Agenda Item No: 16.A

STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** April 18, 2019

Staff Contact: Melanie Bruketta, HR Director

Agenda Title: For Possible Action: Discussion and possible action regarding the employee/retiree health insurance contract with Hometown Health and funding of the health savings accounts for active employees in the following proposed annual amounts for fiscal year 2020: $2,143 (employee only), $3,269 (employee plus spouse), $3,128 (employee plus children) and $4,430 (employee plus family). (Melanie Bruketta, mbruketta@carson.org)

Staff Summary: This action is to approve the health insurance contract with Hometown Health and to continue to fund the health savings accounts for active employees in the following amounts for fiscal year 2020: $2,143 (employee only), $3,269 (employee plus spouse), $3,128 (employee plus children) and $4,430 (employee plus family). There will be no increase in the premiums this year with Hometown Health and they have agreed to a 12% rate cap for next year.

Agenda Action: Formal Action / Motion **Time Requested:** 10 minutes

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Proposed Motion

I move to approve the employee/retiree health insurance contract with Hometown Health and to continue to fund the health savings accounts for active employees in the annual amounts for fiscal year 2020 as proposed.

Board's Strategic Goal

Organizational Culture

Previous Action

The Board of Supervisors approved the health, dental, and life insurance plans at the June 7, 2018 meeting.

Background/Issues & Analysis

The City's combined medical and prescription adjusted claims loss ratio is 91%. Last year, the combined medical and prescription loss ratio was 98%. The 91% loss ratio is driven by overall utilization trends and the presence of large claims. Trend forecasts for medical and prescription costs combined is expected to increase between 5%-8% for 2020. Last year, the City negotiated a 12% rate cap for fiscal year 2019 with Prominence Health. When asked for a renewal quote, Prominence provided a 12% rate increase, but also quoted 5% if the City agreed not to go out to bid.

In light of the 91% loss ratio and the medical and prescription cost trend forecast of 5%-8%, the City's insurance broker, LP Insurance Services, was not surprised by Prominence's 12% increase. The marketing approach taken for last fiscal year's renewal was to ask all carriers in the health insurance market to provide a proposal with a 5% increase. Quotes were solicited from the health insurance market, with the City welcoming responses from any provider who could meet the request for a 5% increase. The only provider that responded was Prominence, who agreed to a 5% increase on the HMO and the POS plans. In light of last year's market request for a 5% increase, and knowing the combined loss ratio is 91% with some major ongoing large claims,

staff did not expect a more favorable result this year. A strategic decision was made to approach Hometown Health asking for a held rate. Due to Hometown Health's responsiveness in past years when the City marketed its medical coverage, the contracts Hometown Health has with local providers, Hometown Health's leading wellness program, and it's in-house authorization process, City staff felt Hometown Health would be the best carrier to achieve the financial goals of the City and provide the best experience for the employees. The City required the quote to be based on the same medical benefit plan and prescription benefit plan currently in place. Hometown Health responded by quoting a 3% increase in premiums with the additional benefit of only offering PPO plans. Staff was still underwhelmed by the 3% quote and told Hometown Health they could have the business, subject to Board of Supervisor approval, if they were willing to give the City a rate pass. After further negotiations, Hometown Health quoted a 0% rate increase and the same plan benefits with the exception of a $10.00 increase for x-ray services. The Insurance Committee met on March 28, 2019 and did not voice an objection to the proposal.

Dental and life coverage was not marketed because the Board approved an agreement with Anthem last year that gave the City a two-year rate guarantee. Vision coverage was not marketed because the Board approved an agreement with EyeMed in 2017 that gave the City a four-year rate guarantee.

Applicable Statute, Code, Policy, Rule or Regulation
N/A

Financial Information
Is there a fiscal impact? Yes

If yes, account name/number: 570-0706-415.63-01 - Health insurance increase of 0%

Is it currently budgeted? Yes

Explanation of Fiscal Impact: The amounts will not change from prior year and have been built into the FY 2020 Tentative Budget that will be on the Board of Supervisors agenda for approval on April 18, 2019. Finance budgeted an additional 3% to cover new employees or employees who add dependents.

Alternatives
The Board may reject the proposed contract with Hometown Health and ask the broker to bring back other options.

Attachments:
LP Insurance Renewal.pdf

HHP Contract.docx

HHP Addendums 3.29.19.docx

Board Action Taken:

Motion: _____	1) _____	Aye/Nay
	2) _____	_____
		_____
		_____
		_____
		_____

_____
(Vote Recorded By)

Market Survey Analysis

Prepared for

Carson City

Presented By:

LP Insurance Services

Employee Benefits Division

Effective: July 1, 2019

LP Insurance Services, Inc.
License #710906

INSURANCE BROKERS * EMPLOYEE BENEFIT CONSULTANTS

Carson City
Medical Benefits & Cost Comparison

		Current								Hometown Renewal Option			
Carrier		Prominence HMO HD Core 1			Prominence HMO Beyond 4		Prominence POS Core 12			Hometown $2700 PPO HSA		Hometown $1500 PPO	
Network													
		HMO			HMO		HMO	PPO	OON	PPO	OON	PPO	OON
Individual Calendar Year Deductible		$2,700			$1,500		$1,500	$3,500	$5,000	$2,700	$5,400	$1,500	$5,000
Family Calendar Year Deductible		$5,400			$4,500		$4,500	$10,500	$15,000	$5,400	$10,800	$4,500	$15,000
Individual Calendar Year Out of Pocket Max.		$2,700			$6,000		$6,000	$6,350	$9,000	$2,700	$10,000	$6,000	$12,000
Family Calendar Year Out of Pocket Max.		$5,400			$12,000		$12,000	$12,700	$18,000	$5,400	$20,000	$12,000	$24,000
Primary Physician Copay		0% (d)			$40		$30	$40	50% (d)	0% (d)	30% (d)	$40	50% (d)
Specialist Physician Copay		0% (d)			$60		$50	$60	50% (d)	0% (d)	30% (d)	$60	50% (d)
Emergency Room		0% (d)			$150		$150	$150	$250	0% (d)	30% (d)	$150	$150
Urgent Care Center		0% (d)			$50		$50	$50	50% (d)	0% (d)	30% (d)	$50	$50
Lab, X-Ray (Non-Hospital)		0% (d)			$0, $50		$0	30% (d)	50% (d)	0% (d)	30% (d)	$0, $60	50% (d)
MRI, PET, CT Scans (Non-Hospital)		0% (d)			$100		$100	30% (d)	50% (d)	0% (d)	30% (d)	$100	50% (d)
Outpatient Surgery		0% (d)			$500		$400	30% (d)	50% (d)	0% (d)	30% (d)	$500	50% (d)
Inpatient Hospitalization		0% (d)			$1,500 (d)		$1,000 (d)	30% (d)	50% (d)	0% (d)	30% (d)	$1,500 (d)	50% (d)
In Network Prescription Benefit:													
Tier I		0% (d)			$15			$15		0% (d)		$15	
Tier II		0% (d)			$40			$40		0% (d)		$40	
Tier III		0% (d)			$60			$60		0% (d)		$60	
Rates:		Current	Renewal		Current	Renewal	Current		Renewal	Proposed		Proposed	
Employee	55	$389.95	$436.79	257	$568.60	$638.26	$636.69		$721.36	$389.95	302	$568.60	
Employee + Spouse	17	$799.52	$895.55	79	$1,165.78	$1,308.63	$1,305.40		$1,479.00	$799.52	85	$1,165.78	
Employee + Children	20	$748.21	$838.07	72	$1,090.96	$1,224.63	$1,221.62		$1,384.06	$748.21	82	$1,090.96	
Family	20	$1,221.97	$1,368.73	87	$1,781.74	$2,000.06	$1,995.12		$2,260.45	$1,221.97	101	$1,781.74	
RATES - RETIRED WITH MEDICARE											0		
Retiree w/ Medicare (A&B)	0	$262.91	$294.46	9	$417.73	$430.30	$463.24		$486.31	$286.46	19	$417.73	
Retiree + Spouse, both w/ Medicare (A&B)	0	$564.44	$632.17	0	$886.61	$923.81	$984.44		$1,044.08	$608.03	1	$886.61	
Retiree + Spouse, one w/ Medicare (A&B)	0	$700.16	$784.18	3	$1,047.79	$1,145.99	$1,169.74		$1,295.18	$718.53	3	$1,047.79	
Retiree + Child(ren), w/ Medicare (A&B)	0	$740.24	$829.07	2	$1,081.50	$1,211.59	$1,210.75		$1,369.32	$741.70	6	$1,081.50	
Retiree + Family, both w/ Medicare (A&B)	0	$631.51	$707.29	2	$1,080.55	$1,033.51	$1,188.98		$1,168.06	$741.00	2	$1,080.55	
Retiree + Family, one w/ Medicare (A&B)	0	$799.37	$895.29	1	$1,256.14	$1,275.55	$1,390.85		$1,441.61	$861.49	7	$1,256.14	
	112			512			96			112	608		
Monthly Premium		$74,443	$83,384		$484,271	$542,670	$95,436		$106,856	$74,443		$569,633	
Annual Premium		$893,312	$1,000,606		$5,811,246	$6,512,035	$1,145,235		$1,282,275	$893,312		$6,835,595	
$ over/(under) current		-	$107,293		-	$700,789	-		$137,039	$0		-$120,887	
% over/(under) current		-	12.0%		-	12.1%	-		12.0%	0.00%		-1.74%	
Monthly HSA Funding		$27,050	$27,050		-	-	-		-	$27,050		-	
Annual HSA Funding		$324,598	$324,598		-	-	-		-	$324,598		-	
Monthly Premium w/ HSA Funding		$101,493	$110,434		$484,271	$542,670	$95,436		$106,856	$101,493		$569,633	
Annual Premium w/ HSA Funding		$1,217,910	$1,325,204		$5,811,246	$6,512,035	$1,145,235		$1,282,275	$1,217,910		$6,835,595	
		Current - HSA + "Base Plan" (with HSA Funding)					Renewal - HSA + "Base Plan" (with HSA Funding)			Proposed - HSA + "Base Plan" (with HSA Funding)			
Monthly Premium		$671,125					$747,650			$671,125			
Annual Premium		$8,053,505					$8,971,804			$8,053,505			
$ over/(under) current		-					$918,299			$0			
% over/(under) current		-					11.40%			0.0%			
										12% rate cap on 2020 renewal			

Hometown Health Providers Insurance Company, Inc.
Schedule of Benefits
Benefit Plan: 19 LG PPO HD-NA CINS E D2700X2 HSA;RX 0/0/0/0

This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Providers Insurance Company, Inc. (Hometown Health), an insurance company licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members.

