STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** 5-18-2017

Staff Contact: Melanie Bruketta, HR Director

Agenda Title: For Possible Action: Discussion and possible action to approve the employee/retiree health insurance contract with Prominence Health Plan, dental and life insurance contracts with Standard, and vision insurance contract with EyeMed. (Melanie Bruketta, mbruketta@carson.org)

Staff Summary: This action is to approve the health insurance contract with Prominence Health Plan, dental and life insurance contract with Standard, and vision insurance contract with EyeMed, for active and retired employees. Prominence Health Plan will increase current plan costs by 6.91% for fiscal year 2018. The Standard dental plan will decrease current plan costs by 6.67%. The EyeMed vision plan will decrease current plan costs with VSP by 28.16%, and the Standard life policy will decrease by 33.33%.

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

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Proposed Motion

I move to approve the employee/retiree health insurance contract with Prominence Health Plan, dental and life insurance contracts with Standard, and vision insurance contract with EyeMed.

Board's Strategic Goal

Organizational Culture

Previous Action

The Board approved the health and dental plans last year at the June 2, 2016 meeting.

Background/Issues & Analysis

The City's combined medical and prescription adjusted claims loss ratio was 93%. The 93% loss ratio represents a significant increase over prior years' experience and is being driven by overall utilization trends and the presence of multiple large claims. Trend forecasts for medical and pharmacy costs are 5% and 12%, respectively.

In light of the current loss ratio, and their expectation that this trend will continue into the next plan year, Prominence originally requested a 18.09% increase. Quotes were solicited from the entire health insurance market with negotiated responses ranging, for similar coverage levels, between 8.97% (United Healthcare) and 66.51% (Sierra Health & Life). Due to the competitive pressure, Prominence conceded its renewal action to 6.91%.

Prominence is exiting the dental insurance market and did not offer the City a dental renewal. Quotes were solicited from 16 dental carriers with negotiated responses ranging between -6.67% (Standard) and 15.05% (Mutual of Omaha). The City's current dental loss ratio is 88%, with trend estimated at 3.5%. Staff is recommending approval of the contract with Standard.

The City's vision loss ratio at the time of renewal was 89.9%. The negotiated renewal from VSP was 7%. Coverage was marketed to 16 vision carriers with EyeMed offering comparable coverage at 28.16% below current VSP costs.

The City provided life insurance was also taken to market, with 18 carriers solicited. Responses ranged between -41.11% (Hartford) and -11% (Mutual of Omaha). Staff is recommending that the City stay with Standard.

Applicable Statute, Code, Policy, Rule or Regulation

Prominence Health Plan contract for health insurance, Standard contract for dental insurance, EyeMed contract for vision insurance, and Standard contract for life insurance.

Financial Information

Is there a fiscal impact? ☒ Yes ☐ No

If yes, account name/number:

570-0706-415.63-01 - Health insurance expected increase of 7%, or approximately$510,000 and Vision insurance expected decrease of 28% or approximately $21,000.

570-0706-415.63-02 - Dental insurance expected decrease 6.67% or approximately $41,000.

570-0706-415.63-03 - Life insurance expected decrease 33.3% or approximately $36,000.

Is it currently budgeted? ☒ Yes ☐ No

Explanation of Fiscal Impact: Finance budgeted a 7% increase in medical/dental/vision/life this year, for a total FY18 budget of $7,353,645. Last year was the final year of the pricing agreement with Prominence. The City hired a broker to issue an RFP for medical, dental, vision and life renewals for July 1, 2017.

Alternatives

The Board may reject the proposed contracts with Prominence, Standard and EyeMed and ask the broker to bring back other options.

Board Action Taken:

Motion: _____ 1) _____ Aye/Nay

2) _____ _____

_____

_____

_____

_____

(Vote Recorded By)

Carson City

Group Health Plan
Cost Analysis Report

September 1, 2016

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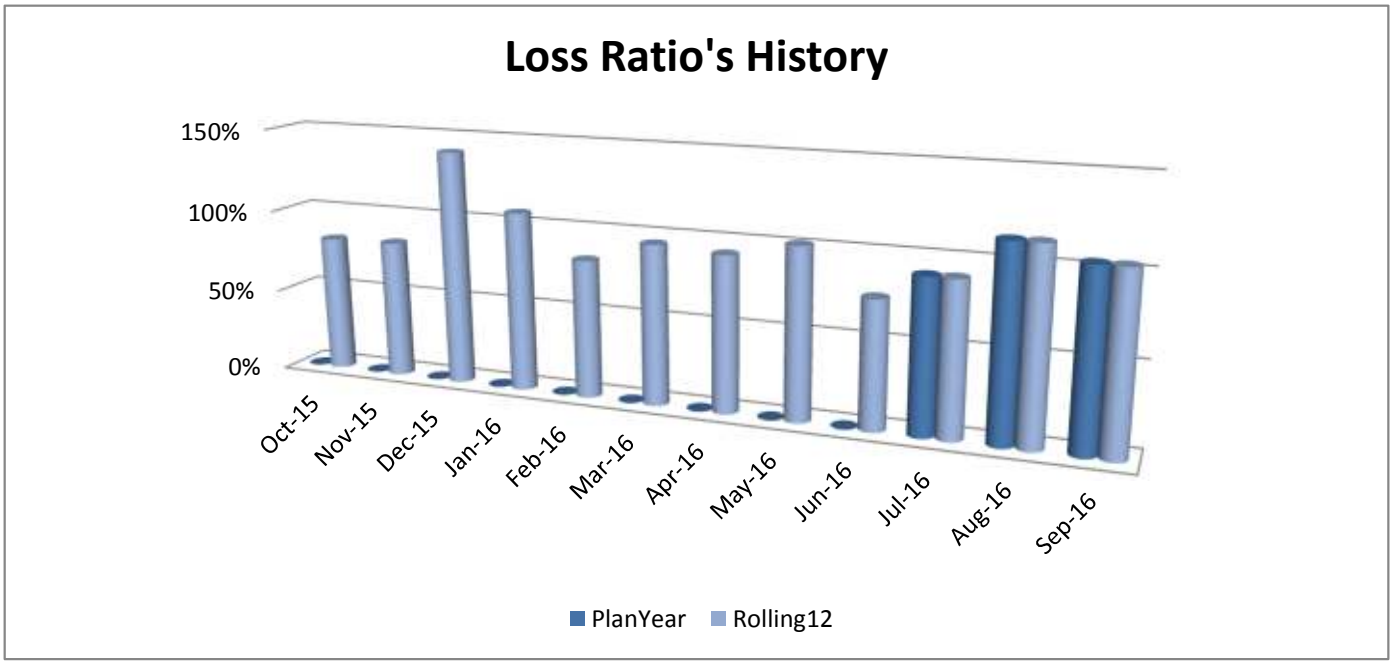
LP Insurance Services

Carson City
Monthly Claims Activity Executive Summary
For the Month of
September-16

	Current Month		
	Premium	Claims	Loss Ratio
TOTALS	**$608,372**	**$635,409**	**104%**

	Plan Year		
	Premium	Claims	Loss Ratio
TOTALS	**$1,821,808**	**$1,874,174**	**103%**
	Per Employee Per Month		
	Current Premium	Rolling 12M Claims	Loss Ratio
TOTALS	**$860**	**$843**	**98%**



Carson City
(Subscriber & Dependent Combined)
Incurred Claims

Plan Year

Month / Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical & Medical Claims*	*Capitated Claims* $12.55*	Total Claims*	Subscriber Composite Claims*	Paid Loss Ratio
Jul-16	703	1,418	607,288	$864	533,350	*$17,796*	$551,146	$784	91%
Aug-16	703	1,413	606,148	$862	669,886	*$17,733*	$687,619	$978	113%
Sep-16	707	1,417	608,372	$860	617,626	*$17,783*	$635,409	$899	104%
Oct-16									
Nov-16									
Dec-16									
Jan-17									
Feb-17									
Mar-17									
Apr-17									
May-17									
Jun-17									
Total	**2,113**	**4,248**	**$1,821,808**	$862	**$1,820,862**	*$53,312*	**$1,874,174**	$887	103%
Average	**704**	**1416**	**$607,269**	$862	**$606,954**	*$17,771*	**$624,725**	$887	103%

Subscriber Composite Claims

Rolling 12 Months

Month / Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical & Medical Claims*	*Capitated Claims* $12.55*	Total Claims*	Subscriber Composite Claims*	Paid Loss Ratio
Oct-15	684	1,367	590,071	$863	467,975	*$17,156*	$485,131	$709	82%
Nov-15	694	1,384	597,585	$861	477,921	*$17,369*	$495,290	$714	83%
Dec-15	697	1,384	596,589	$856	821,227	*$17,369*	$838,596	$1,203	141%
Jan-16	695	1,387	597,404	$860	624,206	*$17,407*	$641,613	$923	107%
Feb-16	694	1,386	596,748	$860	476,154	*$17,394*	$493,548	$711	83%
Mar-16	695	1,402	600,921	$865	556,415	*$17,595*	$574,010	$826	96%
Apr-16	696	1,419	606,167	$871	546,183	*$17,808*	$563,991	$810	93%
May-16	692	1,412	603,364	$872	596,405	*$17,721*	$614,126	$887	102%
Jun-16	696	1,422	607,120	$872	443,539	*$17,846*	$461,385	$663	76%
Jul-16	703	1,418	607,288	$864	533,350	*$17,796*	$551,146	$784	91%
Aug-16	703	1,413	606,148	$862	669,886	*$17,733*	$687,619	$978	113%
Sep-16	707	1,417	608,372	$860	617,626	*$17,783*	$635,409	$899	104%
Total	**8,356**	**16,811**	**$7,217,777**	$864	**$6,830,887**	*$210,978*	**$7,041,865**	$843	
Average	**696**	**1401**	**$601,481**	$864	**$569,241**	*$17,582*	**$586,822**	$843	98%
Underwriting Loss Ratio, Including Capitated Claims Est., Starting Point before Large claim Exceptions									98%

