



STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** May 7, 2020

Staff Contact: Melanie Bruketta

Agenda Title: For Possible Action: Discussion and possible action regarding proposed health, dental and life insurance contracts for Carson City to provide benefits coverage to City employees and retirees with the following providers: (1) health insurance benefits through Hometown Health as a one-year contract renewal without a rate increase and continued funding of health savings accounts for active employees in fiscal year (FY) 2021 in the FY annual amount of \$2,143 (employee only), \$3,269 (employee plus spouse), \$3,128 (employee plus children) and \$4,430 (employee plus family); (2) dental insurance benefits through Cigna as a two-year contract with a 5.9% decrease from the existing rate; and (3) life insurance benefits through Kansas City Life as a two-year contract with an 18% decrease from the existing rate. (Melanie Bruketta, mbruketta@carson.org)

Staff Summary: This item is for the Board of Supervisors to consider the approval of contracts with benefits providers for the provision of health, dental and life insurance for City employees and retirees.

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

Proposed Motion

I move to approve the benefits contracts as presented.

Board's Strategic Goal

Organizational Culture

Previous Action

The Board of Supervisors approved the health insurance plan for FY 2020 at the April 18, 2019 meeting. Contracts for dental, life and vision benefits did not need to be renewed last year.

Background/Issues & Analysis

The City's combined medical and prescription adjusted claims loss ratio is 78%. Last year, the combined medical and prescription loss ratio was 91%. The 78% loss ratio is driven by overall utilization trends and the presence of large claims. The City approved the implementation of a high deductible plan two years ago which has contributed to the decrease in the loss ratio. However, since this is the first year with a new carrier, the loss ratio does not account for incurred but not reported claims, which tend to lag during the first 12 months. Standard underwriting practices would call for an approximate 8% increase to the City's current rates. This includes medical and prescription cost forecasting (or trend) of about 5%-9% and taxes of approximately 4%. However, City staff was able to negotiate a rate pass with Hometown Health for fiscal year 2021.

The City was not so fortunate with the dental renewal quote received from Anthem due to the claims loss ratio which is running in the low 90% range. Anthem refused to provide a renewal quote for anything lower than a 5% increase. As a result, the Human Resources Department requested that the City's broker, LP Insurance,

market for dental coverage. Responses were received from several providers offering rates lower than the 5% increase offered by Anthem. Although Met Life was the lowest response at a 9.3% decrease off the current rates, they do not provide a competitive network of dentists in the area. The second lowest bidder was Cigna with a 5.9% decrease off the current rates for a two-year period and included an increase in benefits from two to three cleanings a year and composite fillings on all teeth, not just the front teeth.

Life insurance is typically marketed with dental. The City received responses from various life insurance providers. Kansas City Life was the lowest responsive bidder at an 18% decrease off the current rates for a two-year period.

The City's Insurance Committee met on April 7, 2020 and Human Resources received no objections to the proposed recommendations.

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: 5700706-506301, 5700706-506302, & 5700706-506303 - Health insurance increase of 0%, dental insurance decrease of 5.9% and life insurance decrease of 18%.

Is it currently budgeted? Yes

Explanation of Fiscal Impact: The health insurance amounts will not change from prior year and will be reduced for the final budget which will come before this Board on May 21, 2020. Staff originally projected a 10% increase, which was built into the FY 2021 Tentative Budget that received Board of Supervisors' approval on April 16, 2020.

Alternatives

Do not approve one or more of the proposed contracts and direct staff to request the City's benefits broker to identify other providers.

Attachments:

[Reporting Data.pdf](#)

[Analysis.pdf](#)

[HHP Contract 2020 - Final.docx](#)

[Attachment 1 HHP Contract.pdf](#)

[PPO Benefit Summary HHP.pdf](#)

[HD Benefit Summary HHP.pdf](#)

[4620_CARSON CITY NEVADA_202007_Model_20191205_HTH Renewal July 2020.pdf](#)

Cigna Administrative Summary.rtf

Cigna Dental Summary.pdf

Cigna Signature Page.pdf

KCL Admin Structure.pdf

KCL Employer Application.pdf

KCL Life Summary.pdf

KCL Signature Page.pdf

Board Action Taken:

Motion: _____

1) _____

2) _____

Aye/Nay

(Vote Recorded By)

