STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** 6-2-16

Staff Contact: Melanie Bruketta, HR Director

Agenda Title: For Possible Action: Discussion and possible action to approve the employee/retiree health and dental insurance contracts with Prominence Health Plan. (Melanie Bruketta)

Staff Summary: This action is to approve the health insurance contract and the dental insurance contract with Prominence Health Plan for active and retired employees. The HMO/POS health plans have a 0% rate increase for active employees and dependents. The PPO out-of-state retiree plan has a 12.7% increase. There are only three retirees on this plan. The retirees, not the City, are responsible for paying the increase. The dental plan will increase by 1.8%.

Agenda Action: Formal Action/Motion **Time Requested:** 15 minutes

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Proposed Motion
I move to approve the employee/retiree health and dental insurance contracts with Prominence Health Plan.

Board's Strategic Goal
Organizational Culture

Previous Action
The Board approved the health and dental plans last year at the May 21, 2015 meeting.

Background/Issues & Analysis
The current medical trend is approximatley 5% and the prescription drug trend is approximately 11-12%. The City's combined medical and prescription loss ratio under the pricing agreement this year is 76.4%. In accordance with the pricing agreement, Prominence demanded a 4% rate increase in medical/prescription. Staff was able to negotiate a 0% rate increase for medical/prescription on the HMO and POS plan.

There is a 12.7% increase on the PPO out-of-state retiree health plan. The City has three retirees enrolled in this plan. The 12.7% increase is paid by the retiree, not the City.

The dental trend is approximately 3.5% this year. The City's dental loss ratio for this year was 89.3%. Staff negotiated a rate pass last year. This year, staff was able to negotiate a 1.8% increase.

Applicable Statute, Code, Policy, Rule or Regulation
Prominence Health/Dental contract

Financial Information
Is there a fiscal impact? ☒ Yes ☐ No

If yes, account name/number: 570-0706-415.63-02/ Dental expected increase of $9,000.00. Total budgeted for FY 2017 $496,662.00.

Is it currently budgeted? ☒ Yes ☐ No

Explanation of Fiscal Impact: Finance budgeted a 5% increase in medical/dental this year. The HMO/POS plan will not increase. There is a 1.8% increase in dental. Although the out-of state retiree PPO increased by 12.7%, the retiree is responsible for paying the cost. This is the last year of the pricing agreement, the City will need to hire a broker to issue an RFP for medical, dental, vision and life renewals for July 1, 2017.

Alternatives

The Board may reject the proposed contract with Prominence Health Plan.

Board Action Taken:

Motion: _____ 1) _____ Aye/Nay

2) _____ _____

_____

_____

_____

_____

(Vote Recorded By)

Prominence
Health Plan

City of Carson

July 2016

Renewal Contract

Prominence℠
Health Plan

PROMINENCE HEALTH PLAN
(Prominence HealthFirst and Affiliated Company Prominence Preferred Health Insurance Company, Inc.)
GROUP CONTRACT

This Group Contract is executed by and between Prominence Health Plan, representing Prominence HealthFirst and its affiliated company Prominence Preferred Health Insurance Company, (hereinafter referred to as "Health Plans" or "Prominence Health Plan"), and Company (hereinafter referred to as "Group").

WHEREAS, Health Plans is organized and operating pursuant to the Nevada Revised Statutes, and;

WHEREAS, Group wishes to provide eligible employees with the opportunity to enroll in and receive health care services;

NOW THEREFORE, the parties hereto have set their hand and mutually agree as follows:

I. Definitions

A. **Anniversary Date** means the date, every twelve (12) months upon which the coverage under Evidence of Coverage or Certificate of Coverage (hereinafter referred to as "Plan Document") renews for another twelve (12) month period.

B. **Health Benefit Plan** means the Health Plan's Plan Document and any and all Attachments and Riders selected by the Group, which is offered to eligible employees.

C. **Grace Period** means the time after the date that the premium is due during which the premium can be paid without penalty to keep the policy in force.

D. **Group** means an employer or other party who has executed a Group Contract with Health Plans, through which health benefits are made available to eligible employees and the employer has agreed to collect and pay premiums.

E. **Group Contract** (hereinafter also referred to as "Contract") means this document between the Group and Health Plans and any attachments hereto, through which the health benefit plan for eligible employees and dependents is elected.

F. **Initial Group Open Enrollment Period** means the enrollment period established by the Group and Health Plans prior to the effective date during which eligible persons may enroll in the health plan. The initial enrollment period will be a period of no less than thirty (30) days in which all eligible persons must enroll or waive their right to coverage. Subsequent Open Enrollment Periods will be held every twelve (12) months from the initial effective date of the Group's coverage.

G. **Premium** means the periodic payment, usually monthly, made to Health Plans by the Group on behalf of eligible enrolled employees, which entitles those employees and dependents to the health benefit plan products detailed in Section III of this contract.

H. **Renewal Date: 12:01 AM on the first day of a renewed group contract.**

II. Introduction

This Group Contract, any amendments, attachments, including the Plan Document any applicable Riders, the application of the employer, the enrollment forms of individual employees and amendments to any of them incorporated by reference herein, shall constitute the entire agreement between Prominence Health Plan and the Group.

The Employer or any individual Member is not authorized to make any promises or representations or warranties concerning Health Plan's services, facilities or supplies provided under the Contract. Any statements by an Employer or the Employer's representative concerning the services provided by Health Plans or under the Plan Document shall not be binding on Health Plans. As such, no such statement shall be used in support of a benefit claim under this Contract unless it is approved in writing by Health Plans. Pursuant to this Contract, Health Plans shall provide covered services and supplies to Members in accord with the Plan Documents.

No agent or employee of Health Plans is authorized to change the form or content of this Contract. Any changes to this Contract can be made only through an endorsement authorized and signed by an officer of Health Plans.

III. Products

Please see the Schedule of Insurance Rates (Medical and/or Dental Addendum) for a list of Products from the Plan and the appropriate Plan Document.

IV. Term of Contract

This Contract becomes effective on the Effective Date, found in the Schedule of Insurance Addendum, at 12:00 a.m. Pacific Time and will remain in effect until the Termination Date unless terminated sooner in accordance with the Termination of Contract set forth in Section V below. Except as expressly provided in the Plan Document incorporated in this Contract, all rights to benefits under this Contract end at 11:59 p.m. on the Termination Date.

V. Termination of Contract

The employer may terminate this Contract by providing Health Plans with a written notice of its intent to terminate this contract at least thirty (30) days in advance of the agreed upon termination date. Health Plans may terminate or not renew this Contract for good cause as set forth below.

Health Plans will provide the Group with an acknowledgment in the Form of a Written Notice of Contract Termination ("Notice"). Promptly upon receipt of the Notice, Group will mail via First Class U.S. Mail to each Member a legible copy of the notice. Group agrees to provide Health Plans with written

proof of that mailing and of the date thereof. If the terms of this Contract are altered by consent of both parties, no resulting reduction in coverage will adversely affect a member who is confined to a hospital at the time of such change.

Termination on Written Advance Notice

Group may terminate this Contract:

1. for any reason, effective on the Termination Date by giving at least thirty (30) days prior written notice to Health Plans;

2. upon written notice within thirty (30) days of notice of an increase in the Total Monthly Premium; and

remitting all amounts payable relating to this Contract, including Premiums, for the period prior to the termination effective date.

Good Cause for termination or not renewing the Group Contract by Health Plans shall include:

1. **Non Payment of Premiums**

   Failure of Group to pay the premium for this Contract when due or within the thirty (30) day grace period. If a Premium is not paid by the end of the grace period, Health Plans may terminate the Group Contract retroactively to the end of the day preceding the grace period. Cancellation will not be effective until at least ten (10) days after Health Plans has delivered or mailed written notice of Group Contract Termination to the group.

2. **Material Breach of the Terms of the Health Benefit Plan Document or the Group Contract**

   For any material breach of the terms detailed in the **Health Benefit Plan Document or the Group Contract**, upon thirty (30) days prior written notice to Group.