Subscriber Composite Claims

*Estimated Fees

Source: Prominence unaudited Monthly Experience Report

Carson City

(Subscriber & Dependent Combined)

Rolling 12 Months - Incurred Claims

Dental

Month / Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Dental Claims	Subscriber Composite Claims	Paid Loss Ratio
Oct-15	692	1,366	48,509	$70	43,829	$63	90%
Nov-15	701	1,382	49,963	$71	45,675	$65	91%
Dec-15	704	1,380	50,667	$72	60,192	$86	119%
Jan-16	703	1,386	49,788	$71	39,569	$56	79%
Feb-16	699	1,382	49,765	$71	46,912	$67	94%
Mar-16	700	1,397	50,323	$72	50,594	$72	101%
Apr-16	702	1,417	49,721	$71	39,307	$56	79%
May-16	698	1,408	50,977	$73	40,173	$58	79%
Jun-16	701	1,414	50,334	$72	43,048	$61	86%
Jul-16	708	1,413	50,713	$72	43,789	$62	86%
Aug-16	708	1,408	50,973	$72	46,170	$65	91%
Sep-16	712	1,412	53,045	$75	34,269	$48	65%
Total	**8,428**	**16,765**	**$604,778**	$72	**$533,527**	$63.30	88%
Average	**702**	**1,397**	**$50,398**		**$44,461**		

Subscriber Composite Claims

Vision

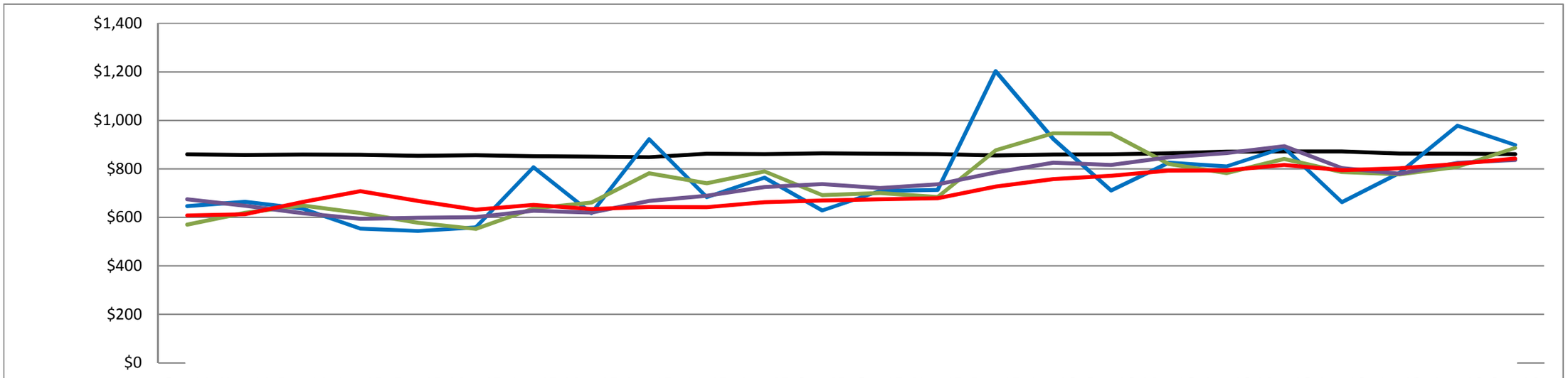
Month / Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Vision Claims	Subscriber Composite Claims*	Paid Loss Ratio
Oct-15							
Nov-15							
Dec-15							
Jan-16	699		6,225	$8.91	7,242	$10.36	116%
Feb-16	706		6,105	$8.65	6,148	$8.71	101%
Mar-16	693		6,117	$8.83	5,142	$7.42	84%
Apr-16	689		6,106	$8.86	4,613	$6.70	76%
May-16	704		6,252	$8.88	5,824	$8.27	93%
Jun-16	697		6,217	$8.92	5,106	$7.33	82%
Jul-16	707		6,234	$8.82	5,379	$7.61	86%
Aug-16	709		6,242	$8.80	5,756	$8.12	92%
Sep-16	706		6,207	$8.79	4,670	$6.61	75%
Total	**6,310**		**$55,705**	$9	**$49,880**	$7.90	90%
Average	**631**		**$5,571**	$9	**$4,988**	$8	

Subscriber Composite Claims

Source: Prominence unaudited Monthly Experience Report

Carson City

Premium as a Per Member Per Month & Claims as Per Member Per Month / Rolling 3-6-12 Month Averages



	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
PremPEPM	860	858	859	859	854	856	852	851	848	862	861	864	863	861	856	860	860	865	871	872	872	864	862	860
ExpPEPM	646	664	636	554	544	559	807	617	923	683	764	629	709	714	1,203	923	711	826	810	887	663	784	978	899
3MnthAvrg	570	619	649	618	578	552	637	661	782	741	790	692	701	684	877	947	946	820	783	841	787	778	809	887
6MnthAvrg	675	648	618	594	598	601	628	620	668	689	726	737	721	737	785	825	816	848	865	894	803	780	825	837
12MnthAvrg	608	613	664	708	668	632	651	634	643	642	662	669	674	679	727	758	771	793	794	816	794	803	821	843
PLR	71%	71%	77%	82%	78%	74%	76%	75%	76%	74%	77%	77%	78%	79%	85%	88%	90%	92%	91%	94%	91%	93%	95%	98%

