursuant to the Declaration of Trust.

6. All resolutions and parts of resolutions so far as they conflict with the provisions of this resolution being the same are hereby rescinded.

PASSED AND APPROVED this 1st day of July 2025.

_____
John McGhehey, Mayor

(SEAL)

Attest: _____
Ammie L. Bedient, Interim City Clerk

Approved as to Form and Legality:

_____
Simmons Olsen Law Office, Legal Counsel

AUTHORIZED PERSONNEL INFORMATION

Participant/Entity Name: _____

Select one of the following:

☐ Activate New Authorized Individual for **Full** Rights (Complete Sections A, B, C and E)

☐ Activate New Authorized Individual for **Limited** Rights (Complete Sections A, B, D and E)

☐ De-Activate Existing Authorized Individual _____ (Insert Name and Complete Section E below.)

SECTION A: NPAIT PARTICIPANT INFORMATION

1. Select one of the following:

☐ I am an existing NPAIT Participant. My account number is: _____

☐ This is a new NPAIT relationship. I am establishing authorized personnel for the first time.

SECTION B: AUTHORIZED PERSONNEL INFORMATION

2. Please designate the NPAIT Authorized Individual for your Entity:

Name: _____ Phone: _____

Fax: _____ Email: _____

Title: _____ Address: _____

SECTION C: ACCOUNT SECURITY / AUTHORITY - FULL RIGHTS

Please complete Section C for Full Rights OR Section D for Limited Rights

3. The above-named authorized person will have the authority to:

- Certify the Authorized Personnel at the Entity, and Specify the PMA GPS® Access Capabilities;
- Add, Change, Delete the Bank Information (ACH/Wire) NPAIT has on File for the Entity;
- Sign up for State Aid Deposits;
- Open, Close, Change and Reactivate NPAIT Account Information; and
- Move money (make purchases, redemptions, transfers and fixed rate investments.)

4. Account Authority:

☐ This authorization applies to all NPAIT sub-accounts for my entity.

☐ This authorization only applies to the following accounts:

_____

5. System Access:

☐ Yes, access to PMA GPS® [1] is necessary; a username and password will be sent via email.

☐ No, access to PMA GPS® is not necessary at this time.

[1]The PMA Governmental Portfolio System ("PMA GPS®") is an online system that provides 24 hour access to your NPAIT account(s).

6. Email Notification:

☐ Yes, send an email when online statements and confirmations are available. To receive these emails, access to PMA GPS® must have been selected in the section above.

☐ No, do not send an email when online statements and confirmations are available.

SECTION D: ACCOUNT SECURITY / AUTHORITY - LIMITED RIGHTS (TRANSACTION OR VIEW ONLY)

7. Security:

☐ Yes, the authorized person is authorized to move money (make purchases, redemptions and transfers.)

☐ No, the authorized person is not authorized to move money; VIEW ONLY access is requested.

8. Account Authority:

☐ This authorization applies to all NPAIT sub-accounts for my entity.

☐ This authorization only applies to the following accounts:

_____

9. System Access:

☐ Yes, access to PMA GPS® is necessary; a username and password will be sent via email.

☐ No, access to PMA GPS® is not necessary at this time.

10. Email Notification:

☐ Yes, send an email when online statements and confirmations are available. To receive these emails, access to PMA GPS® must have been selected in the section above.

☐ No, do not send an email when online statements and confirmations are available.

SECTION E: AUTHORIZATION

This section must be signed by either an authorized person as designated in the Master Account Application (or a Primary Contact or Authorized Personnel Information form), OR the new incumbent in an authorized position, accompanied by a copy of the board minutes covering the appointment/election of a new incumbent. (Please mark the appropriate section and black out salary and other confidential information.) The authorizations set forth on this form shall remain in full force and effect until the Fund receives written notification of a change.

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Title: _____ Email: _____

Send completed forms to your PMA representative or to Client-Service@npait.com

BANK ACCOUNT INFORMATION
ACH INSTRUCTIONS (ADD/CHANGE/DELETE)

The Entity authorizes the Fund to initiate Automated Clearing House (ACH) debits/credits to the bank account indicated below. The Entity acknowledges that the origination of the ACH transactions must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until the Fund receives written notification from the Entity of its termination at least 10 business days prior to the next scheduled payment. **The Fund, the Administrator and PMA are not responsible for ACH transaction failure caused by inaccurate or incomplete information, or for any losses, damages, liabilities, costs or expenses arising out of these Instructions if properly followed.**

Section A: Fund Account Information

Client Name: _____

Fund Account Master: _____

☐ All Sub-Accounts: _____

☐ Limited to Sub-Account(s): _____

Section B: Bank Account Information (ACH Instructions)

☐ Add ☐ Change Existing Wire ID #s _____ ☐ Delete Existing Wire ID #s _____

☐ Checking ☐ Savings

Institution Name: _____

ABA Routing Number (9 digits): _____

Beneficiary Account Number: _____

Beneficiary Account Name (22 characters max): _____

For further credit information (35 characters max): _____

Section C: Authorization

This section must be signed by an authorized person as designated in the Master Account Application or the Primary Contact, or the Authorized Personnel Information forms.

Signature*: _____ Date: _____

Printed Name: _____ Phone: _____

Title: _____ Email: _____

**By signing this form, you hereby acknowledge that the appropriate due diligence has been performed to verify the validity of these instructions.*

Send completed forms to your PMA representative or to gps@pmanetwork.com

From: R.B. Hielscher <ray@nmscom.com>
Sent: Wednesday, May 21, 2025 9:18 AM
To: Katherine Conrad <kconrad@cityofalliance.net>
Subject: Planning Commission Resignation

Hi Katherine,

This letter is to notify you that I am resigning my position with the Alliance Planning Commission, effective today. The past years have been an amazing experience and working as a member of the commission has been very rewarding to say the least. Unfortunately, some health issues within my family will be taking up much of my time for a while and I would not be able to provide the dedication and focus necessary to satisfactorily serve the needs of city of Alliance.

Thank you!

Raymond B Hielscher

CP: 308-760-3367