3. **Fraud, Noncompliance or intentionally furnishing incorrect or incomplete information**

   Health Plans may terminate this Contract retroactively to the date coverage began if:

   A. Group commits fraud or an intentional misrepresentation of material fact in obtaining or maintaining Health Benefit Plan coverage; and

   B. Health Plan provides Group with thirty (30) days prior notice that coverage is being rescinded.

4. **Knowing Failure to Enforce Health Benefit Plan Rules**

Health Plans may terminate this Contract upon thirty (30) days prior written notice to Group if there is:

A. Knowing failure by the Group to abide by the terms of the Group Health Contract, Health Benefit Plan or to properly enforce the conditions of enrollment of Members as set forth in the "Eligibility and Enrollment" provisions of the Health Benefit Plan Document and the Employer Application.

5. **Failure to meet Participation and Contribution requirements**

Failure of the employer to maintain minimum subscription charge contribution requirements or minimum participatory requirements or as stated in the group requirements set forth in the Master Application (see Section VII, item L of this contract).

Group will allow Health Plans to review and audit payroll and other pertinent records for the verification of eligibility of employees as stated in contributions or group requirements. Health Plans will make written and verbal request to Group and conduct all such reviews during regular business hours.

Group agrees to contribute the same amount toward each class of Eligible Employees under the Group Contract. In no event will the Group make a contribution for any class of Eligible Employee less than fifty percent of the Single (employee only) premiums under the Health Benefit Plan.

6. **Discontinuance of a product or all products within a market**

Health Plans reserves the right to terminate a particular product or all products offered in a small or large group market, if it discontinues offering insurance in the geographic area of the state where the employer is located. Health Plans also reserves the right to discontinue the issuance and renewal of coverage to a small employer if the Nevada Insurance Commissioner ("Commissioner") finds that the continuation of coverage would not be in the best interest of the policyholders or certificate holders or would impair the ability of the carrier to meet its contractual obligations. If the Commissioner makes such a finding, the Commissioner shall assist the affected small employers in finding replacement coverage. Health Plans may also discontinue products offered to small employers if the Nevada Insurance Commissioner finds that the form of the product offered by Health Plans is obsolete and is being replaced with comparable coverage. Health Plans will notify the Commissioner and the Chief Regulatory Officer for insurance in each state in which it is licensed of its decision to discontinue the issuance or renewal of a product at least sixty (60) days before Health Plans notifies the affected small employers. Health Plans will notify affected employers at least one hundred eighty (180) days before the date on which it will discontinue offering the product and it will offer each affected small employer the option to purchase any other health benefit plan currently offered by it to small employers in Nevada. In exercising its option to discontinue the product and in offering the option to purchase other coverage, Health Plans will act uniformly without regard

to the claims experience of the affected small employers or any health status-related factor relating to any participant or beneficiary covered by the discontinued product or any new beneficiary who may become eligible for such coverage. Health Plans will comply with the requirements of NRS 689C.310-.320 and NRS 689B.560 if it decides to discontinue providing insurance in a geographic area or discontinue products to the small or large employer market.

7. **A Material change in the nature of the Employer's Business, i.e.,**

- Dropping under 2 employees
- Sale of business
- Change in contribution level
- Other significant changes in the composition or status of the employer's business.

VI. Amendment of Contract

This Contract may be amended by mutual agreement of the Group and Health Plans. All amendments shall be in writing and shall be attached to and become a part of the entire Contract.

Upon sixty (60) days prior written notice to Group, Health Plans may amend this Contract effective as of the next Anniversary Date. If Health Plans has not received all necessary government approval of its Premium rates by the date it gives notice under this section, Health Plans will notify Group of the Premium rates for which it has sought government approval. Health Plans may then amend this Contract with respect to Premium rates by giving notice to the Group after receiving all necessary government approval, in which case the Premium rates go into effect as of the next Anniversary Date.

In addition to amendments effective as of the Anniversary Date, Health Plans may, subject to government approval, amend this Contract at any time by giving notice to Group, in order to (a) comply with applicable law, or (b) expand Health Plan's service area.

All amendments are deemed accepted by the Group unless the Group gives Health Plans written notice of non-acceptance at least fifteen (15) days before the effective date of the amendment and remits all amounts payable related to this Contract, including Premiums, for the period prior to the amendment effective date. If the Group rejects the amendment, this Contract will automatically terminate as of the day before the effective date of the amendment.

VII. Eligibility and Enrollment of Members

A. Eligible Employees include:

1. a bona fide employee of the Group eligible to participate under the terms of the Health Benefit Plan arranged by the Group;

2. those who satisfy any probationary or Waiting Period requirements established by the Group or the Health Benefit Plan and who enroll within 31 days of their eligibility date.

B. Special Enrollments

Employees who decline coverage for themselves, or if eligible, their Spouse or their dependents, for any reason, and later decide that they want coverage will not be eligible until the next open enrollment period unless, the employee has (1) creditable health coverage within the meaning of 26 USC § 9801 and (2) has experienced a qualified life event allowing an election change.

Employees who request special enrollment must do so no later than thirty (30) days after the loss of the other creditable coverage. Special enrollment is effective on the first day of the calendar month beginning after the date the completed enrollment request is received by Health Plans.

C. Dependents include:

1. employee's lawful spouse or domestic partner (if elected by group and this contract is amended);

2. For Qualified Plans, be a Member's child who is not yet 26; or

   For Grandfathered Plans, be a Member's child who is not yet 26 and who is not otherwise covered by other employer provided health plan coverage;

3. Unmarried children over the age of 25, who are chiefly dependent upon the employee for support due to mental illness, developmental disability, mental retardation or physical handicap; with supporting documentation either from the Judicial system or medical professional.

4. The term child includes natural children, step-children, and children for whom You have been appointed by the court as permanent legal guardian, or children who have been legally adopted or are awaiting finalization of adoption by You.

D. For all HMO and POS products sold to the Group, all eligible employees must permanently reside or perform more than 50% of their employment duties within the State of Nevada.

E. All eligible employees must satisfy any probationary or Waiting Period requirements established by the Group. Once the eligible employee has satisfied the probationary or Waiting Period requirements, then that employee will be eligible to enroll for Health Benefit Plan coverage.

F. Group agrees to contribute the same dollar amount toward each class of Eligible Employees as that under the Group Contract. In no event will the Group make a premium contribution for any class of Eligible Employees that is less than 50% of the Single (employee only) premium under the Health Benefit Plan.

If Group elects on the master application to make a premium contribution of 100% of Single (employee only) premium under the Health Benefit Plan, then all employees must be enrolled OR present a valid waiver showing coverage through another Health Benefit Plan.

G. Any employee or dependent, if eligible, who becomes eligible after the Initial Enrollment Period, or between Group Enrollment Periods, must enroll within thirty-one (31) days of a qualifying event, or may not enroll until the next Group Enrollment Period is held.

H. Group will be credited with Premium payments, made for a non-eligible enrollee, only after Health Plans is notified in writing and only if the enrollee has not received covered services during the period in question. In no event will Health Plans credit premium overpayment for a non-eligible enrollee for a period of more than sixty (60) days. In the event that Group overpays Premiums on behalf of a non-eligible enrollee for a period of more than sixty (60) days, overpayments beyond the first sixty (60) days will be forfeited to Health Plans and will not be otherwise reimbursed or credited to the Group.

I. Group agrees to promptly distribute Health Plan's Health Benefit Plan documents, such as the Summary of Benefits of Coverage, as well as other pertinent information to Eligible Employees. Group agrees to notify each Eligible Employee that Health Plans' staff is available to answer any questions about the Health Benefit Plan and will promptly provide additional information about the Health Benefit Plan during the Initial Enrollment as well as all subsequent Group Enrollment Periods.

J. Group will allow Health Plans to review and audit payroll and other pertinent records for the verification of employees' eligibility. Health Plans agrees to notify Group in writing at least seven (7) calendar days before conducting an audit.

K. Age Banded Premium Rates are rates Health Plans has determined by the age of the Eligible Employee or eligible dependents, if eligible. Members move to the rate corresponding to the appropriate age rate upon renewal.