~ as presented by Kevin Monaghan

Renewal & Market Survey Analysis

Prepared for

Carson City

Presented By

L/P Insurance Services, Inc.
Employee Benefits Division

Effective: July 1, 2017

Carson City
Medical Current, Renewal & Options

		CURRENT & RENEWAL									
CARRIER		**PROMINENCE**			**PROMINENCE**				**UNITED HEALTHCARE**		**HOMETOWN HEALTH**	
PLAN NAME		**HMO $1500**			**POS $1500**				**VK-4 Mod 5 (altered option)**		**PPO 40-CO 1500 A 1500x3**	
		In Network			**HMO In Network**	**PPO In Network**	**Out of Network**		**In Network**	**Out of Network**	**In Network**	**Out of Network**
Network		HealthFirst			HealthFirst	PHCN/First Health	N/A		UHC Choice	N/A	Hometown Health	N/A
Local Hospitals		Saint Mary's, Barton, CTRH			Saint Mary's, Barton, CTRH				Saint Mary's, Renown, Barton, CTRH		Renown, Barton, CTRH	
Annual Deductible - Per Member		$1,500			$1,500	$3,500	$4,500		$1,500	$3,000	$1,500	$3,000
Annual Deductible - Per Family		$4,500			$4,500	$10,500	$13,500		$4,500	$9,000	$4,500	$9,000
Inpatient Hospital Services		$1,500/Admit (d)			$1,000/Admit (d)	30% (d)	50% (d)		$1,500/Admit (d)	50% (d)	$1,500/Admit (d)	50% (d)
Same Day Sugery		$500			$400	30% (d)	50% (d)		$500	50% (d)	$500	50% (d)
Diagnostic Lab Services		No Charge			No Charge	30% (d)	50% (d)		No Charge	50% (d)	No Charge	50% (d)
Imaging Services												
Diagnostic X-Ray (Non-Hospital)		$50			$50	30% (d)	50% (d)		**No Charge**	50% (d)	$50	50% (d)
MRI/CT(Non-Hospital)		$100			$100	30% (d)	50% (d)		**$200**	50% (d)	$100	50% (d)
Complex Imaging (Non-Hospital)		$200			$200	30% (d)	50% (d)		$200	50% (d)	$200	50% (d)
Office Visits												
Telemedicine Services		$30			$20	$20	N/A		**$10**	50% (d)	**$40**	50% (d)
Primary Care		$40			$30	$40	50% (d)		$40	50% (d)	$40	50% (d)
Specialist		$60			$50	$60	50% (d)		$60	50% (d)	$60	50% (d)
Emergency Room		$150			$150	$150	$150		$150	$150	$150	$150
Urgent Care Center		$50			$50	$50	$50		$50	50% (d)	$50	50% (d)
Ambulance												
Air		$200			$200	$200	$200		$200	$200	$200	50% (d)
Ground		$200			$200	$200	$200		$200	$200	$200	50% (d)
Durable Medical Equipment												
Rental		$50 (d)			$50 (d)	30% (d)	50% (d)		**20% (d)**	50% (d)	$50 (d)	50% (d)
Purchase		$100 (d)			$100 (d)	30% (d)	50% (d)		**20% (d)**	50% (d)	**$50 (d)**	50% (d)
OOP Maximum - Calendar Year												
OOP Maximum - Per Member		$6,000			$6,000	$6,350*	$9,000		$6,000	$18,000	$6,000	$12,000
OOP Maximum - Per Family		$12,000			$12,000	$12,700*	$18,000		$12,000	$36,000	$12,000	$24,000
Prescription Benefit												
Tier 1		$15			$15	$15	30% (d)		$15	50% (d)	$15	**N/A**
Tier 2		$40			$40	$40	30% (d)		**$35**	50% (d)	$40	**N/A**
Tier 3		$60			$60	$60	30% (d)		$60	50% (d)	**$60 + AC**	**N/A**
Tier 4		20%			20%	20%	30% (d)		$60	50% (d)	20%	**N/A**
Mail Order Supply (90 days)		$30/$80/$180/20%			$30/$80/$180/20%		30% (d)		**$37.50/$87.50/ $150**	50% (d)	$30/$80/**$180+AC** 20%	**N/A**
Active & Retirees without Medicare		**Current**	**Renewal**		**Current**		**Renewal**		**Proposed**		**Proposed**	
Employee Only	**279**	$505.86	$541.51	**54**	$566.55		$606.24	**333**	$551.36		$581.92	
Employee + Spouse	**66**	$1,037.19	$1,110.26	**21**	$1,161.61		$1,242.98	**87**	$1,130.48		$1,193.15	
Employee + Child(ren)	**93**	$970.62	$1,039.00	**11**	$1,087.05		$1,163.20	**104**	$1,057.92		$1,116.57	
Employee + Family	**124**	$1,585.19	$1,696.88	**12**	$1,775.36		$1,899.72	**136**	$1,727.77		$1,823.54	
Retirees with Medicare												
Retiree with Medicare	**20**	$372.88	$398.56	**22**	$413.65		$442.18	**42**	$403.71		$428.95	
Retiree + Spouse both with Medicare	**3**	$791.10	$845.75	**4**	$878.66		$939.38	**7**	$857.13		$910.05	
Retiree + Spouse one with Medicare	**3**	$933.18	$998.46	**1**	$1,042.03		$1,114.67	**4**	$1,014.84		$1,073.50	
Retiree + Child(ren) with Medicare	**0**	$962.29	$1,030.04	**1**	$1,077.48		$1,152.92	**1**	$1,049.25		$1,106.98	
Retiree + Family two with Medicare	**0**	$967.14	$1,032.51	**0**	$1,064.73		$1,137.22	**0**	$1,041.50		$1,112.56	
Retiree + Family one with Medicare	**1**	$1,121.91	$1,198.88	**0**	$1,242.67		$1,328.16	**1**	$1,213.41		$1,290.60	
	589			**126**				**715**				
Monthly Premium by Plan		**$510,173**	**$546,101**		**$102,984**		**$110,184**		**$656,233**		**$692,786**	
Annual Premium by Plan		**$6,122,077**	**$6,553,215**		**$1,235,806**		**$1,322,213**		**$7,874,793**		**$8,313,432**	
$ above/(below) current			**$431,139**				**$86,407**		**$648,000**		**$1,086,638**	
% above/(below) current			**7.04%**				**6.99%**		**8.97%**		**15.04%**	

	Current	**Renewal**
Monthly Premium All Plans	**$613,870**	**$656,286**
Annual Premium All Plans	**$7,366,438**	**$7,875,429**
$ above/(below) current		**$508,991**
% above/(below) current		**6.91%**

Carson City
Dental - Benefits & Cost Comparison

CARRIER		PROMINENCE		STANDARD	
		In Network	Out of Network	In Network	Out of Network
Dental Network:		Dental Guard Preferred		DDS	
Reimbursement Type:		Neg Fee	UCR	Neg Fee	**MAC**
Calendar Year Deductible:					
Individual		$50		$50	
Family		$150		$150	
Coinsurance:					
Preventive		0%	0%	0%	0%
Basic		20% (d)	20% (d)	20% (d)	20% (d)
Major		45% (d)	45% (d)	45% (d)	45% (d)
Orthodontia (child & adult)		50%	50%	50%	50%
Contract Provisions					
Composite Fillings		Anterior only		Anterior only	
Implants		Not Covered		**Covered**	
Endo		Basic		Basic	
Perio		Basic		Basic	
Oral Surgery		Basic		Basic	
Missing Tooth Provision		Not Covered		Not Covered	
Annual Rollover Provision		Yes		Yes	
Annual Maximum:		$2,000		$2,000	
Lifetime Maximum:		$1,500		$1,500	
Rates:		**Current**	**Renewal**	**Proposed**	
Employee Only	370	$52.30	Coverage no longer offered by Prominence	$48.81	
Employee + Spouse	99	$73.56		$68.65	
Employee + Child(ren)	101	$93.02		$86.81	
Employee + Family	134	$114.28		$106.65	
	704				
MONTHLY PREMIUM		**$51,342**	-	**$47,915**	
ANNUAL PREMIUM		**$616,104**	-	**$574,980**	
$ above/(below) current			-	**-$41,124**	
% above/(below) current			-	**-6.67%**	
Rate Guarantee		**Renews 7/1/17**		**12 months (9% Renewal Cap)**	

Carson City
Vision - Benefits & Cost Comparison

CARRIER		VISION SERVICE PLAN			EYEMED	
Vision Network:		VSP Choice			EyeMed	
Frequency:						
Eye Examination		every 12 months			every 12 months	
Lenses		every 12 months			every 12 months	
Frames		every 24 months			every 24 months	
		In-Network		**Out-of-Network**	**In-Network**	**Out-of-Network**
Schedule of Benefits:						
Vision Exam		$25 copay		$45 allowance	**$20 copay**	**$40 allowance**
Single Vision Lenses		$25 copay		$30 allowance	$25 copay	$30 allowance
Bifocal Lenses		$25 copay		$50 allowance	$25 copay	$50 allowance
Trifocal Lenses		$25 copay		$65 allowance	$25 copay	**$70 allowance**
Lenticular Lenses		$25 copay		$100 allowance	$25 copay	**$70 allowance**
Progressive		$55-$175 copay		$50 allowance	**$90-$135** copay	$50 allowance
Anti-Reflective		$41 copay		N/A	**$68 copay**	N/A
Photochromics		$70 copay		N/A	**$75 copay**	N/A
Scratch Resistance		$17 copay		N/A	**$15 copay**	N/A
Polycarbonate		$31 copay		N/A	**$40 copay**	**$32 allowance**
Frames		$140 allowance		$70 allowance	$140 allowance	**$98 allowance**
Additional Glasses		20% Discount		N/A	**40% Discount**	N/A
Contact Lenses		$140 allowance		$105 allowance	$140 allowance	**$140 allowance**
Rates:		**Current**	**Initial Renewal**	**Revised Renewal**	**Proposed**	
Employee	370	$6.27	$7.78	$6.58	$3.85	
Employee + Spouse	99	$8.14	$10.10	$8.88	$7.33	
Employee + Child(ren)	101	$9.73	$12.07	$10.45	$7.71	
Family	134	$15.55	$19.29	$16.95	$11.34	
	704					
MONTHLY PREMIUM		**$6,193**	**$7,684**	**$6,642**	**$4,449**	
ANNUAL PREMIUM		**$74,322**	**$92,209**	**$79,702**	**$53,394**	
$ above/(below) current			**$17,887**	**$5,381**	**-$20,928**	
% above/(below) current			**24%**	**7%**	**-28.16%**	
Rate Guarantee				**24 Months**	**48 Months**	

Carson City
Life/AD&D - Current Cost & Benefits

GROUP LIFE/AD&D	STANDARD	
Eligibility	Active and Retired Employees	
Benefit Formula:	Life	AD&D
Class 1 - Unclassified and Elected Members	$35,000	$35,000
Class 2 - Sheriffs Personnel	$50,000	$10,000
Class 3 - Fire Members	$50,000	$10,000
Class 4 - All Other Active	$20,000	$20,000
Class 5 - Retired Members	$10,000	$10,000
Class 6 - Surviving Spouse	$500	$0
Dependents Class 1-5	$500	
Contributions		
Classes 1-5	Noncontributory	
Class 6	Contributory	
Dependent Life	Contributory	
Plan Features:		
Accelerated Death Benefit	**80%** of Benefit (12 Months Terminal)	
Repatriation	Lesser of $5,000 or 10% of Benefit	
Seat Belt Benefit	AD&D Benefit up to $10,000	
Air Bag Benefit	AD&D Benefit up to $5,000	
Child Care Benefit	Lesser of $10,000 or 25% of Benefit	
Line of Duty Benefit (Classes 2&3)	AD&D Benefit up to $50,000	
Travel Assistance	Included	
ID Theft Services	Not Included	
Conversion	Included	
Portability	Included	
Waiver of Premium	If disabled prior to age 60	
Benefit Reduction:		
at age 65	No reduction	
at age 70	65% of original benefit	
at age 75+	65% of original benefit	
RATES:	**Current**	**Renewal**
Volume	$19,880,875	$19,880,875
Life Rate per $1,000	$0.41	$0.26
AD&D Rate per $1,000	$0.04	$0.04
Depedent Life per Member	$0.30	$0.30
MONTHLY PREMIUM	$8,946	$5,964
ANNUAL PREMIUM	$107,357	$71,571
$ over/(under) current		-$35,786
% over/(under) current		-33.33%
Rate Guarantee		**24 months**

Prominence
Health Plan

City of Carson

July 2017

Renewal Election Form

Prominence
Health Plan

Large Group Renewal Election Form

Group Name:	Carson City		
Renewal Effective Date:	July 1, 2017	Broker Name:	Kevin Monaghan/LP Insurance
Group Number(s):	GRP0004227	Account Manager:	Joyce Toste

Please return the signed Renewal Election Form no later than the 5th of the month **prior** to the renewal. Changes may not be reflected on the renewal billing statement if received after the requested date. All renewals are contingent upon meeting the underwriting guidelines of Prominence Health Plan.