Network. This Policy is an open access Preferred Provider Organization (PPO) that provides access to a network of Preferred Providers who have contracts with Hometown Health. Services from Preferred Providers will generally be paid at the In-Network benefit level. Members may also seek services from Non-Preferred or Out-of-Network Providers generally at a reduced benefit level (higher cost to the Member). Out-of-Network services may be paid at the In-Network coinsurance and copayment level if the services are rendered as part of an Emergency room visit or they have been previously approved by Hometown Health. *Generally, those Members who live or work in the State of Nevada will only have access to the Hometown Health Nevada network of providers at the In-Network benefit level; they will not have access to our national network at the In-Network benefit level.* Those Members who live and work outside the State of Nevada will have access to both the Hometown Health Nevada network and our national network of providers and will be able to receive services from those providers at the In-Network benefit level

Prescription Drug Coverage.
The Enhanced formulary is a list of covered prescription drugs for HometownRx members. The formulary is a valuable resource for members and health care professionals to determine the most effective drug for your condition at the lowest out-of-pocket cost to you. This Policy covers some drugs which are not included in the HometownRx Enhanced Prescription Drug List but at a non-preferred tier 3 copay.

Pharmacy Network. Members must utilize the HometownRx Standard Pharmacy Network. This Policy does not cover drugs which are purchased from pharmacies that are not part of the HometownRx Standard Pharmacy Network.

Geographic Service Area. This Policy is available only to employees of employers who have a physical business location in Nevada. Additional eligibility requirements are detailed in the Hometown Health Large Group PPO Evidence of Coverage (EOC).

Minimum Essential Coverage. This Benefit Plan is considered Minimum Essential Coverage as defined by 26 U.S.C. § 5000A(f) and its implementing regulations.

High Deductible Health Plan. This Policy is a High Deductible Health Plan (HDHP) as described in IRS Publication 969 and IRS Revenue Procedure 2017-37. As such, taxpayers enrolled in this Benefit Plan may be eligible to make pre-tax contributions to their qualified Health Savings Account (HSA). Contact your tax professional for more details.

Additional Requirements. This Schedule of Benefits describes what Hometown Health covers and what you pay. This document is summary in nature. It does not contain all of the Prior Authorization requirements and specific restrictions, exclusions and limitations associated with this Benefit Plan. Refer to the EOC for a more comprehensive list of Prior Authorization requirements and specific cost sharing information, restrictions, exclusions and limitations. In case of conflicts between the EOC and this Schedule of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents.

Nondiscrimination. Hometown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Definitions. Specific capitalized terms used throughout this Schedule of Benefits are defined in the EOC that governs this Schedule of Benefits and the Drug Formulary.

Benefit Summary Table. The following Benefit Summary Table lists the Member's responsibility. This table may not include all eligible benefits. Items marked with "CYD" are subject to the Calendar Year Deductible which resets each January 1.

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Calendar Year Deductibles	In-Network	Out-of-Network
Individual Medical Deductible	$2,700	$5,400
Family Medical Deductible	$5,400	$10,800
Individual Pharmacy Deductible	$0	$0
Family Pharmacy Deductible	$0	$0
This plan has an Embedded Deductible. Hometown Health will begin to pay for non-preventive covered services for a Member once that Member has met the individual Deductible or when the family meets the family Deductible, whichever comes first.		
Calendar Year Out-of-Pocket Maximums		
Individual Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	$2,700	$10,000
Family Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	$5,400	$20,000
The Out-of-Pocket Maximum includes Deductibles, Copayments and Coinsurance. The Out-of-Pocket Maximum does not include Premiums, cost-sharing for non-covered services, expenses associated with denied claims, Ancillary Charges and amounts that Non-Participating Providers bill and are payable that are greater than the Allowed Amount.		
Physician Office Visits		
Primary Care (PCP) Office Visits *(Does not include imaging, surgery and other services.)*	CYD then $0	CYD then 30%
Convenient Care Facility services provided for Medically Necessary, non-urgent Illness or Injury	CYD then $0	CYD then 30%
Primary care ACA wellness visit *(All necessary wellness visits are covered for children less than two years of age. One wellness visit per Calendar Year is covered for members older than two years or as frequently as mandated by the ACA.)*	$0	CYD then 30%
Obstetrics and gynecology ACA services	$0	CYD then 30%
Prenatal and postnatal office visits	$0	CYD then 30%
Specialist Office Visit including covered maternity care *(Referral required; does not include imaging, surgery and other services.)*	CYD then $0	CYD then 30%
PCP and specialist visits include telemedicine only available through select in-network providers. Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.		
Preventive Screenings		
Mammography screening	$0	CYD then 30%
Papanicolaou (Pap) test	$0	CYD then 30%
Prostate Specific Antigen (PSA) screen	$0	CYD then 30%
Colorectal screening	$0	CYD then 30%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0	CYD then 30%
Breastfeeding support, supplies and counseling	$0	CYD then 30%
Screening for interpersonal and domestic violence	$0	CYD then 30%
Contraceptives and in office counseling for FDA approved injections, implants, and contraceptive devices not covered under pharmacy benefits	$0	CYD then 30%
Screening for Gestational Diabetes	$0	CYD then 30%
High-risk human papillomavirus (HPV) testing	$0	CYD then 30%
Hospital Facility Services		
Acute care hospital admission	CYD then $0	CYD then 30%
Inpatient delivery, postpartum care and newborn care services	CYD then $0	CYD then 30%
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	CYD then $0	CYD then 30%
Skilled nursing facility *(limited to 100 days per Calendar Year)*	CYD then $0	CYD then 30%
Rehabilitation facility *(limited to 60 days per Calendar Year)*	CYD then $0	CYD then 30%
All Hospital Facility Services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network inpatient hospital and facility admissions. In emergencies in which a member is admitted to a hospital for an inpatient stay, to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so.		
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Maternity care is covered except as noted in the Infertility section of covered services in the Evidence of Coverage.		
Urgent Care and Emergency Services		
Virtual Visits for Urgent Care Services *(provided by Renown)*	CYD then $0	CYD then $0
Urgent Care Services *(includes Out-of-Area Out-of-Network Urgent Care Center Services; Out-of-Network Providers my charge for amounts greater than the Allowed Amount; Out-of-Network Urgent Care is not covered in Nevada)*	CYD then $0	CYD then $0
Emergency Room Services *(Copayment is waived if admitted; Out-of-Network Providers may charge for amounts greater than the Allowed Amount)*	CYD then $0	CYD then $0
Ambulance (ground)	CYD then $0	CYD then 30%
Ambulance (air and water)	CYD then $0	CYD then 30%
Specialty Imaging and Diagnostic Testing		