L. **For a group with 4 or more** eligible employees, seventy-five percent (75%) of all

eligible employees must enroll in the group health plan or demonstrate other creditable coverage. Those eligible employees waiving with creditable coverage will not be a factor in determining the group participation. **For groups with 3** or fewer eligible employees, one hundred percent (100%) of eligible employees must enroll or show creditable coverage.

VIII. Termination of Group Health Benefit Plan Coverage

Termination due to Nonpayment

Only a Member, and his or her enrolled dependents, if eligible, for which Health Plans has received timely payment of the Group's agreed upon Premiums are entitled to Health Benefit Plan coverage under this Contract. If Group fails to promptly remit any past-due payment for a Member within the thirty (30) day grace period, then Health Plans may terminate the Member in accord with the "Termination of Coverage" section of the Health Benefit Plan Document. In addition, the Group remains liable for all unpaid Premiums for the Member through the termination date.

The Group may be required to continue coverage for an employee or dependent, if eligible, who has lost eligibility within the Group. The specific option for continuation will be determined based on the individual employee or dependent, if eligible, at the time of the qualifying event as detailed in the Health Benefit Plan Document. The Eligible Employee and his or her dependents, if eligible, will be terminated from coverage under the Group Contract according to the Employee Termination Date Rule (as set forth in Addendum I).

Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage

Health Plans recognizes that most employers must comply with the continuation of group coverage requirements of federal laws and regulations, which collectively are commonly referred to as Consolidated Omnibus Budget Reconciliation Act (COBRA) (hereinafter referred to as "COBRA"). Health Plans acknowledges that employers who are so affected cannot discharge their legal obligations without Health Plan's informed and willing participation in providing the continuation coverage.

Health Plans is therefore committed to the following:

A. Maintaining awareness of continuation coverage requirements of the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and regulations, which are issued by the Secretaries of those agencies.

B. Providing continuation coverage to Members upon the request of an employer

when such requests are consistent with the employer's obligations under the law.

C. Sharing knowledge regarding COBRA with employers as they experience problems but Health Plans will not give legal advice on these matters.

Members who are hospitalized on the date coverage under this Contract ends, may be eligible for continuation of coverage. See "Continuation of Coverage" in the Plan Document.

Termination of this Contract, other than for Nonpayment of Premiums (see "Termination due to Nonpayment") or Fraud, shall become effective upon sixty (60) days written notice to the employer.

If this Contract terminates under its own terms, or is otherwise terminated by either Health Plans or Group, then the Group shall promptly mail or hand deliver to each Member covered hereunder, a notice of cancellation of this Contract. The employer shall, upon request by Health Plans, provide Health Plans a copy of notification sent to each Eligible Employee, a written statement that the notice of cancellation was sent by certified mail or hand delivered to each Member, and the date of said mailing or hand delivery.

IX. Premium Payment

A. Group agrees to remit to Health Plans the Total Monthly Premium on behalf of each Eligible Employee who has enrolled in the Health Benefit Plan, in accordance with the Class of Contract and Total Monthly Premium which is attached hereto as Schedule of Insurance Rates

(Addendum 1). Where applicable, any contribution required by an Eligible Employee will be collected by the Group. Only Members for which the Health Plans has received timely premium payments are entitled to services and supplies.

Total Monthly Premium rates are effective from the Effective Date to Termination Date.

B. The Total Monthly Premium is billed to Group prior to the first day of the month for which coverage is provided. Premium payments are due on the first day of the month for the month in which coverage is provided. Health Plans shall calculate the charges from current records as to the number of Members enrolled. Premiums are payable for new Members for the entire month regardless of the effective date of enrollment or termination.

C. Premium adjustments required as a result of terminations or new hires will be applied by Health Plans to the Premium Billing subsequent to its receipt of the necessary forms. Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Members not reflected in Health Plan's records at the time of calculation of Premium charges.

In order for a credit of Premium charges to be applied for terminated members, Health Plans must receive notification as soon as possible following the date of the Member's ineligibility, but in no event later than sixty (60) days following such date. Health Plans will credit a maximum of sixty (60) days of Premium charges to the employer for ineligible Members.

It is the sole responsibility of the Group to review the Total Monthly Premium each month, ensure it accurately reflects any and all Member terminations, and bring any discrepancies to the attention of Health Plans within sixty (60) days of the Member's ineligibility.

Only Members for whom payment is received by Health Plans shall be eligible for services and benefits hereunder and only for the period covered by such payment. If any Member covered hereunder is terminated by Health Plans, prepaid Premiums received on account of the terminated Member or Members applicable to periods after the effective date of the termination will be credited back to the employer on the next following billing statement. The Group agrees that neither Health Plans nor any physician group has any liability or responsibility under this Contract to any such terminated Member.

In the foregoing instances where a Member is being retroactively terminated by the group, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Member under this Contract. In such instances the date of termination will be the first day of the calendar month following the month in which services or supplies were provided, and any applicable credit of premium charges will be calculated from that date.

If the employer seeks to retroactively add Members, enrollment forms must be received by Health Plans as soon as possible following the Member's eligibility date, but in no event later than thirty one (31) days following such date. Health Plans will charge the employer retroactive premiums according to the Member's effective date, which will be calculated using rules

established by Health Plans for determining effective dates of retroactive adjustments, but in no event will the effective date be more than thirty one (31) days prior to when Health Plans receives the enrollment forms.

D. Group shall submit to Health Plans all enrollment, termination and/or change of status forms within thirty one (31) days of each event, but in no case shall credits to remittances be for a premium period (month) of more than sixty (60) days from the date of the event.

E. In situations that include, but are not limited to those found in Section V, item 6, Health Plans reserves the right to change the Total Monthly Premium for the health benefits plan and/or Riders upon sixty (60) days written notice, provided such changes are in accordance with the provisions set forth in the Evidence of Coverage.

X. General Provisions

A. **Acceptance of Contract**

Group acknowledges acceptance of this Contract by signing the signature page and Addendum 1 of this Contract and returning it to Health Plans. If Group does not return the signature page to Health Plans, Group will be deemed as having accepted this Contract if Group pays any amount pursuant to the "Premiums" section.

B. **Charter not part of Contract**

None of the terms or provisions of Health Plan's charter, constitution or bylaws shall form a part of this Contract or be used in the defense of any suit hereunder, unless the same is set forth in full in this Contract.

C. **Interpretation of Contract**

The laws of the State of Nevada shall be applied to interpretation of this Contract. Where applicable, the interpretation of this Contract shall be guided by the direct-service, group practice nature of Health Plan's operations as opposed to a fee-for-service indemnity basis.

D. **Renewals of this Contract**

Group acknowledges this Contract can be renewed for additional one year terms after the expiration of the Initial Term, by the execution of a revised Schedule of Insurance Rates. All of the terms and conditions of this Group Contract, not otherwise changed in the revised Schedule of Insurance Rates, shall remain in full force and effect for one calendar year after the date the revised Schedule of Insurance Rates is executed.

E. **Adoption of Policies**

Health Plans may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Group Contract and the Health Benefit Plan.

F. **Group Agent or Broker**

Health Plans recognizes that Group may work with an Agent/Broker of Record who arranges a variety of insurance programs for the Group. Health Plans will work cooperatively with the Group's Agent/Broker of Record. The Agent/Broker of Record must hold the appropriate State of Nevada health insurance license, and cooperate with Health Plans. The Group agrees to notify Health Plans in writing of any changes in its Broker of Record.

G. **Contract Providers**

Health Plans will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform, of any health care provider that contracts with Health Plans if Group may be materially and adversely affected thereby.

H. **Delegation of Claims review authority**

Health Plans is a named fiduciary to review claims under this Contract. Group delegates to Health Plans the discretion to construe and interpret the terms of the Plan Document and other disclosure statements as well to determine whether a Member is eligible for benefits. In making these determinations, Health Plans has authority to review claims in accordance with the procedures contained in the Plan Document and herein, and to construe this Contract to determine whether the Member is entitled to benefits.