Please write the selected plan names below

Medical plan design:	1500 HMO 1540 (Custom)	1500 POS (Custom)
Pharmacy design	$15/40/60D	$15/40/60D

Rate Cap Agreement: 12% Maximum for Renewal Date - contract period 7/1/18 thru 6/30/19
This replaces the Rate Cap Agreement outlined in the 3/24/17 Service Agreement signed by David Livingston

After reviewing the renewal rates and selecting the plans shown above, we confirm that we intend to renew our health insurance benefit plan(s) through Prominence Health Plan effective on our renewal date.

We also acknowledge that we understand the signed Renewal Election Form must be received prior to the renewal effective date to avoid a disruption in coverage.

_____ _____
Company Authorized Officer (please print) (Date)

_____ _____
Title Please provide email address

_____
Signature

Please e-mail the signed completed form to joyce.toste@uhsinc.com

Prominence
Health Plan

City of Carson

July 2017

Service Level Agreement

Prominence℠
Health Plan

March 24, 2017

Ms. Melanie Bruketta, JD, SHRM-SCP, IPMA-SCP
Carson City Human Resources Director
201. N. Carson Street, #3
Carson City, NV 89701

RE: July 1, 2017 Renewal & Service Level Agreement

Dear Ms. Bruketta:

Prominence Health Plan appreciates the opportunity to provide Carson City members with their health care needs in the coming plan year effective July 1, 2017. We are committed to providing high quality health care at an affordable price while being dedicated to improving quality and the customer service experience. Carson City members will have direct access to the PHP Member Services Department located in Reno, NV effective 4/1/17. Our Renewal, Wellness and Service Level Agreement offer is outlined below.

July 1, 2017 Renewal

1. Renewal rates representing a 7% increase across the current plans effective 7/1/17, subject to any Federal and/or State mandated changes.

Wellness Services

1. Prominence Health Plan will provide the biometric wellness screening at the 2017 Carson City health fair at no cost to Carson City members.
2. Prominence Health Plan will provide a 2017 flu shot clinic for Carson City members at no cost to Carson City.
3. Prominence Health Plan will provide a comprehensive wellness program including coaching by January 1, 2018.

The failure of Prominence Health Plan to perform the Wellness Services listed above by January 1, 2018 shall result in a monetary penalty of $5000.00 per item with a maximum of $15,000.00 to be payable by April 1, 2018.

Rate Cap/Reporting
Effective July 1, 2018, a renewal rate cap will be provided as follows subject to any Federal and/or State mandated changes:

<85% Loss Ratio	8%
<90% Loss Ratio	12%
>90% Loss Ratio	Negotiated

A monthly incurred reporting package will be provided to LP Insurance.

Service Guarantee
Prominence Health Plan will provide the following Service Guarantee to Carson City members when the member is encountering a service issue that requires escalation. Service classification will be prioritized based on the initial notification and nature of the service issue. The Account Manager, Joyce Toste, will be responsible for identifying and prioritizing, and assisting with resolution of the issue.

1. A PHI form must be executed which clearly authorizes the caller to act on the member's behalf, when applicable. This is required for each member.
2. Information required with initial call should include the Member Name, Date of Service, Provider Name and Issue.
3. Priority and TAT: Prominence Health Plan's goal is to provide a TAT less than the maximum shown below depending on the complexity of the issue.

Priority Level	Maximum Turnaround Time	Examples
Level 1	2 Days	Case Management Request Authorization Delay & Status Escalated Med/Rx Claim Issues STAT Appeal Inquiries
Level 2	4 Days	Employer Portal Issues ER Claim Inquiries Incorrectly Processed Claims Packet Orders Wellness Requests

The failure of Prominence Health Plan to perform the services outlined in the Service Guarantee section above within the designated time frame, where applicable, shall result in a monetary penalty as follows:

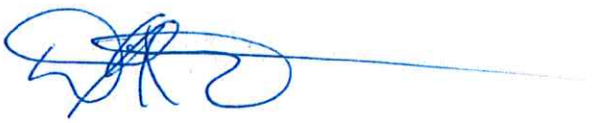
Level 1: After two incidents per quarter, the penalty shall be $500.00 per incident with a maximum quarterly penalty of $5,000.00 to be payable within 90 days of the end of incident quarter.

Level 2: After two incidents, the penalty shall be $500.00 per incident with a maximum annual penalty of $10,000.00 to be payable by October 1, 2018.

Penalties do not apply to provider performance or events that are out of the control of Prominence Health Plan (power outages, natural disasters, system failures).

Prominence Health Plan values our relationship with Carson City and we remain committed to being the partner of choice by delivering high quality cost-effective health care services and customer service excellence.

Regards,



David K. Livingston
Chief Executive Officer
Prominence Health Plan

cc: LP Insurance-Kevin Monaghan

Prominence
Health Plan

City of Carson

July 2017

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) 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.

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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: David K. Livingston
Title: CEO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

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Medical Plan Addendum
Schedule of Insurance Rates
City of Carson City

This Schedule of Insurance Rates Addendum dated July 1, 2017 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)
   b. Rx $15/40/60D
   c. Vision: None
   d. Domestic Partnership: Yes

2. **Term of the Contract:**
   a. Effective Date: July 1, 2017
   b. Termination Date: June 30, 2018

3. **Termination of the Contract:**
   a. Anniversary Date: July 1, 2018

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
Employee	$541.51
Employee & Spouse*	$1,110.26
Employee & Child(ren)*	$1,039.00
Employee & Family*	$1,696.88

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Tier: Retiree	Medical & Rx
Single without Medicare	$541.51
Single with Medicare	$398.56
Retiree & Spouse w/o Medicare*	$1,110.26
Retiree & Spouse both w/ Medicare*	$845.75
Retiree & Spouse one w/ Medicare*	$998.46
Retiree & Child(ren) w/o Medicare*	$1,039.00
Retiree & Child(ren) w/ Medicare*	$1,030.04
Retiree & Family w/o Medicare*	$1,696.88
Retiree & Family two with Medicare*	$1,032.51
Retiree & Family one with Medicare*	$1,198.88

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

Tier	Medical & Rx
Employee	$606.24
Employee & Spouse*	$1,242.98
Employee & Child(ren)*	$1,163.20
Employee & Family*	$1,899.72

Tier: Retiree	Medical & Rx
Single without Medicare	$606.24
Single with Medicare	$442.18
Retiree & Spouse w/o Medicare*	$1,242.98
Retiree & Spouse both w/ Medicare*	$939.38
Retiree & Spouse one w/ Medicare*	$1,114.67
Retiree & Child(ren) w/o Medicare*	$1,163.20
Retiree & Child(ren) w/ Medicare*	$1,152.92
Retiree & Family w/o Medicare*	$1,899.72
Retiree & Family two with Medicare*	$1,137.22
Retiree & Family one with Medicare*	$1,328.16

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

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b. Effective Month: July
c. Effective Day: 1
d. Effective Year: 2017
e. Termination Date: June 30, 2018

7. General Provisions:

a. Broker of Record: LP Insurance Services

For Prominence Health Plan:

Name: David K. Livingston
Title: CEO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

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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) 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.

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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: David K. Livingston
Title: CEO

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, 2017 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)
   b. Rx $15/40/60D
   c. Vision: None
   d. Domestic Partnership: Yes

2. **Term of the Contract:**
   a. Effective Date: July 1, 2017
   b. Termination Date: June 30, 2018

3. **Termination of the Contract:**
   a. Anniversary Date: July 1, 2018

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
Employee	$541.51
Employee & Spouse*	$1,110.26
Employee & Child(ren)*	$1,039.00
Employee & Family*	$1,696.88

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Tier: Retiree	Medical & Rx
Single without Medicare	$541.51
Single with Medicare	$398.56
Retiree & Spouse w/o Medicare*	$1,110.26
Retiree & Spouse both w/ Medicare*	$845.75
Retiree & Spouse one w/ Medicare*	$998.46
Retiree & Child(ren) w/o Medicare*	$1,039.00
Retiree & Child(ren) w/ Medicare*	$1,030.04
Retiree & Family w/o Medicare*	$1,696.88
Retiree & Family two with Medicare*	$1,032.51
Retiree & Family one with Medicare*	$1,198.88

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

Tier	Medical & Rx
Employee	$606.24
Employee & Spouse*	$1,242.98
Employee & Child(ren)*	$1,163.20
Employee & Family*	$1,899.72