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Computer Tomography (CT, CTA) scan	CYD then $0	CYD then 30%
Positron Emission Tomography (PET) scan	CYD then $0	CYD then 30%
Magnetic Resonance Imaging (MRI/MRA)	CYD then $0	CYD then 30%
Nuclear Medicine	CYD then $0	CYD then 30%
Angiograms and Myelograms	CYD then $0	CYD then 30%
All Other (Non-Specialty) Imaging and Diagnostic Testing (including X-rays and ultrasounds)		
X-ray and all other diagnostic imaging services not performed in an office setting	CYD then $0	CYD then 30%
Diagnostic mammography	CYD then $0	CYD then 30%
Services provided in a Primary Care Physician office (*except Specialty Imaging and Diagnostic Testing*)	CYD then $0	CYD then 30%
Services provided in a Specialty Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	CYD then $0	CYD then 30%
Laboratory Services		
General laboratory services *(unless covered under ACA preventive guidelines)*	CYD then $0	CYD then 30%
Outpatient Speech, Occupational and Physical Therapy		
Speech therapy	CYD then $0	CYD then 30%
Occupational therapy	CYD then $0	CYD then 30%
Physical therapy	CYD then $0	CYD then 30%
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy is limited to 90 visits per Calendar Year for all three therapy types combined as per the medical necessity of these services.		
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.)*	CYD then $0	CYD then 30%
Wound therapy in an outpatient hospital or outpatient facility setting *(For wound therapy in an office based setting, see the Physician Office Visit section of this Benefit Summary Table.)*	CYD then $0	CYD then 30%
Chemotherapy in an outpatient hospital, outpatient facility or Physician's office	CYD then $0	CYD then 30%
Radiation therapy in an outpatient hospital, outpatient facility or Physician's office	CYD then $0	CYD then 30%
Infusion therapy *(Includes home infusion therapy. Does not include the cost of special pharmaceuticals used in infusion therapy. For cost of the special pharmaceuticals, used in infusion therapy, see the special pharmaceuticals benefits in the Medical Pharmacy and Immunizations section or your Pharmacy Benefits as appropriate.)*	CYD then $0	CYD then 30%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Port Wine Stain Removal	CYD then $0	CYD then 30%
Rehabilitation services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Surgical Services		
Performed in primary care physician's office	CYD then $0	CYD then 30%
Performed in specialty care physician's office	CYD then $0	CYD then 30%
Performed in outpatient facility or hospital *(if admitted, see the acute care hospital admission cost sharing in the Hospital Services section above.)*	CYD then $0	CYD then 30%
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	CYD then $0	CYD then 30%
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	CYD then $0	CYD then 30%
Diagnostic and/or therapeutic endoscopy	CYD then $0	CYD then 30%
All surgical services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) *(Limited to one purchase, repair or replacement of a specific item of DME every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME, including oxygen and oxygen related equipment, in excess of $150 require Prior Authorization.)*	CYD then $0	CYD then 30%
Orthopedic and prosthetic devices *(Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years. Orthopedic and prosthetic devices in excess of $800 require Prior Authorization)*	CYD then $0	CYD then 30%
Ostomy supplies *(Limited to 30 days of therapeutic supplies per month. Ostomy supplies require Prior Authorization.)*	CYD then $0	CYD then 30%
Special Food Products *(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Calendar Year. Prior Authorization required.)*	CYD then $0	CYD then 30%
If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Alcohol and Substance-Abuse Treatment		
Inpatient treatment	CYD then $0	CYD then 30%
Outpatient treatment – specialist	CYD then $0	CYD then 30%
Withdrawal treatment – inpatient	CYD then $0	CYD then 30%
Withdrawal treatment – outpatient	CYD then $0	CYD then 30%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Inpatient and outpatient programs for alcohol and substance abuse treatment require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require Prior Authorization.		
Mental Health		
Inpatient Medically Necessary services for mental health disorders	CYD then $0	CYD then 30%
Mental health outpatient and office visits	CYD then $0	CYD then 30%
Applied Behavioral Therapy for the treatment of Autism *(Limited to 600 hours (approximately 130 visits) of therapy for habilitation and 600 hours (approximately 130 visits) of therapy for rehabilitation per Calendar Year.)*	CYD then $0	CYD then 30%
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization.		
Other Medical Services		
Kidney dialysis received at home or in an outpatient or office setting *(for kidney dialysis received in an inpatient facility, see the inpatient facility benefit line.)*	CYD then $0	CYD then 30%
Spinal manipulations performed by a chiropractor or other physician *(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime.)*	CYD then $0	CYD then 30%
Alternative Care including acupuncture services *(Limited to $1,000 maximum benefit per Calendar Year.)*	CYD then $0	CYD then 30%
Home health care *(Limited to 30 visits per Calendar Year; May provide for private duty nursing in the home; Prior Authorization required.)*	CYD then $0	CYD then 30%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Calendar Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the EOC. These limits and exclusions apply to both office based and non-office based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in this Benefit Summary Table)*	CYD then $0	CYD then 30%
Temporomandibular Joint (TMJ) Disorder Services *(TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to one (1) surgery per Calendar Year and two (2) surgeries in a lifetime.)*	CYD then $0	CYD then 30%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Office based services (excluding surgical services) *All other services (including surgical services)*		
Hospice Services are covered for Members with a life expectancy of 6 months or 185 days or less as certified by his or her Provider *(Limited to a lifetime benefit maximum of 185 days)*: a. Part-time intermittent home health or respite care services totaling fewer than 8 hours per day and 35 or fewer hours per week. b. Outpatient counseling of the Member and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific Policy). Counseling must be provided by a psychiatrist, psychologist, or social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. Medically Necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above. c. Inpatient hospice care providing nursing care for a maximum of 8 inpatient days per Calendar Year. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical. *Office based services* *All other services*	CYD then $0	CYD then 30%
Medical Pharmacy Benefits (excludes Retail Pharmacy)		
Special Pharmaceutical: drugs eligible for coverage under the medical benefit; may require member cost-sharing in addition to the administration of the drug.	CYD then $0	CYD then 30%
Preventive Immunizations (*as described in the Preventive Services section of the EOC.*)	$0	CYD then 30%
Medical Benefit Drugs: drugs eligible for coverage under the medical benefit; typically drugs that are not self-administered by the member.	CYD then $0	CYD then 30%
Some injection and infusion drugs require Prior Authorization. If you do not obtain Prior Authorization for the administration of the drug, the service and drug may not be covered (even if the service and drug is Medically Necessary).		

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
	In-Network	Out-of-Network
Pharmacy Benefits - Enhanced		
Tier 1 – Generic Drugs *Member Responsibility reflects up to 30-day supply per fill.*	CYD then $0	N/A
Tier 2 – Preferred Brand Drugs – *may also include select Generic drugs. Refer to the EOC for ancillary charge.* *Member Responsibility reflects up to 30-day supply per fill.*	CYD then $0	N/A
Tier 2 – Preferred Brand Oral Oncological Drugs *(Preferred Brand Oral Oncological Drugs require Prior Authorization and must be purchased at a designated pharmacy; the cost to the Member for Orally Administered Chemotherapy will not to exceed $100 per prescription – excludes HSA plans.)* *Member Responsibility reflects up to 30-day supply per fill.*	CYD then $0	N/A
Tier 3 – Non-Preferred Brand or Generic Drugs *Member Responsibility reflects up to 30-day supply per fill.*	CYD then $0 plus the Ancillary Charge	N/A
Tier 4 – Specialty Pharmaceutical Drugs – *may also include non-preferred high cost Generic drugs. (Specialty Pharmaceuticals require Prior Authorization. Most Specialty Pharmaceuticals must be obtained through a specialty Pharmacy designated by Hometown Health and are limited to a 30-day supply per fill.)*	CYD then $0	N/A
Tier 5 – Preventive Drugs *(prescribed in accordance with the U.S. Preventive Task Force Recommendations A & B; excludes select Brand Drug formulations with an available Generic Drug alternative)* *Member Responsibility reflects up to 30-day supply per fill.*	$0	N/A
Cost sharing for diabetic supplies is based on the tier (Generic, Brand, etc.). Includes insulin, insulin syringes with needles, glucose blood-testing strips, lancets and lancet devices.		

For more information go to

www.HometownHealth.com

This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Providers Insurance Company, Inc. (Hometown Health), an insurance company licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members.

Network. This Policy is an open access Preferred Provider Organization (PPO) that provides access to a network of Preferred Providers who have contracts with Hometown Health. Services from Preferred Providers will generally be paid at the In-Network benefit level. Members may also seek services from Non-Preferred or Out-of-Network Providers generally at a reduced benefit level (higher cost to the Member). Out-of-Network services may be paid at the In-Network coinsurance and copayment level if the services are rendered as part of an Emergency room visit or they have been previously approved by Hometown Health. *Generally, those Members who live or work in the State of Nevada will only have access to the Hometown Health Nevada network of providers at the In-Network benefit level; they will not have access to our national network at the In-Network benefit level.* Those Members who live and work outside the State of Nevada will have access to both the Hometown Health Nevada network and our national network of providers and will be able to receive services from those providers at the In-Network benefit level

Prescription Drug Coverage.
The Enhanced or formulary is a list of covered prescription drugs for HometownRx members. The formulary is a valuable resource for members and health care professionals to determine the most effective drug for your condition at the lowest out-of-pocket cost to you. *This Policy covers some drugs which are not included in the HometownRx Enhanced Prescription Drug List but at a non-preferred tier 3 copay.*

Pharmacy Network. Members must utilize the HometownRx Standard Pharmacy Network. *This Policy does not cover drugs which are purchased from pharmacies that are not part of the HometownRx Standard Pharmacy Network.*

Geographic Service Area. This Policy is available only to employees of employers who have a physical business location in Nevada. Additional eligibility requirements are detailed in the Hometown Health Large Group PPO Evidence of Coverage (EOC).

Minimum Essential Coverage. This Benefit Plan is considered Minimum Essential Coverage as defined by 26 U.S.C. § 5000A(f) and its implementing regulations.

Additional Requirements. This Schedule of Benefits describes what Hometown Health covers and what you pay. This document is summary in nature. It does not contain all of the Prior Authorization requirements and specific restrictions, exclusions and limitations associated with this Benefit Plan. Refer to the EOC for a more comprehensive list of Prior Authorization requirements and specific cost sharing information, restrictions, exclusions and limitations. In case of conflicts between the EOC and this Schedule of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents.

Nondiscrimination. Hometown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Definitions. Specific capitalized terms used throughout this Schedule of Benefits are defined in the EOC that governs this Schedule of Benefits and the Drug Formulary.

Benefit Summary Table. The following Benefit Summary Table lists the Member's responsibility. This table may not include all eligible benefits. Items marked with "CYD" are subject to the Calendar Year Deductible which resets each January 1.

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Calendar Year Deductibles		
Individual Medical Deductible	$1,500	$5,000
Family Medical Deductible	$4,500	$15,000
Individual Pharmacy Deductible	$0	$0
Family Pharmacy Deductible	$0	$0
This plan has an Embedded Deductible. Hometown Health will begin to pay for non-preventive covered services for a Member once that Member has met the individual Deductible or when the family meets the family Deductible, whichever comes first.		
Calendar Year Out-of-Pocket Maximums		
Individual Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	$6,000	$12,000
Family Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	$12,000	$24,000
The Out-of-Pocket Maximum includes Deductibles, Copayments and Coinsurance. The Out-of-Pocket Maximum does not include Premiums, cost-sharing for non-covered services, expenses associated with denied claims, Ancillary Charges and amounts that Non-Participating Providers bill and are payable that are greater than the Allowed Amount.		
Physician Office Visits		
Primary Care (PCP) Office Visits *(Does not include imaging, surgery and other services.)*	$40	CYD then 50%
Convenient Care Facility services provided for Medically Necessary, non-urgent Illness or Injury	$40	CYD then 50%
Primary care ACA wellness visit *(All necessary wellness visits are covered for children less than two years of age. One wellness visit per Calendar Year is covered for members older than two years or as frequently as mandated by the ACA.)*	$0	CYD then 50%
Obstetrics and gynecology ACA services	$0	CYD then 50%
Prenatal and postnatal office visits	$0	CYD then 50%
Specialist Office Visit including covered maternity care	$60	CYD then 50%
PCP and specialist visits include telemedicine only available through select in-network providers. Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.		
Preventive Screenings		
Mammography screening	$0	CYD then 50%
Papanicolaou (Pap) test	$0	CYD then 50%
Prostate Specific Antigen (PSA) screen	$0	CYD then 50%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Colorectal screening	$0	CYD then 50%
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0	CYD then 50%
Breastfeeding support, supplies and counseling	$0	CYD then 50%
Screening for interpersonal and domestic violence	$0	CYD then 50%
Contraceptives and in office counseling for FDA approved injections, implants, and contraceptive devices not covered under pharmacy benefits	$0	CYD then 50%
Screening for Gestational Diabetes	$0	CYD then 50%
High-risk human papillomavirus (HPV) testing	$0	CYD then 50%
Hospital Facility Services		
Acute care hospital admission	CYD then $1,500 per Admit	CYD then 50%
Inpatient delivery, postpartum care and newborn care services	CYD then $1,500 per Admit	CYD then 50%
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	$500 per Admit	CYD then 50%
Skilled nursing facility *(limited to 100 days per Calendar Year)*	CYD then $1,500 per Admit	CYD then 50%
Rehabilitation facility *(limited to 60 days per Calendar Year)*	CYD then $1,500 per Admit	CYD then 50%
All Hospital Facility Services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network inpatient hospital and facility admissions. In emergencies in which a member is admitted to a hospital for an inpatient stay, to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so.		
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Maternity care is covered except as noted in the Infertility section of covered services in the Evidence of Coverage.		
Urgent Care and Emergency Services		
Virtual Visits for Urgent Care Services *(provided by Renown)*	$10	$10
Urgent Care Services *(includes Out-of-Area Out-of-Network Urgent Care Center Services; Out-of-Network Providers my charge for amounts greater than the Allowed Amount; Out-of-Network Urgent Care is not covered in Nevada)*	$50	$50