I. **Member Information**

Group will inform enrollees of eligibility requirements for Members and when coverage becomes effective and terminates.

If Health Plans gives Group any information that is material to Members, Group will disseminate that information to Members by the next regular communication to them, but in no event later than thirty (30) days after Group receives the information. For purposes of this paragraph, "material" means information that a reasonable person would consider important in determining action to be taken.

J. **No Waiver**

Health Plan's failure to enforce any provision of this Contract will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

K. **Notices**

Notices from Health Plans to Group or from Group to Health Plans must be mailed to the address indicated on the signature page of this Contract except that Health Plans and Group may change its notice address by giving written notice to the other. Notices are deemed given when deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

L. **Right to Examine Records**

Upon reasonable notice, Health Plans may examine Group's records with respect to eligibility and payments under this Contract.

M. **Successors and Assignees**

Benefits and obligations of this Contract are binding on the successors and permitted assignees of Health Plans and Group.

N. **Non-discrimination**

Health Plans and the employer hereby agree that no person who is otherwise eligible for coverage under this Contract shall be refused enrollment nor shall their coverage be cancelled solely because of race, color, national origin, ancestry, religion, sex, marital status, age, health status, or physical or mental handicap.

O. **Notice of Certain Events**

Health Plans will give the employer written notice, within a reasonable time, of any termination or breach of Contract, or inability to perform services, by a Physician Group or contracting provider, if the employer may be materially and adversely affected thereby.

P. **Record Keeping**

The employer is responsible for keeping records relating to this Contract. Health Plans has the right to inspect and audit these records.

Q. **Relationship of Parties**

Neither Health Plans nor any of its employees are employees or agents of Hospitals or the Physician Groups.

XI. Mediation/Arbitration Agreement

A. **Dispute Resolution**

1. **Mediation.** The parties shall submit any and all disputes relating to this Agreement to mediation prior to the appointment of any arbitrator. The mediation will be administered by the American Arbitration Association ("AAA") under its Commercial Mediation Procedures. The parties further agree to cooperate with one another in selecting a mediator and in promptly scheduling the mediation proceedings. The parties covenant that they will participate in the mediation in good faith, and that they will share equally in its costs. All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the parties, their agents, employees, experts and attorneys, and by the mediator, are confidential, privileged and inadmissible for any purpose, including impeachment, in any arbitration or other

proceeding involving the parties. This rule of confidentiality and inadmissibility does not apply to evidence that is otherwise admissible or discoverable. Such evidence shall not be rendered inadmissible or non-discoverable because it was used in the mediation. If the dispute is not resolved within 45 days from the date of the initial submission of the dispute to mediation (or such later date as the parties may mutually agree in writing), the dispute shall be submitted to arbitration. The mediation may continue, if the parties so agree, after the appointment of the arbitrators. Unless otherwise agreed by the parties, the mediator shall be disqualified from serving as arbitrator in the case. The pendency of mediation shall not preclude a party from seeking provisional remedies in aid of the arbitration from a court of appropriate jurisdiction, and the parties agree not to defend against any application for provisional relief on the ground that mediation is pending.

2. **Arbitration.** The parties agree that any and all disputes, claims or controversies arising out of or relating to this Agreement shall be submitted to mediation, and if the matter is not resolved through mediation, then it shall be submitted to final and binding arbitration. The arbitration will be administered by the AAA under its Commercial Arbitration Rules (the "AAA Rules"), and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Either party may initiate arbitration with respect to the matters submitted to mediation by filing a written demand for arbitration at any time following the initial mediation session or 45 days after the date of filing of the initial written request for mediation, whichever occurs first. The provisions of this Clause may be enforced by any court of competent jurisdiction, and the party seeking enforcement shall be entitled to an award of all costs, fees and expenses, including attorney's fees, to be paid by the party against whom enforcement is ordered.

Prominence℠
Health Plan

Signature Page

When notice is required under this Contract, it shall be sent prepaid, first class US mail to:

Health Plans:	Group:
Sales and Marketing Department Prominence Health Plan 1510 Meadow Wood Lane Reno, Nevada 89502	Robert L. Crowell City of Carson City 201 North Carson Street, No. 4 Carson City, Nevada 89701

Specific Authorization Agreeing to Mandatory Mediation and Arbitration Provision

Most customer concerns can be resolved quickly and to the customer's satisfaction by calling our Customer Service Department at 1-800-863-7515. In the unlikely event that Health Plan's Customer Service Department is unable to resolve a complaint you may have to your satisfaction (or if Health Plans has not been able to resolve a dispute it has with you after attempting to do so informally), both you and Health Plans agree to resolve those disputes through mediation, and if the mediation is not successful, through binding arbitration or Small Claims Court instead of in courts of general jurisdiction.

Arbitration is more informal than a lawsuit in Court. Arbitration uses a neutral arbitrator instead of a judge or jury, allows for more limited discovery than in court, and is subject to very limited review by courts. Arbitrators can award the same damages and relief that a court can award. **Any arbitration under this Agreement will take place on an individual basis; Class Arbitrations and Class Actions are not permitted.**

Health Plans and you agree to arbitrate **all disputes and claims** between us. This Agreement to Arbitrate is intended to be broadly interpreted. It includes, but is not limited to:

- Claims arising out of or relating to any aspect of the relationship between us, whether based in contract, tort, statute, fraud, misrepresentation, or any other legal theory;
- Claims that arose before this or any prior Agreement;
- Claims that are currently the subject of purported class action litigation in which you are not a member of a certified class; and
- Claims that may arise after the termination of this Agreement.

References to Health Plans includes our respective affiliates, agents, parents, subsidiaries, employees, predecessors-in-interest, successors and assigns under this Agreement or prior Agreements between us. Notwithstanding the foregoing, either party may bring an individual action in small claims court. This Arbitration Agreement does not preclude you from bringing issues to the attention of federal, state, or local agencies, including, for example, the Nevada Division of Insurance. Such agencies, if the law

allows, may seek relief against us on your behalf. **You agree that, by entering into this Agreement, you and Health Plans are each waiving the right to a trial by jury or to participate in a class action.**

This Agreement evidences a transaction in interstate commerce, and thus the Federal Arbitration Act governs the interpretation and enforcement of this arbitration provision. This arbitration agreement shall survive termination of this Agreement.

Notice of a Dispute

A party who intends to seek mediation or arbitration must first send to the other, by certified mail, a written notice of dispute ("Notice"). The Notice to Health Plans should be addressed as indicated above. The Notice must (a) describe the nature and basis of the claim or dispute; and (b) set forth the specific relief sought ("Demand"). If Health Plans and you do not reach an agreement to resolve the claim within 30 days after the Notice is received, you or Health Plans may immediately commence a mediation proceeding. The mediation will be administered by the American Arbitration Association ("AAA") under its Commercial Mediation Procedures. If the mediation is not successful, either party may initiate arbitration with respect to the matter submitted to mediation by filing a written demand for arbitration at any time following the initial mediation session or 45 days after the date of filing of the initial written request for mediation, whichever occurs first. The arbitration will be administered by the AAA under its Commercial Arbitration Rules (the "AAA Rules"), and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Arbitration Procedure and Rules

The arbitrator is bound by the terms of this Agreement. All issues are for the arbitrator to decide, except that issues relating to the scope and enforceability of the arbitration provision are for a federal court to decide. Unless Health Plans and you agree otherwise, any arbitration hearings will take place in Reno, Nevada. If your claim is for $10,000 or less, we agree that you may choose whether the arbitration will be conducted solely on the basis of documents submitted to the arbitrator, through a telephonic hearing, or by an in-person hearing as established by the AAA Rules. If your claim exceeds $10,000, the right to a hearing will be determined by the AAA Rules. Regardless of the manner in which the arbitration is conducted, the arbitrator shall issue a reasoned written decision sufficient to explain the essential findings and conclusions on which the award is based. Except as otherwise provided for herein, Health Plans will pay all AAA filing, administration, and arbitrator fees for any arbitration if your claim is less than $10,000 and initiated in accordance with the Notice requirements above. If, however, the arbitrator finds that either the substance of your claim or the relief sought in the Demand is frivolous or brought for an improper purpose (as measured by the standards set forth in Federal Rule of Civil Procedure 11(b)), then the payment of all such fees will be governed by the AAA Rules. In such case, you agree to reimburse Health Plans for all monies previously disbursed by it that are otherwise your obligation to pay under the AAA Rules. If you initiate an arbitration in which you seek more than $10,000 in damages, the payment of these fees will be governed by the AAA Rules.