Tier: Retiree	Medical & Rx
Single without Medicare	$606.24
Single with Medicare	$442.18
Retiree & Spouse w/o Medicare*	$1,242.98
Retiree & Spouse both w/ Medicare*	$939.38
Retiree & Spouse one w/ Medicare*	$1,114.67
Retiree & Child(ren) w/o Medicare*	$1,163.20
Retiree & Child(ren) w/ Medicare*	$1,152.92
Retiree & Family w/o Medicare*	$1,899.72
Retiree & Family two with Medicare*	$1,137.22
Retiree & Family one with Medicare*	$1,328.16

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

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b. Effective Month: July
c. Effective Day: 1
d. Effective Year: 2017
e. Termination Date: June 30, 2018

7. General Provisions:

a. Broker of Record: LP Insurance Services

For Prominence Health Plan:

Name: David K. Livingston
Title: CEO

For Group: City of Carson City

Name: Robert L. Crowell
Title: Mayor

Date_____

Prominence
Health Plan

City of Carson

July 2017

Retiree Addendum

Prominence
Health Plan

Retiree Addendum

Prominence Health Plan

City of Carson City

This Addendum dated **July 1, 2017** 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, 2017**
   b. Termination date: **June 30, 2018**

2. Termination of the Contract:
   a. Anniversary Date: **July 1, 2018**

3. Additional Retiree Language:

Retiree Group Health coverage is provided in accordance with the group Retirement Policy.

   a. Effective Month: **July**
   b. Effective Day: **1**
   c. Effective Year: **2017**
   d. Termination date: **June 30, 2018**

4. General Provisions:
   a. Broker of Record: **LP Insurance**

For Prominence Health Plan:

Name: David K. Livingston
Title: CEO

For Group: **City of Carson City**

Name: **Robert L. Crowell**
Title: **Mayor**

Date_____

FORM#: SMHF-129277341
APPROVAL DATE: 12/09/13
DISTRIBUTION DATE: 01/01/14

Prominence
Health Plan

City of Carson

July 2017

Self-Bill Amendment
Continuation of Agreement

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: 5/12/11	Date: 8-8-11

Prominence
Health Plan

City of Carson

July 2017

Master Application from July 2013

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: 552
Employees waiving without other coverage: 8
Employees waiving with other coverage: 14
Employees in waiting period: 14

COBRA participants enrolling: 3
Employees on other company sponsored plans: 0
Total eligible employees: 569
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 31 (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 60 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	7-1-12	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	Dental plan	Vision plan
1. 1500 HMO 1540		☐ Plan 1	☐ Yes
2. 1500 POS 1030/2040		☐ Plan 2	☐ No
3.	1540/600	☐ Plan 3	
4.		☐ None City of Carson PPO Dental Plan	
6.		Domestic Partner: ☐ No ☒ Yes	
Association (if Applicable):		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.

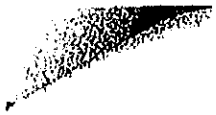
Mediation before Litigation
Group and Preferred Health Insurance Company, agree to first mediate prior to resort to the courts, the disputes described below pursuant to the procedures set forth herein. Group understands that each member/enrollee may decline to participate in Mediation, and that by agreeing 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 Barketto Title: HR Director
(signature of authorized company officer)

Printed Name: Melanie Barketto

1510 Meadow Wood Lane, Reno, Nevada 89502-6503 (775) 770-5055
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.

Carson City

July 1, 2017

Insurance Coverage Requested:

Dental/Employees and Dep(s)

Dental/Orthodontia

Rates:

Employee (EE):	$48.81
EE + Spouse:	$68.65
EE + Children:	$86.81
EE + Spouse + Children:	$106.65

By signing below, Carson City agrees to the above plan and rates.

_____

Signature of Authorized Representative

_____

Title of Authorized Representative

_____

Printed Name

Count on The Standard

Over the course of a century, Standard Insurance Company has earned a reputation for personal service, financial strength and high quality insurance products. From our home office staff to the sales and service representatives in our local offices across the country, everyone at The Standard is dedicated to helping you by providing creative and effective solutions to meet your employee benefit needs.

Simple: Making it easy for you

Whether you have two eligible employees or thousands, we put all our strengths to work to help you create a cost-effective benefits package - for you and for them.

Find the benefits you want and need. We offer understandable, comprehensive products configured to meet your needs. You'll find a full range of disability, life, dental and vision insurance, individual and voluntary insurance products, and retirement plans.

Comprehensive contract pricing and no surprises. We strive to offer the best value, going beyond the formulas, using a long-term pricing philosophy.

Dedicated contacts — no outsourced call centers. Our experienced employees deliver strong, empathetic and personalized service. We pride ourselves on our expert claims-handling, accurate, fair and prompt payments, and clear, accessible appeals process.

Account support tailored for you. You'll enjoy customized administration, implementation and enrollment services. And you'll benefit from insightful reporting, industry benchmarking and program recommendations.

Local: Supporting you where you do business

We have over 40 offices across the nation to serve our customers. Our representatives are committed to their communities and have an insider's understanding of local needs.

Dependable: A track record you can trust

- **More than 100 years** of history and **five decades** of employee benefits experience
- More than **27,100** group insurance policies in force with over **$1.8 billion** in force premium[1]
- Recognized as a **top 10** provider of group Long Term, Short Term Disability and Life insurance based on in force premium[2]
- Over **91%** of our business is employee benefits, letting us focus on what our customers really need
- Our **first group insurance customer** is still with us - after 58 years

[1] Figures are as of June 30, 2009 and are based on internal data developed by Standard Insurance Company. Reinsurance assumed is excluded. Certain statistics are unaudited.

[2] 2008 U.S Group Disability Market Survey, JHA and U.S Group Life Sales and In Force 2008 Annual Results, LIMRA International. These findings used combined data for StanCorp Financial Group's insurance subsidiaries, Standard Insurance Company and The Standard Life Insurance Company of New York.

City of Carson City
Dental Highlight Sheet

Plan 1: Dental Plan Summary **Effective Date: 7/1/2017**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	55%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$2,000 per calendar year
Allowance	Discounted Fee
Max Builder[SM]	Included
Waiting Period	None
Annual Eye Exam	None
LASIK Assist[SM]	None
Annual Open Enrollment	None

Orthodontia Summary - Adult and Child Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,500
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Restorative Amalgams	• Onlays
• Bitewing X-rays (2 in 12 months)	• Restorative Composites	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Endodontics (surgical)	• Denture Repair
• Cleaning (1 in 6 months)	• Periodontics (nonsurgical)	• Implants
• Fluoride for Children 18 and under (1 in 6 months)	• Periodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Sealants (age 16 and under)	• Simple Extractions	
• Space Maintainers	• Complex Extractions	
	• Anesthesia	

Monthly Rates

Employee (EE)	$48.81
EE + Spouse	$68.65
EE + Children	$86.81
EE + Spouse + Children	$106.65

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

City of Carson City
Dental Highlight Sheet

eCard

Once you are enrolled in the plan, your plan participant ID card is provided electronically. Access your eCard online by creating a Secure Member Account – it's fast, easy and secure. Go to standard.com, click on log in (at top right). Enrolled participants may receive care without the card just by giving the provider their name, date of birth, and social security number/member identification number.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$400	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$200	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,200	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose the network found on your ID Card.

City of Carson City
Dental Highlight Sheet

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

City of Carson City
Dental and (if applicable) Orthodontia Exclusions

Covered Expenses will not include and no benefits will be payable for expenses incurred:

- for any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance, or who elects to become covered again after canceling a premium contribution agreement, will be classified as a late entrant.
- for any treatment which is for cosmetic purposes, except as specifically listed in the Table of Dental Procedures.
- to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan participant is covered under the dental expense benefit, it will be a Covered Expense.
- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan participant is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the plan participant was covered under the dental expense benefit.
- for any procedure begun after the participant's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the participant's insurance under the dental expense benefit terminates.
- to replace lost or stolen appliances.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion;
  - splint or replace tooth structure lost because of abrasion or attrition
- for any procedure which is not shown on the Table of Dental Procedures.
- for orthodontic treatment (unless otherwise specified in this contract.)
- for which the plan participant is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
- for charges for which the plan participant is not liable or which would not have been made had no insurance been in force.
- for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- in any quarter of a Program if the participant was not covered under the orthodontic expense benefits for the entire quarter.
- after the participant's insurance under the orthodontic expense benefits terminates.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section is based upon the *Current Dental Terminology* © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- X-ray images, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145 also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180 also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 36 month(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 12 month(s).
- D0277 also contribute(s) to this limitation.

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910 also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Not allowed when done on the same date as periodontal services.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per 36 month(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cement or re-bond space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911 also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.
D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911 also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2929 Prefabricated porcelain/ceramic crown - primary tooth.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT
- D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
- D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
- D2920 Re-cement or re-bond crown.
- D2921 Reattachment of tooth fragment, incisal edge or cusp.
- D6092 Re-cement or re-bond implant/abutment supported crown.
- D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
- D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING
- D2940 Protective restoration.
- D2941 Interim therapeutic restoration - primary dentition.

ENDODONTICS MISCELLANEOUS
- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920
- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)
- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, bicuspid tooth.
- D3330 Endodontic therapy, molar.
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - bicuspid.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332
- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348
- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330 also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS

TYPE 2 PROCEDURES

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - bicuspid (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.

TYPE 2 PROCEDURES

D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER PERIODONTAL SERVICES

D4910 Periodontal maintenance.

OTHER PERIODONTAL SERVICES: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120 also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - deciduous tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.