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Emergency Room Services *(Copayment is waived if admitted; Out-of-Network Providers may charge for amounts greater than the Allowed Amount)*	$150	$150
Ambulance (ground)	$200	CYD then 50%
Ambulance (air and water)	$200	CYD then 50%
Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT, CTA) scan	$100	CYD then 50%
Positron Emission Tomography (PET) scan	$100	CYD then 50%
Magnetic Resonance Imaging (MRI/MRA)	$100	CYD then 50%
Nuclear Medicine	$100	CYD then 50%
Angiograms and Myelograms	$100	CYD then 50%
All Other (Non-Specialty) Imaging and Diagnostic Testing (including X-rays and ultrasounds)		
X-ray and all other diagnostic imaging services not performed in an office setting	$60	CYD then 50%
Diagnostic mammography	$60	CYD then 50%
Services provided in a Primary Care Physician office (*except Specialty Imaging and Diagnostic Testing*)	$40	CYD then 50%
Services provided in a Specialty Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	$60	CYD then 50%
Laboratory Services		
General laboratory services *(unless covered under ACA preventive guidelines)*	$0	CYD then 50%
Outpatient Speech, Occupational and Physical Therapy		
Speech therapy	$60	CYD then 50%
Occupational therapy	$60	CYD then 50%
Physical therapy	$60	CYD then 50%
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy is limited to 90 visits per Calendar Year for all three therapy types combined as per the medical necessity of these services.		
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.)*	$60	CYD then 50%
Wound therapy in an outpatient hospital or outpatient facility setting *(For wound therapy in an office based setting, see the Physician Office Visit section of this Benefit Summary Table.)*	$60	CYD then 50%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Chemotherapy in an outpatient hospital, outpatient facility or Physician's office	$60	CYD then 50%
Radiation therapy in an outpatient hospital, outpatient facility or Physician's office	$60	CYD then 50%
Infusion therapy *(Includes home infusion therapy. Does not include the cost of special pharmaceuticals used in infusion therapy. For cost of the special pharmaceuticals, used in infusion therapy, see the special pharmaceuticals benefits in the Medical Pharmacy and Immunizations section or your Pharmacy Benefits as appropriate.)*	$60	CYD then 50%
Port Wine Stain Removal	$60	CYD then 50%
Rehabilitation services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Surgical Services		
Performed in primary care physician's office	$40	CYD then 50%
Performed in specialty care physician's office	$60	CYD then 50%
Performed in outpatient facility or hospital *(if admitted, see the acute care hospital admission cost sharing in the Hospital Services section above.)*	$500	CYD then 50%
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	$500	CYD then 50%
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	CYD then $1,500	CYD then 50%
Diagnostic and/or therapeutic endoscopy	CYD then$1,500	CYD then 50%
All surgical services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) *(Limited to one purchase, repair or replacement of a specific item of DME every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME, including oxygen and oxygen related equipment, in excess of $150 require Prior Authorization.)*	CYD then $60	CYD then 50%
Orthopedic and prosthetic devices *(Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years. Orthopedic and prosthetic devices in excess of $800 require Prior Authorization)*	CYD then $60	CYD then 50%
Ostomy supplies *(Limited to 30 days of therapeutic supplies per month. Ostomy supplies require Prior Authorization.)*	CYD then $60	CYD then 50%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Special Food Products *(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Calendar Year. Prior Authorization required.)*	CYD then $60	CYD then 50%
If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Alcohol and Substance-Abuse Treatment		
Inpatient treatment	CYD then $1,500 per Admit	CYD then 50%
Outpatient treatment – specialist	$60	CYD then 50%
Withdrawal treatment – inpatient	CYD then $1,500 per Admit	CYD then 50%
Withdrawal treatment – outpatient	$60	CYD then 50%
Inpatient and outpatient programs for alcohol and substance abuse treatment require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require Prior Authorization.		
Mental Health		
Inpatient Medically Necessary services for mental health disorders	CYD then $1,500 per Admit	CYD then 50%
Mental health outpatient and office visits	$60	CYD then 50%
Applied Behavioral Therapy for the treatment of Autism *(Limited to 600 hours (approximately 130 visits) of therapy for habilitation and 600 hours (approximately 130 visits) of therapy for rehabilitation per Calendar Year.)*	$60	CYD then 50%
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization.		
Other Medical Services		
Kidney dialysis received at home or in an outpatient or office setting *(for kidney dialysis received in an inpatient facility, see the inpatient facility benefit line.)*	$60	CYD then 50%
Spinal manipulations performed by a chiropractor or other physician *(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime.)*	$60	CYD then 50%
Alternative Care including acupuncture services *(Limited to $1,000 maximum benefit per Calendar Year.)*	$60	CYD then 50%

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Home health care *(Limited to 30 visits per Calendar Year; May provide for private duty nursing in the home; Prior Authorization required.)*	$60	CYD then 50%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Calendar Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the EOC. These limits and exclusions apply to both office based and non-office based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in this Benefit Summary Table)*	$60	CYD then 50%
Temporomandibular Joint (TMJ) Disorder Services *(TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to one (1) surgery per Calendar Year and two (2) surgeries in a lifetime.)* *Office based services (excluding surgical services)* *All other services (including surgical services)*	 $60 CYD then $1,500 per Admit	 CYD then 50% CYD then 50%
Hospice Services are covered for Members with a life expectancy of 6 months or 185 days or less as certified by his or her Provider *(Limited to a lifetime benefit maximum of 185 days)*: a. Part-time intermittent home health or respite care services totaling fewer than 8 hours per day and 35 or fewer hours per week. b. Outpatient counseling of the Member and his or her immediate family (limited to 6 visits for all family members combined if		

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
they are not otherwise eligible for mental health benefits under their specific Policy). Counseling must be provided by a psychiatrist, psychologist, or social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. Medically Necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above. c. Inpatient hospice care providing nursing care for a maximum of 8 inpatient days per Calendar Year. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical.		
Office based services *All other services*	$60 CYD then $1,500 per Admit	CYD then 50% CYD then 50%
Medical Pharmacy Benefits (excludes Retail Pharmacy)		
Special Pharmaceutical: drugs eligible for coverage under the medical benefit; may require member cost-sharing in addition to the administration of the drug.	CYD then 20%	CYD then 50%
Preventive Immunizations (*as described in the Preventive Services section of the EOC.*)	$0	CYD then 50%
Medical Benefit Drugs: drugs eligible for coverage under the medical benefit; typically drugs that are not self-administered by the member.	CYD then 20%	CYD then 50%
Some injection and infusion drugs require Prior Authorization. If you do not obtain Prior Authorization for the administration of the drug, the service and drug may not be covered (even if the service and drug is Medically Necessary).		
Pharmacy Benefits - Enhanced		
Tier 1 – Generic Drugs *Member Responsibility reflects up to 30-day supply per fill.*	$15	N/A
Tier 2 – Preferred Brand Drugs – *may also include select Generic drugs. Refer to the EOC for ancillary charge.* *Member Responsibility reflects up to 30-day supply per fill.*	$40	N/A

Benefit Summary Table		
Benefit Category	***Member Responsibility***	
Benefit Tier Level	**PPO Network**	**Out-of-Network**
Tier 2 – Preferred Brand Oral Oncological Drugs *(Preferred Brand Oral Oncological Drugs require Prior Authorization and must be purchased at a designated pharmacy; the cost to the Member for Orally Administered Chemotherapy will not to exceed $100 per prescription – excludes HSA plans.)* *Member Responsibility reflects up to 30-day supply per fill.*	$40	N/A
Tier 3 – Non-Preferred Brand or Generic Drugs *Member Responsibility reflects up to 30-day supply per fill.*	$60 plus the Ancillary Charge	N/A
Tier 4 – Specialty Pharmaceutical Drugs – *may also include non-preferred high cost Generic drugs. Specialty Pharmaceuticals require Prior Authorization.* *Most Specialty Pharmaceuticals must be obtained through a specialty Pharmacy designated by Hometown Health and are limited to a 30-day supply per fill.*	20%	N/A
Tier 5 – Preventive Drugs *(prescribed in accordance with the U.S. Preventive Task Force Recommendations A & B; excludes select Brand Drug formulations with an available Generic Drug alternative)* *Member Responsibility reflects up to 30-day supply per fill.*	$0	N/A
Cost sharing for diabetic supplies is based on the tier (Generic, Brand, etc.). Includes insulin, insulin syringes with needles, glucose blood-testing strips, lancets and lancet devices.		

For more information go to www.HometownHealth.com

HOMETOWN HEALTH
GROUP SUBSCRIPTION AGREEMENT
FOR A
GROUP MEDICAL AND HOSPITAL SERVICE PLAN

This GROUP SUBSCRIPTION AGREEMENT FOR A GROUP MEDICAL AND HOSPITAL SERVICE PLAN ("Agreement") is made and entered into by and between Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc., both licensed in the State of Nevada to provide health coverage together referred to as "Hometown Health" and Group, as specified on the signature page.

SECTION I. GENERAL AGREEMENT

Group has submitted to Hometown Health an application for insurance ("Application"; see Appendix A) and Hometown Health has approved Group's Application. This Agreement, the Application, any addenda, riders or endorsements, the Evidence of Coverage (EOC) and the Schedule of Benefits shall constitute the entire Contract ("Contract") between Hometown Health and Group. Upon Group's acceptance of the terms of the Contract indicated by Group signing in SECTION XVIII TERM OF AGREEMENT, the Contract shall take effect on the date and at the time outlined in SECTION XVIII TERM OF AGREEMENT (Contract Effective Date). The Contract shall supersede all other contracts, either oral or written, between the parties with respect to the Contract's subject matter.