The right to attorneys' fees and expenses discussed above supplements any right to attorneys' fees and expenses you may have under applicable law. Thus, if you would be entitled to a larger amount under applicable law, this provision does not preclude the arbitrator from awarding you that amount. However, you may not recover duplicative awards of attorneys' fees or costs. Although under some

laws, Health Plans may have a right to an award of attorneys' fees and expenses if it prevails in arbitration, Health Plans agrees that it will not seek such an award.

The arbitrator may award declaratory or injunctive relief only in favor of the individual party seeking relief and only to the extent necessary to provide relief warranted by that party's individual claim.

YOU AND HEALTH PLANS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. FURTHER, UNLESS BOTH YOU AND HEALTH PLANS AGREE OTHERWISE, THE ARBITRATOR MAY NOT CONSOLIDATE MORE THAN ONE PERSON'S CLAIMS, AND MAY NOT OTHERWISE PRESIDE OVER ANY FORM OF A REPRESENTATIVE OR CLASS PROCEEDING. IF THIS SPECIFIC PROVISION IS FOUND TO BE UNENFORCEABLE, THEN THE ENTIRETY OF THIS ARBITRATION PROVISION SHALL BE NULL AND VOID.

Notwithstanding any provision in this Agreement to the contrary, we agree that if Health Plans makes any future changes to this arbitration provision (other than a change to the Notice Address) during the term of this Agreement, you may reject any such change by sending us written notice within 30 days of the change to the Notice Address provided above. By rejecting any future change, you are agreeing that you will arbitrate any dispute between us in accordance with the language of this provision.

For Prominence Health Plan:

Name: Dave Challis
Title: Vice President and CFO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

Prominence℠
Health Plan

Medical Plan Addendum
Schedule of Insurance Rates
City of Carson City

This Schedule of Insurance Rates Addendum dated July 1, 2016 to the Group Contract is hereby entered into by and between Prominence Health Plan and City of Carson City. All of the terms of the Group Contract, not otherwise changed in this Schedule of Insurance Rates, shall remain in full force and effect for the period of one calendar year upon execution of this Addendum.

1. Products:
- a. 1500 HMO 1540 (custom) 1500 POS 1030/2040 (custom) POS Core 4
- b. Rx $15/40/60D
- c. Vision: None
- d. Domestic Partnership: Yes

2. Term of the Contract:
- a. Effective Date: July 1, 2016
- b. Termination Date: June 30, 2017

3. Termination of the Contract:
- a. Anniversary Date: July 2017

4. Waiting Period:
- a. The Probationary or Waiting Period Requirements:
  First of the month following sixty (60) days of employment
  Rehires: no waiting period for any employee laid off and rehired within one year.

5. Employee Termination Date Rule:
- a. An employee will be terminated from the Health Plans on the Eligible Employee's Termination Date, but coverage will continue for the remainder of that month provided the Eligible Employee's monthly premium was previously paid in full; according to the group's selection on their Master Application.

6. Premium Payment:
- a. Total Monthly Premium:

1500 HMO 1540 (custom) / Rx $15/40/60D

Tier	Medical & Rx	Vision	Total Monthly Premium
Employee	$505.86	$0.00	$505.86
Employee & Spouse*	$1,037.19	$0.00	$1,037.19
Employee & Child(ren)*	$970.62	$0.00	$970.62
Employee & Family*	$1,585.19	$0.00	$1,585.19

Prominence Health Plan

Tier: Retiree	Medical & Rx	Vision	Total Monthly Premium
Single without Medicare	$505.86	$0.00	$505.86
Single with Medicare	$372.88	$0.00	$372.88
Retiree & Spouse w/o Medicare*	$1,037.19	$0.00	$1,037.19
Retiree & Spouse both w/ Medicare*	$791.10	$0.00	$791.10
Retiree & Spouse one w/ Medicare*	$933.18	$0.00	$933.18
Retiree & Child(ren) w/o Medicare*	$970.62	$0.00	$970.62
Retiree & Child(ren) w/ Medicare*	$962.29	$0.00	$962.29
Retiree & Family w/o Medicare*	$1,585.19	$0.00	$1,585.19
Retiree & Family two with Medicare*	$967.14	$0.00	$967.14
Retiree & Family one with Medicare*	$1,121.91	$0.00	$1,121.91

1500 POS 1030/2040 (custom) / Rx $15/40/60D

Tier	Medical & Rx	Vision	Total Monthly Premium
Employee	$566.55	$0.00	$566.55
Employee & Spouse*	$1,161.61	$0.00	$1,161.61
Employee & Child(ren)*	$1,087.05	$0.00	$1,087.05
Employee & Family*	$1,775.36	$0.00	$1,775.36

Tier: Retiree	Medical & Rx	Vision	Total Monthly Premium
Single without Medicare	$566.55	$0.00	$566.55
Single with Medicare	$413.65	$0.00	$413.65
Retiree & Spouse w/o Medicare*	$1,161.61	$0.00	$1,161.61
Retiree & Spouse both w/ Medicare*	$878.66	$0.00	$878.66
Retiree & Spouse one w/ Medicare*	$1,042.03	$0.00	$1,042.03
Retiree & Child(ren) w/o Medicare*	$1,087.05	$0.00	$1,087.05
Retiree & Child(ren) w/ Medicare*	$1,077.48	$0.00	$1,077.48
Retiree & Family w/o Medicare*	$1,775.36	$0.00	$1,775.36
Retiree & Family two with Medicare*	$1,064.73	$0.00	$1,064.73
Retiree & Family one with Medicare*	$1,242.67	$0.00	$1,242.67

Prominence℠
Health Plan

POS Core 4 / Rx $15/40/60D

Tier: Retiree	Medical & Rx	Vision	Total Monthly Premium
Single without Medicare	$804.19	$0.00	$804.19
Single with Medicare	$580.97	$0.00	$580.97
Retiree & Spouse w/o Medicare*	$1,648.85	$0.00	$1,648.85
Retiree & Spouse both w/ Medicare*	$1,235.79	$0.00	$1,235.79
Retiree & Spouse one w/ Medicare*	$1,474.27	$0.00	$1,474.27
Retiree & Child(ren) w/o Medicare*	$1,543.01	$0.00	$1,543.01
Retiree & Child(ren) w/ Medicare*	$1,529.03	$0.00	$1,529.03
Retiree & Family w/o Medicare*	$2,520.02	$0.00	$2,520.02
Retiree & Family two with Medicare*	$1,482.57	$0.00	$1,482.57
Retiree & Family one with Medicare*	$1,742.37	$0.00	$1,742.37

* Employee and Spouse, Employee and Children and Employee and Family rates are only applicable when dependents are made eligible by the group.

b. Effective Month: July
c. Effective Day: 1
d. Effective Year: 2016
e. Termination Date: June 30, 2017

7. General Provisions:

a. Broker of Record: None

For Prominence Health Plan:

Name: Dave Challis
Title: Vice President and CFO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

Prominence Health Plan

Dental Plan Addendum
Schedule of Dental Insurance Rates
City of Carson City

This Schedule of Dental Insurance Rates Addendum dated July 1, 2016 to the Group Contract is hereby entered into by and between Prominence Health Plan and City of Carson City. All of the terms of the Group Contract, not otherwise changed in this Schedule of Dental Insurance Rates, shall remain in full force and effect for the period of one calendar year upon execution of this Addendum.