TYPE 2 PROCEDURES

D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for deep sedation or general anesthesia.
D9223 Deep sedation/general anesthesia - each 15 minute increment.
D9243 Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment.

GENERAL ANESTHESIA: D9223, D9243

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9223 or D9243) will be considered.

TYPE 2 PROCEDURES

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.

D9440 Office visit - after regularly scheduled hours.

D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.

D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.

D2951 Pin retention - per tooth, in addition to restoration.

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990 also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic substrate.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.

TYPE 3 PROCEDURES

D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

TYPE 3 PROCEDURES

D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D6010, D6040, D6050 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

DENTURE REPAIR

D5510 Repair broken complete denture base.

D5520 Replace missing or broken teeth - complete denture (each tooth).
D5610 Repair resin denture base.
D5620 Repair cast framework.
D5630 Repair or replace broken clasp-per tooth.
D5640 Replace broken teeth - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL
D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES
D5730 Reline complete maxillary denture (chairside).
D5731 Reline complete mandibular denture (chairside).
D5740 Reline maxillary partial denture (chairside).
D5741 Reline mandibular partial denture (chairside).
D5750 Reline complete maxillary denture (laboratory).
D5751 Reline complete mandibular denture (laboratory).
D5760 Reline maxillary partial denture (laboratory).
D5761 Reline mandibular partial denture (laboratory).

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.

IMPLANT: D6010, D6040, D6050

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits for procedures D6051, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6056 and D6057 are limited to 1 of any of these procedures per 5 years.

IMPLANT SERVICES
D6052 Semi-precision attachment abutment.
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.

TYPE 3 PROCEDURES

D6095 Repair implant abutment, by report.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.

IMPLANT SERVICES: D6052, D6080, D6090, D6091, D6095, D6100, D6190

- Coverage for D6080 is limited to 1 in a 12 month period. Coverage for D6090, D6091, D6052 and D6095 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.

TYPE 3 PROCEDURES

D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

TYPE 3 PROCEDURES

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 60 month(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953

- Each quadrant is limited to 1 of any of these procedures per 5 year(s).

TYPE 3 PROCEDURES

- Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

New Business Submission Checklist – Dental and Vision Only

Thank You for choosing The Standard for your Employee Benefits needs.

Your local Employee Benefits Sales and Service Team are here for you, as your first point of contact.

Your San Francisco Sales and Service Office

Account Manager/ Account Specialist:	Linda French	**Phone:**	925-280-5306	**Email:**	linda.french@standard.com
Sales Rep:	Josh Levine	**Phone:**	925-280-5307	**Email:**	josh.levine@standard.com

Checklist

☒ **Application for Group Insurance**.
Please review your application and verify it has been completed in its entirety (ensure Active Work is initialed, effective date is included, signature and date present, etc.).

☒ **First Premium Payment** (based upon premium information from the sold proposal).
Please make the check payable to Standard Insurance Company, and submit to your local Sales Office.

☒ **Complete Census - Please e-mail census to your Standard Account Manager/Specialist in Microsoft Excel format.**

- Employee's First and Last name
- Social Security Number
- Date of Birth
- Gender
- Date of Hire
- Occupation
- Home Address
- Dependent elections with names
- Dependent relationship (child, spouse, domestic partner)
- Dates of birth of each dependent electing coverage.

Policyholder Information

Policy #: 755240

Group Name City of Carson City **Employer Federal Tax ID #:** 88-6000189 *(9 digits)*

Effective Date of Coverage: 7 1 2017

Physical Address: 201 N. Carson St. Suite 4, Carson City, NV 89701

Form of Organization

☐ C-Corporation
☐ Limited Liability Company
☐ S-Corporation
☐ PC - Professional Corporation (taxed as a C-Corporation)
☐ Labor Union Health Benefit Trust
☐ Sole Proprietorship
☐ Partnership
☐ PC - Professional Corporation (taxed as an S-Corporation)
☐ School District
☒ Government / Public Unit
☐ Association (Requires UW Approval)
☐ Trust (Requires UW Approval)
☐ Other (Please explain in the Notes field)

New Business Submission Checklist – Dental and Vision Only

Contact Information

Executive Correspondence Contact:

☐ Mr. ☐ Mrs. ☒ Ms. Name: Melanie Bruketta Title: Human Resources Director
Phone: 775-283-7088 Email: mbruketta@carson.org
Mailing address if different from above:

Administrative/Claims Contact: ☐ Same as Executive ☐ Same as TPA

☐ Mr. ☐ Mrs. ☒ Ms. Name: Jacque Cassinelli Title: HR Generalist Benefits
Phone: 775-283-7043 Email: jcassinelli@carson.org
Mailing address if different from above:

Billing Contact: ☐ Same as Executive ☒ Same as Administrative / Claims ☐ Same as TPA

☐ Mr. ☐ Mrs. ☐ Ms. Name: Title:
Phone: Email:
Mailing address if different from above:

Which contact should be used for your online Policy Administration tool? (Select one)

☐ Executive ☒ Administrative / Claims ☐ Billing ☐ Other (Please provide contact information in the Notes field)

Do you use a Third Party Administrator (TPA)? If YES, please provide the following information:
TPA Function: ☐ Billing ☐ Administrative / Claims ☐ Other:
TPA Name: Contact Name:
Address:
Phone: Email:

Do you have any Affiliates? If YES, please provide the following information:

(If more than two Affiliates, please include additional information in the Additional Notes & Comments section.)

Affiliate Name:
Org. Type: Nature of Business:
Federal Tax ID #: Address:
Contact Name: Title:
Phone: Email:

Affiliate Name:
Org. Type: Nature of Business:
Federal Tax ID #: Address:
Contact Name: Title:
Phone: Email:

Billing Information

List Bill - The Standard provides a detailed monthly bill identifying each employee, and premium by line of coverage.

Billing Frequency will be on a monthly basis. If you require something different, please specify:

Billing grace period will be 31 days *or other per State Requirement*.
If you require something different, please specify : Days. *Note: This request may require underwriting approval*

Notice of Renewal will be 31 days *or other per State Requirement***.**
If you require something different, please specify: Days *Note: This request may require underwriting approval.*

New Business Submission Checklist – Dental and Vision Only

Billing Options

Do you require separate bills by location or billing class? ☒ NO ☐ YES (*If yes, please select one billing option below):*

☐ **One Bill sent to one address showing Separate Billing Classes** (to be sent to Billing Contact specified on page 2)
Please indicate the employee's Billing Class on the Census.

Billing Class Name: _____
Billing Class Name: _____
Billing Class Name: _____
Billing Class Name: _____
Billing Class Name: _____

☐ **Multiple Bills** (to be sent to separate addresses showing Separate Billing Divisions).
Please discuss this billing option with your Account Specialist/Manager and indicate the employee's Billing Division on the Census.

1. Billing Division Name: _____ Contact Name: _____
   Phone: _____ Address: _____
2. Billing Division Name: _____ Contact Name:
   Phone: _____ Address: _____
3. Billing Division Name: _____ Contact Name: _____
   Phone: _____ Address: _____
4. Billing Division Name: _____ Contact Name:
   Phone: _____ Address: _____
5. Billing Division Name: _____ Contact Name: _____
   Phone: _____ Address: _____

ERISA Information*

*ERISA info is required except for religious or public groups. For more information about ERISA, please contact your Account Specialist/Manager.

Plan year ends on: _____ (mm dd)

Plan numbers for: (i.e. 501, 502, etc.) Dental _____ Vision _____

Certificates / Policies / Dental I.D. Cards

Are separate Certificates by class needed? ☒ YES ☐ NO

Certificates, in PDF format, will be provided electronically through your online policy administration tool.

Are printed certificates needed? ☐ YES ☒ NO

Dental I.D. cards will be provided electronically.

Definition of a Member/Spouse/Dependent

How many hours per week must an active/regular employee work to be considered a member? 30 hours per week

Note: This request may require underwriting approval if different from what was originally proposed.

Are you **including** anyone that **DOES NOT** meet the Definition of a Member above? (e.g. grandfathered, retired employees, etc.)

☐ YES *If yes, please provide details:* _____

☒ NO

Are you **excluding** anyone from coverage that **MEETS** the Definition of a Member above?

☐ YES *If yes, please provide details:* _____

☒ NO

If your state recognizes domestic partners, would you like to cover domestic partners in your policy?

☒ YES

☐ NO

Unmarried children are eligible THROUGH age: 26

Full time student, unmarried children are eligible THROUGH age: 26

**Please note that domestic partner language will automatically be included if required under state law. If you prefer an expanded definition, beyond the state required minimum, please specify in the Additional Notes & Comments Section.*

*Please note that civil union partners will automatically be included if required under state law.

Credit Time Served

How do you credit time served for employees that do not currently meet the Definition of a Member for coverage, but at some point in the future have a status change that meets the Member definition? Example changes: Part-time to full-time, hourly to salaried, union to non-union.

☐ Employee Eligibility Waiting Period begins the date of the status change. (Default if "No Waiting Period" option is selected below.)

☐ Employee Eligibility Waiting Period is shortened by the period of time the employee was employed before he or she met the Member Definition (credit prior service).

Eligibility Waiting Period

Eligibility Waiting Period for Current Employees (select one):

☐ All are eligible regardless of length of service. (Default if "No Waiting Period" option is selected below.)