If any inconsistency exists between the terms of the Application and the terms of this Agreement, the terms of this Agreement will prevail. A signature by an authorized representative of the Group on this Agreement signifies the Group's agreement to comply with the terms and provisions contained herein.

Hometown Health will arrange for those health care benefits outlined in the Evidence of Coverage for Members who are to receive covered services under the terms of the Contract. In no event will Hometown Health provide benefits for services rendered before the Contract Effective Date or after the termination date of the Contract.

No course of action, usage, custom or internal policy of Hometown Health or Group may amend or become a part of the Contract. No agent employee, broker or other person acting on the Group's behalf has the actual or apparent authority to change the Contract or waive any of its provisions, and no change in the Contract will be valid unless approved by an officer of the Group and evidenced by an endorsement, rider, amendment or revision to the Contract signed by a duly authorized officer of Hometown Health. Except as outlined in Paragraphs A and B immediately below, no change, modification or amendment to this Agreement will be valid unless such change or modification is allowable by law, provided in writing and signed by the parties to this Agreement. Changes to the Agreement not requiring the signatures of both parties are limited to the following:

(a) As allowed by law, this Agreement may be amended at renewal by an endorsement or the issuance of a revised Agreement, signed by a duly authorized officer of Hometown Health. Such modification shall be uniformly applied to all Groups, and those Groups affected shall be given the opportunity to purchase other health insurance products offered by Hometown Health with no lapse in coverage. When the endorsement or revised Agreement has been so signed and issued by the Company, it shall be deemed binding and effective as of the date specified by the endorsement or revised Agreement, without the need for the signature of a Group representative or any other entity.

(b) Any amendment resulting from state or federal law or regulation, or ruling or approval by the Commissioner of Insurance of the State of Nevada may be made at any time by endorsement to the Agreement signed by a duly authorized officer of Hometown Health, and it will become effective as of the effective date of such law, regulation, ruling or approval.

SECTION II. DEFINITIONS

The definitions contained in this SECTION II DEFINITIONS and the definitions and other terms contained in the Evidence of Coverage are incorporated herein by reference.

COBRA: Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Contract Effective Date: The effective date of this Contract as listed in SECTION XVIII TERM OF AGREEMENT.

Enrollment/Change Form: A form or submission through an electronic format approved by Hometown Health indicating that an eligible person is electing to enroll in a Plan or make a change to existing enrollment in a Plan.

Grace Period: A period that begins the first day a Member's premium becomes due and extending for thirty (30) days.

Large Group: Any group applying for group coverage that is not a Small Group.

Member: A Subscriber or the Subscriber's eligible dependents who is covered as outlined in the Evidence of Coverage and pursuant to the Application.

Member's Effective Date: The date a Member's coverage under a Plan begins.

Open Enrollment Period: Those periods of time established by the Group and Hometown Health pursuant to the Application, during which all eligible persons may enroll in a Plan.

Plan: The group health care plan or plans selected by the Group and described in SECTION XVI COVERAGE.

Qualifying Life Event: Those events as described in the EOC that occur during an individual's life that would allow them to enroll in a Plan outside of the Group Open Enrollment period. An eligible dependent may only enroll if the Subscriber enrolls or is enrolled in a Plan.

Small Group: An employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

Special Enrollment Period: A thirty (30) day period immediately following a Qualifying Life Event during which an eligible individual may enroll in a Plan, except in the case of a birth, adoption or placement for adoption, in which case the period is thirty one (31) days.

Subscriber: A person who meets all applicable eligibility requirements of SECTION VIII ENROLLMENT, and who's Enrollment Form has been accepted by Hometown Health in accordance with the requirements of the Evidence of Coverage. The Subscriber is normally an employee. The Subscriber's coverage is generally the basis for coverage for any dependents.

Waiver of Coverage: The act of an eligible person choosing not to elect coverage for himself or herself and/or his or her eligible dependent(s) at time of Enrollment Eligibility.

SECTION III. HOMETOWN HEALTH'S OBLIGATIONS

Hometown Health will administer the Plan. Hometown Health will furnish appropriate forms and materials necessary and appropriate for the enrollment of eligible individuals and will provide such assistance as may reasonably be necessary to Group for enrollment purposes. Hometown Health will maintain current eligibility status records on all Members, with information submitted by Group, for the adjudication of claims.

SECTION IV. GROUP'S OBLIGATIONS

If requested by Hometown Health, Group shall make available to Hometown Health such payroll and other records that may have a bearing upon the eligibility status of an individual.

Group must maintain contribution and participation levels required by Hometown Health's underwriting guidelines.

If Group is a Small Group, then Group shall ensure that all Members have access to pediatric dental coverage.

If Plan is a grandfathered plan as described by 45 CFR § 147.140 a change to plan provisions may result in the loss of grandfathered status.

Group will provide Hometown Health with timely information as is reasonably required by Hometown Health for the purposes of determining eligibility for coverage, enrolling and disenrolling Members, determining the amount of premium payable by Group, verifying the continued eligibility of Group, or any other purpose reasonably related to the administration of the Contract.

Group will give notification of eligibility to each employee or other person who is or will become eligible for enrollment as a Subscriber. The Group will collect an application for each eligible individual who wants to enroll and submit the applications to Hometown Health.

The Group will keep such records and furnish to Hometown Health such notification and other information as Hometown Health may require for the purpose of enrolling Members, processing terminations, affecting changes due to a Member becoming eligible for Medicare, affecting changes due to a Member becoming disabled or being eligible for short-term or long-term disability, determining the amount payable by the Group under the Contract, or for any other purpose reasonably related to the administration of this Agreement.

The Group shall immediately advise Hometown Health when the Group has knowledge that a Member does not meet the membership requirements as outlined in The Group’s Master Application. The Group agrees that no person will be represented as a Member for the sole purpose of obtaining or maintaining coverage under the Contract if they do not meet the Group’s eligibility requirements.

The Group will designate a person as the principal contact for all matters related to the Group's coverage. That person (referred to as the Group Administrator) will assist Members in the administration and payment of claims. The Group Administrator understands that Hometown Health is acting as a claims administrator and is not the plan administrator or other named fiduciary, for purposes of ERISA. As claims administrator, Hometown Health assumes only those responsibilities as expressly agreed to under this Agreement. Nothing contained in this Agreement will designate or render Hometown Health an ERISA plans agent for services of legal process.

The Group must make the insurance coverage available to all eligible individuals.

The Group will permit Hometown Health or a representative appointed by Hometown Health to perform a payroll audit.

The Group will maintain records and furnish to Hometown Health or its designated agents any information, including tax records, required in connection with the administration of the insurance coverage.

The Group will notify eligible Members of applicable conversion rights and rights to continued health coverage under COBRA.

The Group agrees not to impede any Member from performing his or her obligations related to coverage by Hometown Health and to assist Members in performing their obligations to the extent consistent with

this Agreement.

The Group shall comply with all applicable local, state and federal laws, rules and regulations.

SECTION V. MEMBER ELIGIBILITY

Eligible Employees of the Group and their eligible Family Dependents shall be those persons who meet the criteria set forth in the Evidence of Coverage and described below.

The below eligibility requirements are considered material to the execution of this Agreement. During the term of the Agreement, no change in the eligibility requirements shall be permitted to affect eligibility or enrollment in any manner deemed adverse by Hometown Health unless such change is effected by mutual agreement, in writing, between Hometown Health and Group.

Those individuals which satisfy the eligibility requirements in the Application and the EOC will be enrolled in a Plan as described below. Hometown Health may inspect such public and private records as are necessary to verify eligibility.

The Group will have the opportunity to submit applications to add new transferred individuals to the group of Members initially enrolled under the Contract in accordance with Hometown Health's underwriting guidelines and the following procedures:

(a) Applications will be submitted on behalf of all newly eligible individuals who want to enroll at the time the individual becomes eligible (i.e. hiring, transfer, etc.). Applications will specify the date of hire for new employees, the date of transfer for transferred employees, or the date of eligibility for other new participants. For Large Groups, such individual may be required to complete a medical assessment form as part of the application process. The answers the individual supplies on such form will not prevent enrollment.

(b) The Member’s Effective Date for any such additional Member whose application Hometown Health accepts will be in accordance with the underwriting guidelines in effect at the time the Member’s application is approved.

(c) Eligible individuals enrolled in another benefit plan offered by the Group may submit applications to Hometown Health during the Open Enrollment Period.

(d) Eligible individuals who do not enroll will be recorded accordingly. Such records will become part of the Group's data and will constitute a Waiver of Coverage under this Agreement. The Group will also keep a record of eligible individuals who did not apply because they have healthcare coverage through another source.

(e) Employees who are returning from an absence from work due to a health-related absence or disability, maternity leave, or regularly scheduled vacation are not subject to the provisions immediately above.

Hometown Health must receive applications for Member coverage during the Open Enrollment Period or Special Enrollment Period. If Hometown Health does not receive the application within this time period, the Member may not enroll in a Plan until the next Open Enrollment Period or Special Enrollment Period.

Coverage under the Contract for eligible individuals enrolled in health coverage provided by the Group on or before the Contract Effective Date and who apply for coverage in a Plan during the Open Enrollment Period will commence on the Contract Effective Date. Thereafter, coverage for any eligible individual who submits a timely enrollment application will begin on the date determined by Hometown Health and as described in the EOC.

Following the loss of eligibility of an individual, Hometown Health will allow continued coverage for such individual only if eligible under COBRA, such individual is notified of their continuation rights by the employer and if the individual has elected and paid for the continued coverage to the extent required by COBRA. The Group further understands and agrees that any notice, collection of premium or communication about continuation coverage will be the responsibility of the Group (or employee were applicable) and not Hometown Health.

The Group acknowledges that it is the Group's obligation under the Family and Medical Leave Act of 1993, as amended (FMLA) to maintain group health benefits for eligible employees on the same conditions as if the employee had been continuously working during the entire period. The Group's act of keeping the coverage in force ensures that the Group will be able to comply with its obligations under the FMLA to provide equivalent benefits to employees returning from FMLA leave without any requalification requirements. If the employee does not retain coverage during the leave period, the employee and any eligible dependents who were covered immediately before the leave may be reinstated upon return to work without the imposition of any waiting periods. To obtain coverage for an employee upon return from FMLA leave, the Group must provide Hometown Health with evidence satisfactory to Hometown Health of the applicability of the FMLA to the employee's leave, including a copy of the health care provider statement allowed by the FMLA.