1. Products:

a. Dental: Plan 4 (custom)

b. Contributory:

i. Page 7, Section VII, Item L, does not apply to the dental program;

ii. The following participation requirements shall apply to the contributory dental program:

- 100 percent participation is required for groups with five or less full-time eligible employees; a 75 percent participation requirement, with a minimum of five enrolled, is required for groups with six or more full time eligible employees.

c. Voluntary:

i. Page 7, Section VII, Item L, does not apply to the dental program;

ii. The following participation requirements shall apply to the voluntary dental program:

- Voluntary dental plans require a minimum of three employees enrolled or 25 percent participation of the eligible full-time employees, whichever is greater.

d. Domestic Partnership: Yes

2. Term of the Contract:

a. Effective Date: July 1, 2016

b. Termination Date: June 30, 2017

3. Termination of the Contract:

a. Anniversary Date: July 2017

4. Waiting Period:

a. The Probationary or Waiting Period Requirements:
First of the month following sixty (60) days of employment.

5. Employee Termination Date Rule:

a. An employee will be terminated from the Health Plans on the Eligible Employee's Termination Date, but coverage will continue for the remainder of that month provided the Eligible Employee's monthly premium was previously paid in full; according to the group's selection on their Master Application.

Prominence℠
Health Plan

6. Total Monthly Dental Premium Payment:

Dental Plan 4 (custom)

Tier	Dental
Employee	$52.30
Employee & Spouse*	$73.56
Employee & Child(ren)*	$93.02
Employee & Family*	$114.28

Tier: Retiree	Dental
Single without Medicare	$52.30
Single with Medicare	$52.30
Retiree & Spouse w/o Medicare*	$73.56
Retiree & Spouse both w/ Medicare*	$73.56
Retiree & Spouse one w/ Medicare*	$73.56
Retiree & Child(ren) w/o Medicare*	$93.02
Retiree & Child(ren) w/ Medicare*	$93.02
Retiree & Family w/o Medicare*	$114.28
Retiree & Family two with Medicare*	$114.28
Retiree & Family one with Medicare*	$114.28

* Employee and Spouse, Employee and Children and Employee and Family rates are only applicable when dependents are made eligible by the group.

a. Effective Month: July
b. Effective Day: 1
c. Effective Year: 2016
d. Termination Date: June 30, 2017

7. General Provisions:

a. Broker of Record: None

For Prominence Health Plan:

Name: Dave Challis
Title: Vice President and CFO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

Prominence
Health Plan

City of Carson

July 2016

Retiree Addendum

Prominence
Health Plan

Retiree Addendum

Prominence Health Plan

City of Carson City

This Addendum dated July 1, 2016 to the Group Contract is hereby entered into by and between Prominence Health Plan and City of Carson City. All of the terms of the Group Contract, not otherwise changed in this amendment, shall remain in full force and effect for the period of one calendar year upon execution of this Addendum.

1. Term of the Contract:
   a. Effective Date: July 1, 2016
   b. Termination date: June 30, 2017

2. Termination of the Contract:
   a. Anniversary Date: July 1, 2017

3. Additional Retiree Language:

Retiree Group Health coverage is provided in accordance with the group Retirement Policy and Nevada Revised Statutes governing Retirees.

   a. Effective Month: July
   b. Effective Day: 1
   c. Effective Year: 2016
   d. Termination date: June 30, 2017

4. General Provisions:
   a. Broker of Record: None

For Prominence Health Plan:

Name: Dave Challis
Title: Vice President and CFO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

Prominence
Health Plan

City of Carson

July 2016

Multi-Year Pricing Agreement

MULTI-YEAR PRICING - AMENDMENT 4

Saint Mary's Preferred Health Insurance Company, Inc. Group Contract
City of Carson City

In accordance with Article VI of the Contract executed by and between Saint Mary's Preferred Health Insurance Company, Inc. (hereinafter referred to as "SMPHIC") and City of Carson City ("Group"), on July 1, 2011, the parties mutually agree to amend the Contract as follows:

1. Term of Contract.

Section IV ofthe Group Contract is amended to state:

This Contract becomes effective on July 1, 2011 at 12:00 a.m. Pacific Time and will remain in effect for a term of (seventy-two) 72 consecutive calendar months, until June 30, 2017 (the "Termination Date") unless earlier terminated pursuant to the Termination of Contract section (below). Except as expressly provided otherwise in any COC document(s) incorporated into this Contract by reference, all rights to benefits under this Contract expire and will have no further force or effect as of 11:59 p.m. as of the Termination Date.

2. Termination of Contract

Section V of the Group Contract is hereby amended to state:

The Group and SMPHIC have agreed to a six (6) year contract with annual pricing adjustments as specified below. SMPHIC and/or Group may only terminate this Contract for good cause on or before June 30, 2017 at 11:59 p.m. (the "Termination Date") as set forth below:

In the event the Contract is terminated for Good Cause (described below), SMPHIC will provide the Group with an acknowledgment in the Form of a Written Notice of Contract Termination ("Notice"). Promptly upon receipt ofthe Notice, Group will mail via First Class U.S. Mail to each Member a legible copy of the notice. Group agrees to provide SMPHIC with written proof of that mailing and of the date thereof. If the terms of this Contract are altered by consent of both parties, the parties agree no resulting reduction in coverage or benefits will adversely affect a member who is confined to a hospital at the time of such change.

Good Cause for Contract termination by Group shall mean:

1. Significant change in the SMPHIC provider network

Should SMPHIC experience a decrease of thirty percent (30%) or more in the number of physicians available in the SMPHIC network in the Carson City, Minden, Gardnerville and Dayton areas combined, the Group may terminate this Contract upon sixty (60) days prior written notice to SMPHIC.

2. Fraud, Noncompliance or intentionally furnishing incorrect or incomplete information

Group may terminate this Contract upon fifteen (15) days prior written notice to SMPHIC if:

A. SMPHIC knowing fails to provide services as specified in the provisions of the COC, or

B. SMPHIC has performed an act that constitutes fraud or knowingly furnishes Group with materially false information.

Good Cause for termination by SMPHIC shall include:

1. Non Payment
Failure of Group to pay the premium for this Contract when due or within the thirty (30) day grace period. If a Premium is not paid by the end of the grace period, SMPHIC may terminate the contract of insurance retroactively to the end of the day preceding the grace period. Cancellation will not be effective until at least ten (10) days after SMPIDC has delivered or mailed written notice to the group.

2. Material Breach of COC requirements
For any material breach of the terms detailed in the COC, upon sixty (60) days notice to Group.

3. Fraud, Noncompliance or intentionally furnishing incorrect or incomplete information
SMPHIC may terminate this Contract upon fifteen (15) days prior written notice to Group if:

A. Group fails to comply with its material obligations under this Contract (including but not limited to its obligations under the "Eligibility and Enrollment" section of this Contract), or

B. Knowing failure by the employer to abide by and enforce the conditions of enrollment of Members as set forth in the "Eligibility and Enrollment" provisions of the COC and the Employer Application, or

C. Has performed an act that constitutes fraud or misrepresents or intentionally furnishes incorrect or incomplete material information (including but not limited to the employees covered under the plan or other information regarding eligibility for coverage under the plan).

4. **Failure to meet Participation and Contribution requirements**
Failure of the employer to maintain minimum subscription charge contribution requirements or minimum participatory requirements or as stated in the group requirements set forth in the Master Application (see Section VII, item K of this contract).

Group will allow SMPHIC to review and audit payroll and other pertinent records for the verification of eligibility of employees as stated in contributions or group requirements. SMPHIC will make written and verbal request to Group and conduct all such reviews during regular business hour .

Group agrees to pay **SMPHIC a minimum of 50% of the insurance premium** for all Group employees.