☒ Only those who have satisfied the waiting period as selected below are eligible. (Date of Hire required on census)

Eligibility Waiting Period for New Employees hired after policy effective date (select one):

☒ First of the month coinciding with or next following 60 days as a member
Example using 30 days: Date of hire 4/1, employee effective date is 5/1. Date of hire 4/2, employee effective date is 6/1

☐ First day after _____ days as a member

☐ First day of the month following date of hire

☐ First day of the month coinciding with or next following becoming a member
Example: Date of hire 4/1, employee effective date is 4/1. Date of hire 4/2, employee effective date is 5/1

☐ No waiting period

☐ Check here if you require employees to be enrolled in your medical plan to participate in The Standard's plan(s).
What is your medical plan waiting period _____
For future EE's: Will the group provide eligibility effective dates or dates of hire? _____

☐ Other (if a different Eligibility Waiting Period is requested for each coverage or Class, please describe in detail):

_____

New Business Submission Checklist – Dental and Vision Only

Premium Contributions

Will the Employer pay 100% of the premium for all coverage(s) requested?

☐ YES ☒ NO

If NO, what percentage of premium does the employer pay?

99 % Dental Employee _____ % Vision Employee

65 % Dental Dependent _____ % Vision Dependent

If contributory coverage(s) and not otherwise indicated on the census, the total number of ELIGIBLE members is:_____.

If non-contributory coverage(s) are waivers allowed for other coverages?:_____.

Section 125 Participation (if applicable)

Is the employee portion of the premium paid through a **Section 125** / Premium Only Plan?

If a dental and/or vision plan is voluntary, typically 100% employee paid, a Section 125 plan is required.

☒ YES

☐ NO

If yes, which coverage(s) are included in the Section 125 plan?

☒ Dental

☐ Vision

What is the Section 125 plan year?

☐ Calendar year (January-December)

☒ Other: 07/01 (mm dd)

What is the Section 125 election period?

Begins: 05/01 (mm dd) Ends: 6/30 (mm dd)

Dental and/or Vision Premium (if applicable)

Will The Standard administer COBRA for Dental or Vision?

☐ YES *If Yes, there may be a rating impact if not included at the time of proposal.*

☒ NO

Employee Termination (select one):

☒ End of Month

☐ Immediate

☐ Other (if a different termination is requested for each coverage or Class, please describe in detail):

If non-contributory coverage(s) are employee waivers allowed: ☐ Yes ☐ No

New Business Submission Checklist – Dental and Vision Only

Broker / Commission Information

Broker 1:

Name: Kevin Monaghan Firm Name: LP Insurance Services

Phone: _____ E-mail: _____

Commission level: ☐ Escale ☐ Flat _____ % ☒ None ☐ Other

Commission split (by product): _____

Commissions payable to: ☐ Firm ☐ Individual Producer ID: _____
To be filled out by Standard

Are commissions the same for dental and vision? ☐ Yes ☐ No If no, explain _____

Broker 2:

Name: _____ Firm Name: _____

Phone: _____ E-mail: _____

Commission level: ☐ Escale ☐ Flat _____ % ☐ None ☐ Other

Commission split (by product): _____

Commissions payable to: ☐ Firm ☐ Individual Producer ID: _____
To be filled out by Standard

Are commissions the same for dental and vision? ☐ Yes ☐ No If no, explain _____

Additional Notes & Comments:

Thank you again for choosing The Standard. We look forward to partnering with you and delivering on our promise to provide the highest quality of service for your employees' needs.

For Sales and Service Office Use Only:
Approvals, Notes & Customization:

STANDARD INSURANCE COMPANY
Employee Benefits - Underwriting
900 SW Fifth Ave. Portland, OR 97204-1282

Application for Group Insurance

Please type or print

REQUESTED EFFECTIVE DATE 7/1/2017

APPLICANT

Full Legal Name of Group (Exactly as it is to be shown in the policy.)

City of Carson City

Street Address **201 N. Carson Street, Ste 4**

City **Carson City** State **NV** Zip Code **89701**

Phone No. (**775**) **283-7043** Fax No. (**775**) **887-2067** Email **jcassinelli@carson.org**

Group Contact **Jacque Cassinelli** Contact's Title **HR Generalist - Benefits**

Contact's Phone No. if different (**775**) **283-7043** Contact's Fax No. if different (**775**) **887-2067**

Nature of Business **Government**

INSURANCE COVERAGE REQUESTED

☐ Life Only	☐ Supplemental Life	☐ Dental/Employees	☐ LTD with Transitional Duty Agreement	
☐ Life and AD&D	☐ Additional/Optional Life	☑ Dental/Employees and Dep(s)	☐ LTD	☐ Accident*
☐ Dependent Life	☐ Stand Alone AD&D	☑ Dental/Orthodontia	☐ STD	☐ Critical Illness*
		☐ Eye Care	☐ _____	☐ Hospital Indemnity*

**I understand and agree if Applicant utilizes an enrollment platform not directly supported by The Standard, that Applicant is required to and will timely present to each enrollee appropriate disclosures and any state mandated fraud notices which are contained on the supplied enrollment form.*

OTHER INSURANCE

A. Does this insurance supplement other insurance? ☐ Yes ☑ No
If yes, specify for each line of coverage and Insurance Carrier: _____

B. Does this insurance replace existing insurance? ☑ Yes ☐ No
If yes, specify for each existing line of coverage: **Prominence Dental**

- Please submit a copy of each in force policy, certificate or plan document.

Effective date of Prior Plan: **7/1/2013** Termination date of Prior Plan: **6/30/2017**

ACTIVE WORK REQUIREMENT: A person must meet an Active Work requirement to become insured. Members who have not met an Active Work requirement are not insured until returning to work for one full day and meeting all other contractual requirements.
Initial: MB

Note: Some members who do not meet an Active Work requirement may be eligible for Waiver of Premium with a prior carrier.

***APPLICANT AGREES THAT:* I hereby apply for Group Insurance as provided in the attached proposal.**

The above information is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance.

If the requested insurance is acceptable to Standard Insurance Company under its current rules and practices and is legally permissible, a Group Policy will be issued in the language customarily used by Standard. It will be effective on the date determined by Standard. No producer has the authority to guarantee the acceptability of the requested insurance.

Standard may issue separate Group Policies if more than one coverage is requested in this Application. The insurance, if approved, will be subject to Standard Insurance Company's usual underwriting requirements, including the exclusions and limitations in the Group Policy and, if applicable, Evidence Of Insurability. The effective date of insurance for which a person is required to submit satisfactory Evidence Of Insurability will be determined in accordance with the terms of the Group Policy, subject to the Active Work requirement. No premiums will be collected or paid by the Applicant for such insurance until notification of approval.

No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard Insurance Company.

Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.

The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.

This Application is made a part of the Group Policy.

Applicant authorizes the producer, broker of record, or consultant to receive information regarding the applicant's claims status and experience that the applicant has a right to receive and which is reasonably necessary to assist the applicant in conducting a review of the information.

Melanie Bruketta
Signature and Title of Applicant's Authorized Representative

4-21-17
Date

(Must be signed or submitted prior to the requested effective date.)

Initial Deposit $ _____

STANDARD INSURANCE COMPANY
Employee Benefits - Underwriting
900 SW Fifth Ave. Portland, OR 97204-1282

Receipt for Initial Deposit

Received from _____, an initial deposit of $ _____* in connection with the Application for Group Insurance bearing the same date as this conditional receipt.

Date_____
This receipt is subject to the terms and conditions below.
Received By

_____ _____
Name Title

*All premium checks must be made payable to Standard Insurance Company.
Do not make check payable to the producer or leave payee blank.

Terms of Receipt (Please read carefully.)

If the requested insurance is acceptable to Standard Insurance Company under its current rules and practices and is legally permissible, a Group Policy will be issued in the language customarily used by Standard. It will be effective on the date determined by Standard. No producer has the authority to guarantee the acceptability of the requested insurance.

Standard may issue separate Group Policies if more than one coverage is requested in this Application. The insurance, if approved, will be subject to Standard Insurance Company's usual underwriting requirements, including the exclusions and limitations in the Group Policy and, if applicable, Evidence Of Insurability. The effective date of insurance for which a person is required to submit satisfactory Evidence Of Insurability will be determined in accordance with the terms of the Group Policy, subject to the Active Work requirement. No premiums will be collected or paid by the Applicant for such insurance until notification of approval.

No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard insurance Company

Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.

The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.

This Application is made a part of The Group Policy.

Request for Group Insurance Amendment

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1282

Employee Benefits Consultant: Josh Levine
Employee Benefits Service Representative: Linda French
Employee Benefits Sales and Service Office: San Francisco

Employer Name: City of Carson City
Group Number: 602813

As an authorized representative of the Employer, I request that Standard Insurance Company ("The Standard") amend the above Employer's coverage under the Group Policy to make the following change(s):

Life:

Increase current Accelerated Benefit to 80%;
Add Expanded AD&D benefits to Classes 1 through 5; and
New rates: 0.260/.04. Rate Guarantee is 2 years.

I request that the amendment become effective on 07/01/2017. I understand that the amendment will not become effective unless approved and issued by The Standard.

I request that the amendment be approved by The Standard subject to The Standard's usual underwriting requirements, including, if applicable, Evidence of Insurability or a Pre-existing Condition provision.