When an eligible employee is on leave without pay, the employee may be eligible to maintain group health benefits in accordance with the City's leave without pay policy. An employee who returns from a leave of absence and who lost his/her insurance during the leave of absence period is not required to complete another waiting period before re-enrolling in the health insurance.

Hometown Health reserves the right to cancel or rescind any health care benefits provided under the Contract to any individual who engages in misrepresentation and/or fraudulent conduct, as determined by Hometown Health, in relation to any claims made for coverage or any application for coverage under the Contract. In addition, Hometown Health reserves the right to cancel or terminate coverage provided under the Contract to any individual who has erroneously been represented by the Group or the Member

as being eligible for coverage under the Contract, and reserves the right to terminate any individual's coverage in accordance with cancellation and termination provisions in the EOC.

SECTION VI. PREMIUM CHARGES

Premiums shall be due on the first day of each month of coverage. On or before the first day of each month of coverage, Group shall pay Hometown Health the total premium outlined in SECTION XVII PREMIUM RATE SCHEDULE for each Member. Charges will be based on the number of Members enrolled. If this Agreement is cancelled, the Group shall be liable for all premiums. Only Members for whom payment is received by Hometown Health shall be eligible for services and benefits only for the period covered by such payment. If the Group fails to notify Hometown Health of Member's loss of eligibility due to termination of employment, or other reasons within sixty (60) days after the date of loss of eligibility, premium reimbursement or credit will be limited the two (2) month period immediately prior to the date of notification of such date of loss of eligibility.

If a required premium is not paid on or before the date it is due, it may be paid within the Grace Period. During the Grace Period, the Agreement will remain in effect. If payment is not received by the expiration of the Grace Period, then the Agreement may be terminated by Hometown Health pursuant to SECTION XII TERMINATION OF AGREEMENT BY HOMETOWN HEALTH. The accruing of premiums shall only cease upon termination of the Agreement. If this Agreement is terminated for any reason, Group shall continue to be held liable for all premium due, including but not limited to, premium payments due for any active period of current Contract. Alternatively, Hometown Health will hold Group and /or Members liable for the fee-for-service equivalent of any services or benefits received during the period for which premiums have not been paid, including the Grace Period. All premium payments received shall be applied in the following order: past due premiums, Benefit Funding, late and/or reinstatement fees, current premiums.

Monthly premium payments are due by the first of each month. If payment is not received by the due date, Group will be sent a ten (10) day notice of termination for non-payment prior to the end of the Grace Period. Groups may be reinstated at Hometown Health's sole and absolute discretion, twice in a twelve (12) month period without a break in coverage.

Any past due premiums, benefit funding and late (reinstatement) fees as defined immediately below, as well as any current premiums due, must be paid to Hometown Health within sixty (60) days of Group's termination date before Hometown Health will consider reinstatement of Group. Should Group be terminated for non-payment three (3) times within a twelve (12) month period, Hometown Health will no longer consider reinstatement of the Group upon the third termination and Group will be required to re-apply for benefits regardless of whether Group pays any or all past due premiums and/or late penalties. Group will experience a break in coverage should this occur.

Late (reinstatement) fees apply only to Large Groups. Late (reinstatement) fees will be five (5) dollars per Subscriber, not to exceed two thousand five hundred (2,500) dollars.

Hometown Health (subject to such approvals by governmental agencies as may be required by law) may revise the premiums on the first and subsequent anniversary of the Contract Effective Date. Any such

revision of premium shall apply to all Members on the effective date of the revision. Hometown Health shall give at least sixty (60) days prior notice to Group of the premium revision. Notice shall be considered to have been given when mailed to the Group or its agent at the address in the records of Hometown Health.

If Group is a Small Group, Group's premiums may be revised if the Group has elected to change its selected Plan by terminating this Agreement and replacing it with a new agreement. If Group is a Large Group, Group's premiums may be revised more frequently, including during the initial term, when: (a) the Group has elected to change in its selected Plan by terminating this Agreement and replacing it with a new agreement; (b) there has been a change in the number of employees covered by the Group that would affect the insurance premium rate of the Group; or (c) there has been a change in federal or state law which affects the cost of providing services under the group health care plan. In such event, the change in premiums shall coincide with the effective date of such change and shall, when appropriate, be calculated on a pro rata basis. Any monies that may be due or owing shall be paid and credited by the next premium due date. Group has the right to terminate without penalty or negotiate new rates in the event of changes to federal or state laws affecting the cost of providing services under the group health care plan.

Hometown Health shall not have any obligation to accept partial premium payment. The Group shall make premium payments to Hometown Health regardless of any contributions to premium payments by Members. The Group shall have the responsibility for collecting and remitting payments to Hometown Health as they become due. Even if the Group has not received a premium bill from Hometown Health, the Group is still obligated to pay, at a minimum, the amount of the prior premium bill. Hometown Health shall not assume any liability to Members or any other individual by reason, in whole or in part, of any delay or failure of the Group to remit applicable payments.

Initial premium shall become payable on or before the Contract Effective Date. Subsequent premiums will be payable as outlined above. Claims processing and payment will be pended if premium is not timely paid. In no event shall coverage under the Contract become effective until Hometown Health accepts the Application and Hometown Health receives payment of the initial premium.

In the event the Contract is terminated and Group has paid more than the amount of premium required for the term of the Contract, Hometown Health shall refund any such overpayment.

Negotiation or deposit checks shall not be deemed to be acceptance by Hometown Health of such payment, nor shall such negotiation or deposit of the Groups check prevent Hometown Health from later returning such payment by issuing a check for the amount of the Group's check to Hometown Health.

Acceptance of payments from the Group or the payment of benefits to persons no longer eligible will not obligate Hometown Health to provide benefits, except where specifically required by applicable law.

SECTION VII. BENEFIT CHANGES

Hometown Health reserves the right to change the benefit provisions under the Contract, effective on the

anniversary date, by giving written notice to the Group not less than sixty (60) days before the effective date of such change. If the Group requests a change to the benefit provisions under this Agreement, the Group shall give Hometown Health at least forty five (45) days advance written notice of the requested change.

If any change to the benefits or the payment amount is unacceptable to the Group the Group will have the right to terminate coverage under the Contract by giving written notice of termination to Hometown Health before the effective date of the change. If the benefit provision is changed, payment of the new amounts or continued payment of current amounts shall constitute the Group's acceptance of the change, without Hometown Health being required to obtain the Group's signature on the schedule and or addenda. The schedule and/or addenda will become a part of the Contract.

SECTION VIII. ENROLLMENT

Member(s) shall be enrolled by Hometown Health upon timely receipt of a properly completed Enrollment/Change Form approved by the Group. The Enrollment/Change Form must have been completed by the Member within the Open Enrollment Period or applicable Special Enrollment Period. Group shall provide Hometown Health with the Member’s completed Enrollment/Change Form within sixty (60) days after the Member’s Effective Date. Members who do not enroll within this period will not be allowed to enroll until their next Open Enrollment Period or Qualifying Life Event. Additional documentation, including, but not limited to, medical assessment forms (Large Groups only), birth certificates, marriage licenses, court orders, social security number or other items may be requested by Hometown Health from the Member to complete the enrollment process. Notification of coverage eligibility shall be the responsibility of the Group.

Subscribers and/or their Dependent(s) who have previously waived coverage with Hometown Health are not considered eligible to enroll in the group health care Plan until the next Open Enrollment Period or Qualifying Life Event.

Member(s) shall be deleted from coverage by Hometown Health upon receipt of written notice from the Group in a timely manner. Timely shall be defined as within sixty (60) days following the final date of coverage upon termination of the Member. Notification of any continuation privileges required under law shall be the responsibility of the Group.

SECTION IX. GROUP CONTRIBUTION

Group shall offer Plan to all eligible Employees and eligible dependents in terms no less favorable regarding contribution by the Group toward premium than those applicable to such other health benefits coverage as may be available to all eligible individuals through the Group. Subject to applicable laws, the Group contribution mentioned in the Premium rate schedule and on the Group Application shall not be changed during the term of the Agreement unless such change is agreed to in writing by Hometown Health and Group. If however, the Group’s contribution to such other coverage as may be available through the Group is increased during the term of the Agreement, Group agrees to increase its contribution to Hometown Health coverage effective the same date as such increase to such other coverage becomes effective.

SECTION X. INELIGIBLE MEMBER

Group shall receive a credit for premiums paid, or be relieved of liability for unpaid but accrued premium, if Group gives Hometown Health notice of the ineligibility no later than sixty (60) days after the date eligibility ceased; provided, however, that Hometown Health has not provided or arranged for covered health services for the Member after the Member's eligibility ceased and Hometown Health received notice of ineligibility. Notwithstanding the above or Hometown Health's receipt and acceptance of a premium payment on behalf of an ineligible Member, Hometown Health may refund such premium payment(s) to Group and hold the Member liable for the fee-for-service equivalent for any services or benefits received during the period for which the Member was not eligible for coverage.

SECTION XI. NOTICE

Any notice to be given to Hometown Health must be sent by certified mail, return receipt requested, and shall be addressed as follows:

Hometown Health
ATT: VP of Insurance Services
10315 Professional Circle
Reno NV, 89521

The Group will identify the current Agent or Broker of Record on the Group Application. If the Group wishes to change the Agent or Broker of Record, written notice shall be provided to Hometown Health in advance of the change. Hometown Health will make the change effective on the first day of the month after receipt of proper written notice from the Group. The Agent or Broker of Record must hold a health insurance license required by the State of Nevada.

SECTION XII. TERMINATION OF AGREEMENT BY HOMETOWN HEALTH

Hometown Health may terminate this Agreement upon sixty (60) days written notice to the Group for the following:

(1) If the Group fails to meet eligibility requirements,

(2) If the Group fails to maintain enrollment percentage requirements as provided in the application,

(3) For misrepresentation of material facts or for any other material breach of the Contract,

(4) If the Group commits a fraudulent act (when this occurs, Hometown Health will recover paid claims),

(5) If the Group does not remit to Hometown Health any assessment billed for Hometown

health or any similar state or federal program,

(6) In the event of insolvency or bankruptcy of the Group; or

(7) For any reason as permitted by applicable law or regulation, upon giving the Group such advance notice, if any, as may be required by such law or regulation.