5. **Discontinuance of a product or all products within a market**
SMPHIC may terminate a particular product or all products offered in a small or large group market, if it discontinues offering insurance in the geographic area of the state where the employer is located. SMPHIC may also discontinue the issuance and renewal of coverage to a small employer if the Nevada Insurance Commissioner finds that the continuation of coverage would not be in the best interest of the policyholders or certificate holders or would impair the ability of the carrier to meet its contractual obligations. If the Commissioner makes such a finding, the Commissioner shall assist the affected small employers in finding replacement coverage. SMPHIC may also discontinue products offered to small employers if the Nevada Insurance Commissioner finds that the form of the product offered by SMPHIC is obsolete and is being replaced with comparable coverage. SMPHIC will notify the Commissioner and the Chief Regulatory Officer for insurance in each state in which it is licensed of its decision to discontinue the issuance or renewal of a product at least sixty (60) days before SMPHIC notifies the affected small employers. SMPHIC will notify affected employers at least one hundred eighty (180) days before the date on which it will discontinue offering the product and it will offer each affected small employer the option to purchase any other health benefit plan currently offered by it to small employers in Nevada. In exercising its option to discontinue the product and in offering the option to purchase other coverage, SMPHIC will act uniformly without regard to the claims experience of the affected small employers or any health status-related factor relating to any participant or beneficiary covered by the discontinued product or any new beneficiary who may become eligible for such coverage. SMPHIC will comply with the requirements ofNRS 689C.310-.320 and NRS 689B.560 if it decides to discontinue providing insurance in a geographic area or discontinue products to the small employer market.

6. A Material change in the nature of the Employer's Business Affecting Underwriting

An annual change of thirty percent (30%) or more in the number of eligible employees which would materially change underwriting for the Group.

Other significant changes in the composition or status of the employer's business.

3. Pricing.

The pricing for the July 1, 2011 to June 30, 2012 period will be as specified in the Group Contract. After the initial year of the contract, the pricing for the five subsequent years of the contract period will be determined as follows:

Year 1: The July 1, 2012 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2012 with claims experience from December 1, 2010 through November 30, 2011. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00%- 79.99%	4.00%
80.00%- 84.99%	6.00%
85.00%- 89.99%	9.00%
90.00%-94.99%	12.00%
> 95.00%	(See Note 1)

Year2: The July 1, 2013 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2013 with claims experience from December 1, 2011 through November 30, 2012. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00%- 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00%-89.99%	9.00%
90.00%-94.99%	12.00%
> 95.00%	(See Note 1)

Year3: The July 1, 2014 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2014 with claims experience from December 1, 2012 through November 30, 2013. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
<74.99%	2.00%
75.00%- 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00%- 89.99%	9.00%
90.00%-94.99%	12.00%
> 95.00%	(See Note 1)

Year4: The July 1, 2015 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2015 with claims experience from December 1, 2013 through November 30, 2014. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
< 74.99%	2.00%
75.00%- 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00%- 89.99%	9.00%
90.00% - 94.99%	12.00%
>95.00%	(See Note 1)

YearS: The July 1, 2016 rate adjustment will be capped according to the table below based on the 12-month Combined Medical and Rx Loss Ratio as calculated as a part of Saint Mary's Health Plan's normal underwriting process. The Combined Medical Loss Ratio will be calculated on an incurred basis in January 2016 with claims experience from December 1, 2014 through November 30, 2015. The Combined Medical Loss Ratio will include Saint Mary's standard completion factors to estimate completed claims for the 12-month period and the standard capitation charges.

Loss Ratio	Maximum Increase
<74.99%	2.00%
75.00%- 79.99%	4.00%
80.00% - 84.99%	6.00%
85.00%- 89.99%	9.00%
90.00% - 94.99%	12.00%
> 95.00%	(See Note 1)

Note 1: For any Loss Ratio greater than 95%, the parties will negotiate in good faith to determine a mutually agreeable increase. If a mutually agreeable increase cannot be reached, then the parties may terminate the agreement. If Saint Mary's Health Plan unilaterally agrees to an increase of 12.0% or less when the Loss Ratio is greater than 95%, then this five year arrangement remains intact.

4. Confidentiality.

As part of the consideration for SMPHIC to enter into this Agreement, Group agrees that it shall not use, or divulge to anyone, SMPHIC's trade secrets. A trade secret means information, including, but not limited to, programs, methods, techniques and processes, that has independent economic value from not being generally known to either the public or to other persons who can obtain economic value from its disclosure or use. Example of SMPHIC's trade secrets include, but are not limited to, actual and potential membership lists, fee schedules, billing rates, compiled information concerning its beneficiaries, key provider agreements, and administrative manuals. This paragraph does not apply to information that is already in the public domain or that has been made available to the public by SMPHIC.

For Saint Mary's Preferred Health Insurance Company, Inc.:

Name: Dave Challis

Title: Vice President and CFO

Date: 7/8/11

For Group: City of Carson City

Name: Robert L. Crowell

Title: Mayor

Date: 6/28/11

Prominence
Health Plan

City of Carson

July 2016

Self-Billing Amendment

AMENDMENT NUMBER TWO TO

GROUP CONTRACTS

Whereas, Saint Mary's Preferred Health Insurance Company, Inc. and Saint Mary's Health First ("Health Plan") and City of Carson City ("Group") have entered into a Group Contract effective on **July 1, 2011.**

Whereas, Health Plan and Group desire to make the premium billing and payment process more efficient and user friendly by permitting the use of Self-Billing;

Whereas, in accordance with Article VI, and pursuant to a mutual agreement between the undersigned parties to the Group Contract, the Group Contract is hereby amended as follows to permit Group to make its premium payments:

Article IX titled "Premium Payment" is supplemented with the following Section IX(F), titled "Self-Billing Reports" which provides as follows:

1. **Self-Billing Reports** – As of October 1, 2011, Group hereby agrees to submit premium payments to Health Plan, in accordance with the provisions stated below.

2. **Self-Billing Report Format Requirements** – The Self-Billing Report Format shall provide the following information:

(a) Each Member's identification number assigned by the Health Plan; newly enrolled members may be initially posted without their I.D. number until it is assigned.

(b) Each Member's last name/first name

(c) Group's Group identification number (not the Plan number) and

(d) The dollar amount of premium being remitted for each identified Member.

3. **Multiple Group Identification Numbers** – If there are multiple Group identification numbers used by Group, Group shall separate the information described in Item 3 by unique Group identification numbers.

4. **Changes to Self-Billing Reporting Format** – Saint Mary's may in its sole discretion, change the Reporting format requirements, described in Item 3 above, by providing Group with 60-days' advance written notice.

5. **Attestation** – Each month Group will submit their Self-Billing Report and it shall be acknowledged by Health Plan and Group as a declaration and attestation by Group that all employees listed on the Self-Billing Report have been properly enrolled for the month being reported. Any prospective change in the amount of an Eligible Employee's premium, due to a change in status, requires Group to timely file an appropriate change form with Health Plan.

6. **Premium Adjustments** – Group agrees that any premium adjustments required as the result of the termination of employment of employees or the hiring of new employees not previously shown on a Self-Billing Report shall be made by Group within the time frame described in the Group Contract.

7. **When Employee Coverage Ends** – Group agrees that an Eligible Employee's coverage shall end as of the last day of the month immediately preceding the Self-Billing Report which no longer shows the Eligible Employee as an Eligible Employee for coverage, unless a Termination Date is indicated during a reporting month on a Self-Billing report submitted by Group.

8. **Employees Not Listed Are Not Covered** – Group agrees that any Eligible Employee not listed on the Self-Billing Report certifies to Health Plan that the Employee is no longer eligible for coverage. No other formal notice terminating an Eligible Employee's coverage is required.

9. **Due Date For Self-Billing Report** – Group's Self-Billing Report shall be due (that is communicated to Health Plan) on the first day of each calendar month for which coverage is provided. In no event shall the Self-Billing Report be provided to Health Plan later than the 10th day of a calendar month. Premium Payments are due as of the first day of each calendar month for which coverage is provided.

10. **Timely Payment of Premiums** – Group agrees to remit to Health Plan on the due date the total monthly premium owed on behalf of each Eligible Employee who is shown as an enrolled member of the Group Contract, in accordance with the terms of the Group Contract.

11. **Unilateral Right To Terminate This Addendum** – Group agrees that Health Plan has the unilateral right to terminate this Addendum to the Group Contract upon delivery of written notice of termination to Group.

