



**LATE MATERIAL**

MEETING DATE 6/7/18

ITEM # 12A

# Carson City

July 1, 2018  
thru  
June 30, 2019

Renewal Contract  
With  
Addendums/Memos

# 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.

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*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](mailto:joyce.toste@uhsinc.com)



**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.

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## Health Plan

- 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: 12:00 AM on the first day of a renewed group contract.**

### II. Introduction

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

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

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

### III. Products

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

### IV. Term of Contract

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

### V. Termination of Contract

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

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

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

**Termination on Written Advance Notice**

Group may terminate this Contract:

1. for any reason, effective on the Termination Date by giving at least thirty (30) days prior written notice to Health Plans;
2. upon written notice within thirty (30) days of notice of an increase in the Total Monthly Premium; and

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

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

1. **Non Payment of Premiums**

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

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

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

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

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

- A. Group commits fraud or an intentional misrepresentation of material fact in obtaining or maintaining Health Benefit Plan coverage; and
- B. Health Plan provides Group with thirty (30) days prior notice that coverage is being rescinded.

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

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

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

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

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

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

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

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

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

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

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

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

**VI. Amendment of Contract**

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

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

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

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

**VII. Eligibility and Enrollment of Members**

**A. Eligible Employees include:**

1. a bona fide employee of the Group eligible to participate under the terms of the Health Benefit Plan arranged by the Group;
2. those who satisfy any probationary or Waiting Period requirements established by the Group or the Health Benefit Plan and who enroll within 31 days of their eligibility date.

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### 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-one (31) 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.



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- 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.

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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

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(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.

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**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.

**Signature Page**

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

Health Plans:

Sales and Marketing Department  
Prominence Health Plan  
1510 Meadow Wood Lane  
Reno, Nevada 89502

Group:

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.

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Health Plan

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:

For Group: City of Carson City



\_\_\_\_\_  
Name: David K. Livingston  
Title: CEO

\_\_\_\_\_  
Name: Robert L. Crowell  
Title: Mayor

Date \_\_\_\_\_

**Medical Plan Addendum<sup>1</sup>**  
**Schedule of Insurance Rates**  
City of Carson City

This Schedule of Insurance Rates Addendum dated July 1, 2018 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. Custom Plans: 1500 HMO 1540      1500 POS 1030/2040      HMO HD \$2700 100%
  - b. Rx \$15/40/60D
  - c. Vision:      None
  - d. Domestic Partnership:      Yes
  
2. **Term of the Contract:**
  - a. Effective Date:              July 1, 2018
  - b. Termination Date:          June 30, 2019
  
3. **Termination of the Contract:**
  - a. Anniversary Date:          July 1, 2019
  
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 / Rx \$15/40/60**

<u>Tier</u>	<u>Medical &amp; Rx</u>
Employee	\$568.60
Employee & Spouse*	\$1,165.79
Employee & Child(ren)*	\$1,090.96
Employee & Family*	\$1,781.76

<u>Tier: Retiree</u>	<b>Medical &amp; Rx</b>
Single without Medicare	\$568.60
Single with Medicare	\$417.73
Retiree & Spouse w/o Medicare*	\$1,165.79
Retiree & Spouse both w/ Medicare*	\$886.62
Retiree & Spouse one w/ Medicare*	\$1,047.80
Retiree & Child(ren) w/o Medicare*	\$1,090.96
Retiree & Child(ren) w/ Medicare*	\$1,081.50
Retiree & Family w/o Medicare*	\$1,781.76
Retiree & Family two with Medicare*	\$1,080.57
Retiree & Family one with Medicare*	\$1,256.15

**1500 POS 1030/2040 / Rx \$15/40/60**

<u>Tier</u>	<b>Medical &amp; Rx</b>
Employee	\$636.69
Employee & Spouse*	\$1,305.39
Employee & Child(ren)*	\$1,221.63
Employee & Family*	\$1,995.13

<u>Tier: Retiree</u>	<b>Medical &amp; Rx</b>
Single without Medicare	\$636.69
Single with Medicare	\$463.24
Retiree & Spouse w/o Medicare*	\$1,305.39
Retiree & Spouse both w/ Medicare*	\$984.44
Retiree & Spouse one w/ Medicare*	\$1,169.74
Retiree & Child(ren) w/o Medicare*	\$1,221.63
Retiree & Child(ren) w/ Medicare*	\$1,210.75
Retiree & Family w/o Medicare*	\$1,995.13
Retiree & Family two with Medicare*	\$1,188.99
Retiree & Family one with Medicare*	\$1,390.86

**HMO HD \$2700 100% / Rx \$15/40/60D**

<u>Tier</u>	<b>Medical &amp; Rx</b>
Employee	\$389.95
Employee & Spouse*	\$799.52
Employee & Child(ren)*	\$748.21
Employee & Family*	\$1,221.97

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

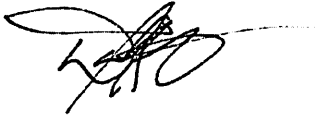
- b. Effective Month: July
- c. Effective Day: 1
- d. Effective Year: 2018
- e. Termination Date: June 30, 2019

**7. General Provisions:**

- a. Broker of Record: LP Insurance Services

For Prominence Health Plan:

For Group: City of Carson City



\_\_\_\_\_  
Name: David K. Livingston  
Title: CEO

\_\_\_\_\_  
Name: Robert L. Crowell  
Title: Mayor

Date \_\_\_\_\_