If a voluntary or involuntary insolvency or bankruptcy petition under Title XI of the United States Code is filed by or against the Group then within ten (10) days of the Petition date the Group shall file in the bankruptcy court a motion for authority to assume or reject this Agreement, effective in either case as of the date the motion is filed. If the Group fails to timely file such a motion, the Group acknowledges that Hometown Health may file in the bankruptcy court a motion requiring the Group to assume or reject this Agreement, effective in either case as of the date the motion is filed, and the Group agrees that it shall not oppose such motion. Hometown Health shall have no obligation to pay any claims under this Agreement unless and until all pre-Petition and all post-Petition premiums have been and are paid in full when due.

Hometown Health may terminate the Contract at any time during its term and without written notice to the Group for the Group's failure to make timely payment of amounts due under the Agreement. If the Group fails to pay the amounts due under this Agreement before the expiration of the applicable Grace Period, Hometown Health may then treat this Agreement as having immediately and automatically terminated, without any further notice or action being required by Hometown Health, and such termination shall be effective as of the last day for which the Group has made payment due under this Agreement.

Except as otherwise required by law, upon termination of the Agreement, regardless of the reason or manner of termination, Hometown Health shall cease to have any liability for claims or for the reimbursement of services incurred after the effective date of termination or the end of any applicable Grace Period (whichever is earlier) and shall have no liability to offer continuation or conversion coverage to Members under the Contract. If Hometown Health remains liable hereunder for a Member’s claims which are incurred after termination of this Agreement, the Group shall pay Hometown Health a pro rata premium for said Member during the period of post termination coverage.

When this Agreement is financed on an alternative (i.e. partially self-insured or shared funding) basis (Large Group only), the Group's failure to provide the requisite advance written notice of termination will entitle Hometown Health to recover, as liquidated damages, a sum equal to the average of the monthly charges imposed by Hometown Health under such alternative funding arrangement for the 90 days preceding the termination date, or any other termination amount as described in the alternative funding arrangement.

Nothing herein shall be construed as a waiver of that Agreement termination, or as a limitation on Hometown Health's remedies in the event of such termination.

If the Contract is terminated for any reason, reinstatement of the Contract is within Hometown Health's sole and absolute discretion.

SECTION XIII. TERMINATION BY GROUP

The Group may terminate this Agreement upon thirty (30) days written notice to Hometown Health for the reasons listed below. In no case will Hometown Health be obligated to terminate this Agreement in fewer than thirty (30) days.

(a) In the event of insolvency or bankruptcy of Hometown Health;

(b) In the event of revocation of Hometown Health's Certificate of Authority; or

(c) Upon material breach of any of the terms and provisions of this Agreement by Hometown Health. However, Hometown Health reserves the right to cure during the notice period thereby voiding the termination notice.

(d) For any reason as permitted by applicable law or regulation, upon giving Hometown Health such advance notice, if any, as may be required by such law or regulation.

When Hometown Health or the Group terminates this Agreement, regardless of the reasons or manner of termination, within ten (10) days of receipt of notice of termination, the Group shall notify the Members that this Agreement is to be or has been terminated.

SECTION XIV. SUBROGATION

(a) Group agrees that unless otherwise classified by regulations or statutes, the benefits to be issued by Hometown Health under the terms of this Agreement shall be second to any and all other sources of recovery. This includes any and all Group policies of insurance or other benefits available to Members, and any other party liable to Members or responsible for the payment of medical expenses or other damages of Members.

(b) If there are any other sources of recovery, Hometown Health shall have a right of recovery against other benefits arising out of other sources of recovery available to Member or Member's families, and shall have the right to seek recovery up to the full amount of the actual medical, hospital, or other health service bills for which Hometown Health has issued benefits.

(c) Hometown Health and Group agree that the premiums and costs of the benefits that are being rendered for the benefit of the Group Members have been computed and based upon the right of Hometown Health to make recoveries under the terms of this Agreement.

(d) If a Member reasonably fails to cooperate and assist Hometown Health in the recovery, payment and/or application for the sources described in SECTION XIV SUBROGATION Paragraph B, Hometown Health shall have the right to bill and seek recovery of such charges and/or costs from non - cooperating Member.

(e) The Group agrees to fully cooperate with Hometown Health to fully advise all Members of the rights of Hometown Health under the terms of the subrogation in the Evidence of Coverage that is a part of this Agreement.

(f) The Group also agrees to reasonably cooperate with Hometown Health and to take any actions needed for the enforcement of the Subrogation in the Evidence of Coverage that is a part of this Agreement.

(g) Hometown Health has the sole right and discretion to decide whether to retain a recovery/subrogation company or attorney to perform the task of recovering Plan funds or excess loss insurance funds in the event of a third party liability situation and the right and discretion to effectuate such retention. Hometown Health has the right to decide whether any such third party liability cases shall be settled and at what amount. The Group acknowledges that fees charged by said recovery/subrogation company or attorney shall be paid by the Group and may include payment to Third Party Administration for its services in the subrogation process.

(h) Upon any recovery by the Member, the Member agrees that any funds received by the Member and/or their attorney, if any, from any source for any purpose shall be held in trust until the Member's obligation under this provision is fully satisfied.

(i) Certain facts are needed to process subrogation recoveries. Hometown Health has the right to decide which facts are needed. Hometown Health may get necessary facts from or give them to any other organization or person. Hometown Health need not tell, or get the consent of, any Member to investigate, obtain or provide such facts except where specifically required by law. Each Member claiming benefits under the Contract must give Hometown Health any facts needed to process any claim and pursue any subrogation recovery. For benefits paid pursuant to this Agreement, the authority granted by the provisions of this paragraph will survive termination of this Agreement.

SECTION XV. GENERAL PROVISIONS

Acts of God: If war, public disaster, public emergency, general epidemic, or other similar conditions prevent Providers of Services from providing services to Members, Hometown Health shall attempt to provide for such services in a comparable manner to the extent possible. If not possible, then Hometown Health may terminate this Agreement, fully satisfy any payments then due and owing to any third party and refund the amount of the unearned prepaid premiums held by Hometown Health on the date such event occurs.

Amendments: Neither party to this Agreement may amend the Agreement without prior written consent of the other party.

Assignment: Neither the Group, Member nor Subscriber may assign the benefits provided pursuant to this Agreement, and the applicable Evidence of Coverage. Any assignment by the Group, Member or Subscriber shall not be effective. Hometown Health may assign this Agreement to a successor organization or corporate affiliate without the Group's consent.

Authority to Adopt Policies: Hometown Health may adopt such policies, procedures, and rules to promote orderly and efficient administration of this Agreement.

Construction of Terms and Headings: Words used in this Agreement shall be read as the masculine, feminine, or neuter gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this Agreement.

Entire Agreement: This Agreement constitutes the entire Agreement between the parties and contains all the Agreements between the parties with respect to the subject matter hereof. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

Evidence of Coverage: Hometown Health will issue to the Group and its Members who are covered under this Agreement, an Evidence of Coverage. The Evidence of Coverage sets forth the coverage to which the Member is entitled. The Evidence of Coverage issued to the Group shall be fully incorporated into the terms of this Agreement.

Governing Law: To the extent not preempted by federal law or regulation, this Agreement will be governed, interpreted, construed and enforced under and in accordance with the laws of the State of Nevada along with applicable federal statutes and regulations.

Venue: Exclusive venue for any litigation arising out of this Agreement shall be the Second Judicial District Court, Washoe County, Nevada.

Attorneys' Fees: If either party to this Agreement seeks the assistance of an attorney for litigating or

arbitrating any action against the other party arising in whole or in part from any part of this Agreement, the prevailing party will be awarded its reasonable attorneys' fees and entitled to recover said fees from the losing party. In addition, the prevailing party will be entitled to recover all other reasonably incurred costs and expenses from the losing party.

Identification Cards: A card shall be issued to each Member and must be presented whenever services are sought. Possession of a card confers no right to services or guarantees of payment by Hometown Health. A person must be eligible and premiums must be paid for services to be covered. A card is not a guarantee of eligibility. Persons receiving services to which they are not entitled shall be charged and responsible for payment for the services. The identification card is the property of Hometown Health.

New Subscribers: All new Employees eligible to and applying for coverage within their eligibility date for coverage shall be added to the original Group.

No Third Party Rights: except as provided in this Agreement, anything in this Agreement shall be construed as creating or leading to any rights to any third parties or any persons.

Relationship to Providers: The relationship between Hometown Health and its Providers is that of an independent contractor. Hometown Health does not undertake to furnish any healthcare services but will pay for such services furnished to Members as provided for under and limited by the Contract, including the certificates issued under this Agreement. Nothing contained in this Agreement will give the Group or Members any right or cause of action, either at law or in equity, against Hometown Health or any of its medical directors, employees or agents for acts or omissions of any hospital or other health care providers from which any Members receive service. The parties acknowledge that Hometown Health, its medical directors, employees and/or agents are not engaged in the practice of medicine; Hometown Health merely makes decisions regarding the coverage of services. Contracted physicians and other medical providers acknowledge and agree within the provisions of their provider agreements that they must exercise independent medical judgment regarding the treatment of their patients, regardless of Hometown Health's coverage determinations.

Relationship of Hometown Health and Group: Nothing contained in this Agreement will be considered to constitute the Group and Hometown Health as partners, or as employees, agents or representatives of one another, nor will either party have the expressed or implied right or authority to assume or create any obligation on behalf of, or in the name of, the other party through its actions, omissions or representations.

Strict Performance: No failure by either party to insist upon the strict performance of any term of this Agreement, or to exercise a right or remedy, shall constitute a waiver. No waiver of any breach shall affect or alter this Agreement but each and every term of this Agreement shall continue in full force and effect with respect to any other existing or subsequent breach.

Except as specifically described in this Agreement, the Group is not responsible for the services provided under and/or the benefits of the insurance coverage offered in connection with this Agreement but the Group is simply agreeing that it's eligible employees or plan participants have the option of enrolling in the health care benefits program offered by Hometown Health. In holding itself out to perform services

under this Agreement, Hometown Health does not act as an agent for, or for the benefit of, the Group.