12. **Supporting Documents** – Group agrees that upon the request of Health Plan, supporting documentation shall be provided to buttress its Eligible Employee representations.

13. **Record Retention** – Group agrees to retain written records supporting the information contained in the Self-Billing Reports for two calendar years after the date of the submission of each monthly Self-Billing Report.

14. **Rejection of Self-Billing Reports** – Group understands that Health Plan may reject an entire Self-Billing Report at any time for failing to comply with any of the requirements set forth above. Group agrees that a rejected Self-Billing Report will be corrected and resubmitted to Health Plan no later than five (5) business days after it receives notice that a Self-Billing Report has been rejected.

15. **Voluntary Agreement** – Group agrees that its participation in the Self-Billing Report program is completely voluntary and that it will continue to comply with all of the other terms of the Group Contract.

Agreed and Accepted

For Saint Mary's Preferred Health Insurance Company, Inc.	For Group: City of Carson City
Name: Dave Challis	Name: Robert L. Crowell
Title: Vice President and CFO	Title: Mayor
Date: 8/12/11	Date: 8-8-11

Prominence
Health Plan

City of Carson

July 2016

July 2013 Master Application

Saint Mary's
Preferred Health Insurance Company
A Dignity Health Member

Group Master Application – Preferred PPO
Attachment A to the Group Enrollment Agreement

This information produces your group contract and rates; therefore, it is imperative you complete this information form accurately and return it in a prompt manner.

Company's Legal Name Carson City, Nevada

Street Address 201 N. Carson St., Suite 4

Mailing Address (if different than above) _____

City Carson City State NV Zip Code 89701 Email Address mbruketta@carson.org

Telephone Number (775) 283-7088 Fax Number (775) 887-2067

State/Province/Jurisdiction (where Corporate Headquarter is located) Nevada

Are other divisions, subsidiaries, or affiliates covered under this plan? ☐ No ☐ Yes

If yes, Name Carson Water Subconservancy District & Carson City Convention & Visitors Bureau **Relationship** Local Government Agencies

Location Carson City/Douglas County, NV **Nature of Business** Government

Contact person for company's employee benefits Melanie Bruketta **Title** HR Director

Type of Organization (please check one)

☐ Partnership ☐ Sole Proprietorship ☐ Corporation (C & S) ☐ Trust ☐ Association ■ Government segment ☐ New business (6 weeks)

☐ Non-profit Organization ☐ LLC ☐ Other (please specify) _____

Nature of business (please specify) government **Standard Industrial Code (SIC)** _____

FEIN # 88-6000189

Does the company participate in a Worker's Comp/PERS Program? ☐ No ■ **Yes – Attach list of non-covered employees.**

Description of eligible employees:
■ All full-time employees ■ Other (please specify) See attached

Total number of full time employees: 550
Employees waiving without other coverage: 50
Employees waiving with other coverage: 14
Employees in waiting period: 14

COBRA participants enrolling: 3
Employees on other company sponsored plans: Ø
Total eligible employees: 564
Total employees enrolling: 536

Name of alternate plan sponsored by you: N/A

Are any employees excluded? ☐ No ☐ Yes If yes, describe _____

For Small Groups (2-50) the mandatory minimum hourly requirement for offering health benefits is 30 hours per week.
For Large Groups (51 or greater) please indicate minimum hourly requirements for full time employment 32 (Carson City employees) hours per week
Nevada Small Employer: Did your firm employ between 2 to 50 employees during at least one half of the preceding year? ☐ No ☐ Yes

Waiting Period

Present employees: Are all current employees covered as of the effective date? ☐ No ■ Yes
If no, do they have the same waiting period as future hires? ☐ No ☐ Yes

Future employees:
■ No waiting period OR First of the month following 90 days (s) of employment
☐ Other _____
(specify here if multiple employee classes have different waiting periods)

Terminations: Coverage terminates for employee(s) ☐ Last day worked ■ Last day of the month

Rehire Policy:
■ No Waiting Period OR First of the month following _____ days(s) of employment
☐ Other _____

Leave of Absence Policy:
■ No Waiting Period OR First of the month following _____ days(s) of employment
☐ Other _____

Does company file 5500 Form? If yes, when does plan year end? NO

Prior Plan Information
Does this plan replace other group coverage? ☐ No ■ Yes Dental
If yes, attach a copy of the prior plan's most recent premium billing statement and complete the following:

	Name	Effective Date	Termination Date
Medical Carrier:			
Dental Carrier:	The Standard	7-1-13	6-30-13
Vision Carrier:			

Contributions (please check one) Are you paying at least 50% of the lowest plan? ☐No ■Yes

REQUESTED PLAN(S)

Medical	RX
1. 1500 HMO 1540	
2. 1500 POS 1030/2040	
3.	15/40/60D
4.	
5.	

Association (if Applicable): _____

Dental plan	Vision plan
☐ Plan 1	☐ Yes
☐ Plan 2	☐ No
☐ Plan 3	
☐ None City of Carson PPO Dental Plan	

Domestic Partner: ☐ No ☒ Yes

Section 125 (Flex Spending Account): ☐ No ☐ Yes

Requested effective date for plan: 7-1-13 Requested anniversary date for plan: July 1st

Representative (broker/agent): N/A
Appointed: ☐ No ☐ Yes

I have conspicuously posted or distributed to all employees the "THE NOTICE OF A CHANGE IN GROUP COVERAGE" at least 15 days prior to the requested effective date in such a way to ensure all modifications have been posted or distributed on the group health plan.

I, undersigned, understand and agree this application is for the health care coverage offered by Saint Mary's Preferred Health Insurance Company, and will form a part of any contract issued in reliance upon it; and acceptance of the group for coverage and final rates are based upon the above information and the census of actual enrollees; and any material misrepresentation therein, whether intentional or unintentional, will permit Saint Mary's Preferred Health Insurance Company, to terminate such coverage. I acknowledge my Representative has explained the coverage's, limitations, and exclusions, and other details of the coverage applied for; and I have read and understand the Nevada Statutory Disclosures. I understand and agree it is my responsibility to offer coverage to all eligible employees and their dependents; and I will provide to Saint Mary's Preferred Health Insurance Company, an enrollment form or a waiver of coverage form signed by each employee within 31 days of his/her eligibility date; and collect any employee contribution(s) toward premium. I understand and agree my group must maintain a minimum participation and contribution level for the coverage.

It is also understood any existing coverage presently being provided to employees should not be cancelled until written approval of this application has been received. A one-month deposit is being submitted, to be held without obligation until this application is approved. If the application is approved, the deposit will be applied to the first month's premium under the policy. If coverage does not become effective, the deposit will be refunded.

Mediation before Litigation

Group and Preferred Health Insurance Company, agree to first mediate prior to resort to the courts, the disputes described below pursuant to the procedures set forth herein. Group understands that each member/enrollee may decline to participate in Mediation, and that by agreeing to mediate disputes relating to the Evidence of Coverage, the Health Plan or health care services provided by Preferred Health Insurance Company, the member/enrollee has not forgone their right to resolve any such dispute in a court of law or equity. Group agrees that any claim Group may assert for alleged violation of any duty to a Member arising out of this Contract, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this Contract, irrespective of legal theory, shall be resolved by first submitting the dispute to mediation which shall be conducted by JAMS/Endispute (916) 921-5300. In the event the dispute is not resolved through mediation, the dispute shall be resolved in a court of law or equity.

Signed at Carson City, NV on the 27th day of June, 2013 (year)

Signature: Melanie Buketta Title: HR Director
(signature of authorized company officer)

Printed Name: Melanie Buketta

1510 Meadow Wood Lane, Reno, Nevada 89502-8503 (775) 770-6065
www.saintmaryshealthplans.com

*Carson City participates in worker's compensation and PERS. All employees have worker's compensation coverage. All full-time employees participate in PERS.

*The Carson Water Subconservancy District and the Carson City Convention and Visitor's Bureau may allow part-time employees to participate in the group health program.