I understand that the amendment, if approved by The Standard, will be issued in the policy language customarily used by The Standard.

I understand that any increase in Insurance for a Member who is not Actively At Work all day on the Member's last regular work day before the scheduled effective date of the amendment will be deferred until the first day after the Member completes one full day of Active Work.

I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Sign Name: _____ Title: _____
Authorized Representative

Print Name: _____ Date: _____

City of Carson City

July 1, 2017

Plan/Benefit Design: $20/$0 12/12/24

Rates:

Subscriber:	$3.85
Subscriber + Spouse:	$7.33
Subscriber + Child(ren):	$7.71
Subscriber + Family:	$11.34

By signing below, the City of Carson City agrees to the above plan and rates.

_____ _____

Signature Date

_____

Printed Name

City of Carson City

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option 1

Exam and Materials

Access Network

Fully Insured

Employer Paid or Bundled with Medical

Funded Benefits

Frequency

Examination
Once every 12 months

Lenses (in lieu of contact lenses)
Once every 12 months

Contact Lenses (in lieu of lenses)
Once every 12 months

Frame
Once every 24 months

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement up to:
Exam *With Dilation as Necessary*	$20 Copay	$40
Frames *Any available frame at provider location*	$0 Copay; $140 allowance, 20% off balance over $140	$98
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 Copay, $140 allowance, 15% off balance over $140	$140
Disposable	$0 Copay, $140 allowance, plus balance over $140	$140
Medically Necessary	$0 Copay, Paid-In-Full	$210
Standard Plastic Lenses		
Single Vision	$25 Copay	$30
Bifocal	$25 Copay	$50
Trifocal	$25 Copay	$70
Lenticular	$25 Copay	$70
Standard Progressive	$90 Copay	$50
Premium Progressive	$90 Copay, 20% off charge less $120 Allowance	$50
Covered Lens Options		
Standard Polycarbonate - under age 19	$0 Copay	$32

Monthly Rate	
Subscriber	$3.85
Subscriber + Spouse	$7.33
Subscriber + Child(ren)	$7.71
Subscriber + Family	$11.34

All plans are based on a 48-month contract term and 48-month rate guarantee
Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

EyeMed Vision Care reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, visit http://www.discovereyemed.com

Plan Details
Quote for group situsedin the State of NV and will be valid until the 7/1/2017 implementation date. Benefit allowances provide no remaining balance for future use within the same benefit frequency. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Insured benefits are underwritten by Fidelity Security Life Insurance Company. Policy Number VC-19; Policy Form No. M-9083

Plan Exclusions
No benefits will be paid for services or materials connected with or changes arising from:
-orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
-medical and/or surgical treatment of the eye, eyes or supporting structures;
-any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
-services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
-plano (non-prescription) lenses;
-non-prescription sunglasses;
-two pair of glasses in lieu of bifocals;
-services or materials provided by any other group benefit plan providing vision care;
-services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and services rendered to the Insured Person are within 31 days from the date of such order; or
-lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If City of Carson City has chosen this benefit design, attach this document to the group application and sign here:

Jacque Cassinelli — 4/24/2017 | 2:25 PM EDT

Signature — Date

City of Carson City
Saving our members some extra green

We're committed to keeping money in our members' pockets.
That's why we offer our members additional discounts above the proposed plan benefits.

$avings for Members

40% off
additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

20% off
any item not covered by the plan, including non-prescription sunglasses

Lasik
Lasik or PRK from US Laser Network
15% off retail price or 5% off promotional price

Hearing Care
Amplifon Hearing Health Care Network
40% off hearing exams and a low price guarantee on discounted hearing aids

Additional Discounts

Vision Care Services	**Member Cost In-Network**
Discounted Exam Services	
Retinal Imaging Benefit	Up to $39
Contact Lens Fit and Follow-up	
(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)	
Standard Contact Lens Fit & Follow-Up:	$55
Premium Contact Lens Fit & Follow-Up:	10% off retail price
Discounted Lens Options	
Photochromic (Plastic)	20% off Retail
Standard Anti - Reflective Coating	$45
Tint (Solid & Gradient)	$15
UV Treatment	$15
Standard Plastic Scratch Coating	$15
Standard Polycarbonate - age 19 and over	$40
Other Add-on Services and Materials	20% off Retail Price

Discount Details
Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Plan discounts cannot be combined with any other discounts or promotional offers.
In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.
Discounts on vision materials may not be applicable to certain manufacturers' products
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
Service and amounts listed above are subject to change at any time

The secret is out

5 ways we challenge the status quo

We want every person to see life to the fullest. That's why we're doing things differently and providing you with more of what's best, not more of the same. And that includes the network employees want with vision benefits that redefine expectations, all while making the experience easy. After all, it takes vision to see beyond the status quo.

1

Network

We offer so many options for care

Your employees can choose a provider on their terms, not ours. That's because we have the right mix of independent, national retail and regional retail providers.

2

Network

In-network means online, too

Now our members canuse Glasses.com andContactsDirect as in-network providers.

3

Benefits

Members love even more perks

With us, members receive an industry-leading 40% off additional pairs of glasses* and special offers for additional savings can always be found on our website.

*At participating, in-network providers only

4

Easy

We're all about providing user friendly tools

We have the resources to help your employees when they need it: open enrollment support, our enhanced provider search tool and the industry's first mobile vision app for members.

5

Easy

Service that barely sleeps

We offer award-winning service,[1] even on Sundays! Our live agentsare available to assist you untilthe wee hours of the night – an average of 15 hours per day.

[1] Purdue University Benchmark Portal Independent assessment of call centers nationwide, 2015.

Tangible results you see.
Performance we're proud to guarantee.

97% member satisfaction
97% client satisfaction
99% client retention

* Results are based upon EyeMed's internal satisfaction surveys conducted by Convergys and Walker 2014

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company

Kansas City, Missouri

I. GROUP INFORMATION

Group Name: City of Carson City Tax ID#: 88-6000189

DBA Name (If other than above):

Business Address: 201 N Carson St, Suite 4 City Carson City State: NV ZIP: 89701

Mailing Address: City State: ZIP:

Primary Contact: Melanie Bruketta Title: Human Resources Director

Phone Number: (775-)383-7088 Fax Number: ( )

E-mail Address: mbruketta@carson.org

Type of Business: ☐ Proprietorship ☐ Corporation ☒ Other (Specify): government

Service Area: ☐ National (United States – does not include Puerto Rico) ☐ State Specific (List)

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the business address above, please explain.

Billing Contact Name: Jacque Cassinelli Phone: (775-)283-7043

Billing Address: 201 N Carson St. Suite 4 City: Carson City State: NV ZIP: 89701

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you: • Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage? ☒ Yes ☐ No

If "Yes," indicate name of existing insurer:

Name: VSP

If "Yes," are any Employees/Members on COBRA continuation? ☐ Yes ☒ No How many?

Do you intend to offer Employees/Members COBRA continuation? ☒ Yes ☐ No

II. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. PREMIUMS

Group's Premium Contribution for*: Employees/Members: 99 % Dependents: 65 %

Employee's/Member's Premium Contribution for: Employees/Members: 1 % Dependents: 35 %

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ☒ Yes ☐ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ☒ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: 704 Number Applying: _____

Number of Dependents: _____ Number of Retirees: _____

Are Domestic Partners covered under this Plan*? [X] Yes [ ] No

Dependent Children Covered to Age*: [ ] 19 [ ] 23 [X] 26** [ ] Other _____

Dependent Children Covered if Full-Time Student*? [X] Yes [ ] No

If "Yes," Dependent Full-Time Students Covered to Age*: [ ] 23 [ ] 25 [ ] 27 [X] Other 26

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

Eligibility Reporting Contact (produces the eligibility file): Jacque Cassinelli

Address (if different from Group): 201 N. Carson St. Suite 4

City: Carson City State: NV ZIP: 89701

E-mail Address: jcassinelli@carson.org Phone: 775-283-7043 Fax: ( )

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: _____ Phone: ( )

Days/Hours of Availability: _____ E-mail Address: _____

PROBATIONARY PERIOD

For New Employees/Members: [ ] 30 days [X] 60 days [ ] 90 days [ ] 180 days [ ] Other _____

Probationary Period is waived for present Employees/Members: [ ] Yes [X] No

Number of Employees/Members who have not yet completed the probationary period: _____

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of July, 20 17, provided all of the following have been completed prior to this effective date:

A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

The Group certifies that all the information shown on this application and any attachments are correct and complete as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated at: _____ this 24 day of April, 20 17

Signed for the Group: ▶ Jacque Cassinelli Title: HR Generalist Benefits

VI. COMPANY DISPLAY NAME (Your Group name as it should appear to your employees)

Company Name Carson City
(Maximum of 30 characters, including punctuation and spacing.)

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

Broker's Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Contact: Kevin Monaghan Secondary Contact: Bridget Brundige

Title: Producer Title: Associate Producer

E-mail Address: kevin.monaghan@lpins.net E-mail Address: bridget.brundige@lpins.net

Commission checks payable to: ☐ Firm ☐ Broker

Broker's Signature: ▶ Kevin Monaghan

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

General Agent's Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Contact: _____ Secondary Contact: _____

Title: _____ Title: _____

E-mail Address: _____ E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ General Agent

General Agent's Signature: ► _____