HIPAA and Protected Health Information: For the purposes of this paragraph, the following definitions have the same meaning as defined in the health insurance portability and accountability act of 1996 ("HIPAA") and regulations under HIPAA:

(a) "Group Health Plan" as defined at 45 CFR part 160, Sec. 160. 103

(b) "Protected Health Information" (PHI) as defined at 45 CFR Part 164, Sec. 164.501

(c) "Summary Health Information" as defined at 45 CFR Part 164, Sec. 164.504(a)

Hometown Health may disclose summary health information to the Group if the Group requests such information for the purpose of obtaining premium bids from health insurers, HMOs or other Third-Party payers under the group health plan, or for modifying, amending or terminating the group health plan.

Hometown Health may disclose PHI to the Group to enable the Group to carry out plan administration functions, that such disclosure may occur only upon receipt of a certification from the Group that:

(a) the Group's plan documents include all the requirements described in 45 CFR Part 164, Sec. 164.504.(f)(2)(i), (ii) and (iii);

(b) the Group has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, SEC. 164. 520 (B) (1) (iii)(C); and

(c) that such PHI will not be used for the purpose of employment–related actions or decisions or in connection with any other benefits or employee benefits plan of the Group.

Hometown Health agrees to use its best efforts to treat all Members' medical records and information concerning claims, conditions or treatment in a confidential manner. Hometown Health will not disclose such confidential information except as authorized by the Member or Member's authorized representative or as outlined above and permitted by law.

No Representations and Warranties: The Group acknowledges that no warranties or representations other than those contained in this Agreement have been made or given by Hometown Health or its representatives and that in entering into this Agreement, the Group has relied solely on the express terms of the Agreement and not on any other oral or written statement not incorporated in the Contract. The Group further acknowledges that Hometown Health has made no representations or warranties, express or implied, about whether the Group's health benefits plan, as administered and implemented by the Group, complies with state and federal laws.

Proprietary Information: Hometown Health agrees to treat all proprietary information about the Group's operations in the plan in a confidential manner. The Group agrees to treat all information about Hometown Health's business operations, ideas, know-how, trade secrets, discount information and other proprietary data in a confidential manner. Neither party will disclose any such information to any other

person, entity or organization without the prior written consent of the party to whom the information pertains, provided, however, and notwithstanding any other provision in the Contract to the contrary, that Hometown Health may disclose such information to its legal advisers, lenders and business advisors, and Hometown Health may also make such disclosures as are required or appropriate under the Securities Act of 1933, as amended, the Securities Exchange Act of 1934, as amended, and other applicable securities laws and rules of the New York Stock Exchange. Nothing in this provision will prohibit the disclosure of any information required by law, but if any such disclosure occurs, the disclosing party will immediately notify the other party in writing, detailing the circumstances and extent of the disclosure. The provisions of this paragraph will survive termination of this Agreement.

Section XVI. COVERAGE

Medical Benefit Plan:	19 LG PPO 40-CO 1500 A D1500X3
Rx Benefit:	RX $15/$40/$60/20%
Renown Occ Health:	N

Section XVII. PREMIUM RATE SCHEDULE

TYPE OF COVERAGE	Total Premium
Individual Subscriber	$568.60
Subscriber Plus Spouse	$1,165.78
Subscriber Plus Child	$1,090.96
Subscriber Plus Children	$1,090.96
Subscriber Plus Family	$1,781.74

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of City of Carson City under this Agreement by and between Hometown Health and City of Carson City shall become effective as of 12:01 AM on 7/1/2019, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2020, or unless otherwise terminated as allowed herein.

The undersigned representative of City of Carson City has reviewed the above information, approves the terms of the Contract, and is not an insurance agent, broker, pension consultant, or insurance company involved in the transaction.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Contract Effective Date.

Hometown Health
BY

Ty Windfeldt
CEO, Hometown Health

3/4/2019
Date

City of Carson City
BY

(Authorized Signature of Group)

Date

Section XVI. COVERAGE

Medical Benefit Plan:	19 LG PPO 40-CO 1500 A D1500X3
Rx Benefit:	RX $15/$40/$60/20%
Renown Occ Health:	N

Section XVII. PREMIUM RATE SCHEDULE

TYPE OF COVERAGE	Total Premium
Retiree w/ Medicare	$417.73
Retiree & Spouse (One w/ Medicare)	$1,047.79
Retiree & Spouse (Both w/ Medicare)	$886.61
Retiree & Child (Retiree w/ Medicare)	$1,081.50
Retiree & Children (Retiree w/ Medicare)	$1,081.50
Family (Retiree or Spouse w/ Medicare)	$1,256.14
Family (Retiree & Spouse w/ Medicare)	$1,080.55

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of City of Carson City under this Agreement by and between Hometown Health and City of Carson City shall become effective as of 12:01 AM on 7/1/2019, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2020, or unless otherwise terminated as allowed herein.

The undersigned representative of City of Carson City has reviewed the above information, approves the terms of the Contract, and is not an insurance agent, broker, pension consultant, or insurance company involved in the transaction.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Contract Effective Date.

Hometown Health
BY

Ty Windfeldt
CEO, Hometown Health

3/4/2019
Date

City of Carson City
BY

(Authorized Signature of Group)

Date

Section XVI. COVERAGE

Medical Benefit Plan:	19 LG PPO HD-NA CINS D2700X2 HSA
Rx Benefit:	RX 0%/0%/0%/0%
Renown Occ Health:	N

Section XVII. PREMIUM RATE SCHEDULE

TYPE OF COVERAGE	Total Premium
Individual Subscriber	$389.95
Subscriber Plus Spouse	$799.52
Subscriber Plus Child	$748.21
Subscriber Plus Children	$748.21
Subscriber Plus Family	$1,221.97

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of City of Carson City under this Agreement by and between Hometown Health and City of Carson City shall become effective as of 12:01 AM on 7/1/2019, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2020, or unless otherwise terminated as allowed herein.

The undersigned representative of City of Carson City has reviewed the above information, approves the terms of the Contract, and is not an insurance agent, broker, pension consultant, or insurance company involved in the transaction.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Contract Effective Date.

Hometown Health
BY

Ty Windfeldt
CEO, Hometown Health

3/4/2019
Date

City of Carson City
BY

(Authorized Signature of Group)

Date

Section XVI. COVERAGE

Medical Benefit Plan:	19 LG PPO HD-NA CINS D2700X2 HSA
Rx Benefit:	RX 0%/0%/0%/0%
Renown Occ Health:	N

Section XVII. PREMIUM RATE SCHEDULE

TYPE OF COVERAGE	Total Premium
Retiree w/ Medicare	$286.46
Retiree & Spouse (One w/ Medicare)	$718.53
Retiree & Spouse (Both w/ Medicare)	$608.03
Retiree & Child (Retiree w/ Medicare)	$741.70
Retiree & Children (Retiree w/ Medicare)	$741.70
Family (Retiree or Spouse w/ Medicare)	$861.49
Family (Retiree & Spouse w/ Medicare)	$741.00

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of City of Carson City under this Agreement by and between Hometown Health and City of Carson City shall become effective as of 12:01 AM on 7/1/2019, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2020, or unless otherwise terminated as allowed herein.

The undersigned representative of City of Carson City has reviewed the above information, approves the terms of the Contract, and is not an insurance agent, broker, pension consultant, or insurance company involved in the transaction.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Contract Effective Date.

Hometown Health
BY

Ty Windfeldt
CEO, Hometown Health

3/4/2019
Date

City of Carson City
BY

(Authorized Signature of Group)

Date

Addendums to Contract Plan Year 2019-2020

Addendum 1 – Wellness/Travel/Rehires/Lay-Offs

1. Hometown Health will provide a biometric wellness screening at the 2019 Carson City Health Fair provided it occurs after the effective date of the contract, July 1, 2019 at no cost to Carson City employees enrolled in Hometown Health.

2. Hometown Health will provide a 2019 Flu Shoot Clinic for Carson City enrolled members at no cost to the Carson City.

3. Hometown Health will provide a $2,500 wellness allowance to Carson City to be used for Wellness services other than those listed in items #1 and #2 above. The wellness vendor, any services, or supplies must be approved prior to purchase, which will not be unreasonably withheld by Hometown Health. Hometown Health will remit payment to the approved vendor within 30 days of receipt of invoice. Funds must be spent within the July 1, 2019 thru June 30, 2020 contract period.

4. Hometown Health will grandfather in the covered travel benefit for employee #4095 traveling to Utah for treatment.
    - This benefit allows a maximum of $200 per day for travel expenses, up to a cumulative limit of $2000 per trip (includes covered living expenses for the patient and his/her primary caregiver; if the patient is a minor, covered living expenses for the patient and his/her parents or family members). You will be reimbursed the lesser of your actual expenses of $200 per day.
    - This benefit also allows a maximum of $1,000 for travel expenses incurred for each trip to the city of the Utah facility. The annual limit on all eligible travel expenses is $10,000. If the employee loses insurance eligibility during the contract term and has $2,500 remaining from the $10,000 allowance, HHP will give Carson City an additional $2,500 wellness allowance which must be used outlined in section 3 above.

      Covered travel expenses include:

1. Airfare for the patient and one support person (primary care giver) or both parents if patient is a dependent.
2. Rental Car and IRS mileage allowance for mileage recorded on the rental car receipt. Mileage is reimbursed at the current IRS rate- visit www.irs.gov for current 2019 rates.
3. If the member is driving or being driven from home to University of Utah and back, mileage is reimbursed at the current IRS rate.

5. Employees reinstated pursuant to an arbitrator's decision or Court order may be entitled to reinstate insurance immediately. Employees who are rehired and/or reinstated due to a layoff, must wait to reinstate insurance until the 1st of the month following 60 days of employment.

Addendum 2 – July 1, 2020 Renewal

Hometown Health will guarantee that if the parties agree to renew the contract on July 1, 2020, the renewal rate will not exceed 12%. This rate cap guarantee does not require Carson City to renew with Hometown Health.

10315 Professional Circle • Reno, Nevada 89521 • 775-982-3000 • www.hometownhealth.com