Benefit Program Reporting Package

Prepared For:



Claims data through: January 2020

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Section 1: Claims Data Review - Current and Prior Period

Medical

Dental

Vision

Section 2: Medical Claims vs Premium Graph





Medical & Pharmacy Performance

Rolling 12 Months - Current									
Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical Claims	Rx Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Jan-19	720	1,434	\$653,639	\$908	\$447,701	\$135,840	\$583,541	\$810	89%
Feb-19	719	1,429	\$650,024	\$904	\$676,098	\$152,483	\$828,581	\$1,152	127%
Mar-19	718	1,432	\$649,450	\$905	\$383,050	\$159,722	\$542,772	\$756	84%
Apr-19	717	1,429	\$648,732	\$905	\$667,376	\$136,473	\$803,849	\$1,121	124%
May-19	720	1,437	\$652,385	\$906	\$493,594	\$146,492	\$640,086	\$889	98%
Jun-19	719	1,438	\$652,371	\$907	\$415,840	\$133,166	\$549,006	\$764	84%
Jul-19	717	1,433	\$616,149	\$859	\$44,617	\$40,430	\$85,047	\$119	14%
Aug-19	717	1,436	\$623,641	\$870	\$182,772	\$101,390	\$284,162	\$396	46%
Sep-19	719	1,449	\$617,286	\$859	\$277,976	\$94,484	\$372,460	\$518	60%
Oct-19	719	1,455	\$627,764	\$873	\$363,892	\$91,343	\$455,235	\$633	73%
Nov-19	720	1,457	\$622,112	\$864	\$300,706	\$104,980	\$405,686	\$563	65%
Dec-19	724	1,462	\$621,904	\$859	\$347,327	\$93,210	\$440,537	\$608	71%
Total	8,629	17,291	\$7,635,457	-	\$4,600,949	\$1,390,012	\$5,990,961	-	78%
Average	719	1,441	\$636,288	\$885	\$383,412	\$115,834	\$499,247	\$694	78%

Rolling 12 Months - Prior									
Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical Claims	Rx Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Jan-18	712	1,426	\$652,018	\$916	\$342,813	\$128,008	\$470,821	\$661	72%
Feb-18	712	1,421	\$648,843	\$911	\$304,172	\$137,279	\$441,451	\$620	68%
Mar-18	718	1,424	\$650,987	\$907	\$429,477	\$155,606	\$585,083	\$815	90%
Apr-18	721	1,435	\$654,867	\$908	\$377,501	\$94,492	\$471,993	\$655	72%
May-18	717	1,439	\$656,698	\$916	\$342,868	\$151,410	\$494,278	\$689	75%
Jun-18	716	1,432	\$655,688	\$916	\$723,757	\$170,547	\$894,304	\$1,249	136%
Jul-18	713	1,426	\$650,258	\$912	\$330,432	\$125,789	\$456,221	\$640	70%
Aug-18	713	1,435	\$652,509	\$915	\$491,882	\$162,541	\$654,423	\$918	100%
Sep-18	710	1,424	\$648,328	\$913	\$301,221	\$142,642	\$443,863	\$625	68%
Oct-18	709	1,409	\$646,013	\$911	\$323,122	\$176,295	\$499,417	\$704	77%
Nov-18	711	1,413	\$648,201	\$912	\$352,230	\$167,289	\$519,519	\$731	80%
Dec-18	717	1,422	\$650,996	\$908	\$447,300	\$144,304	\$591,604	\$825	91%
Total	8,569	17,106	\$7,815,406	\$912	\$4,766,775	\$1,756,202	\$6,522,977	\$761	83%
Average	714	1,426	\$651,284	\$912	\$397,231	\$146,350	\$543,581	\$761	83%

Current / Prior	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical Claims	Rx Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Average	719	1,441	\$636,288	\$885	\$383,412	\$115,834	\$499,247	\$694	78%
Average	714	1,426	\$651,284	\$912	\$397,231	\$146,350	\$543,581	\$761	83%
Changes:	0.7%	1.1%	-2.3%	-3.0%	-3.5%	-20.9%	-8.2%	-8.8%	-6.0%

Underwriting Loss Ratio, Including Capitated Claims Est., Starting Point before Large claim Exceptions	80%
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Rolling 12 Medical Claims vs Paid Premium





Dental Performance

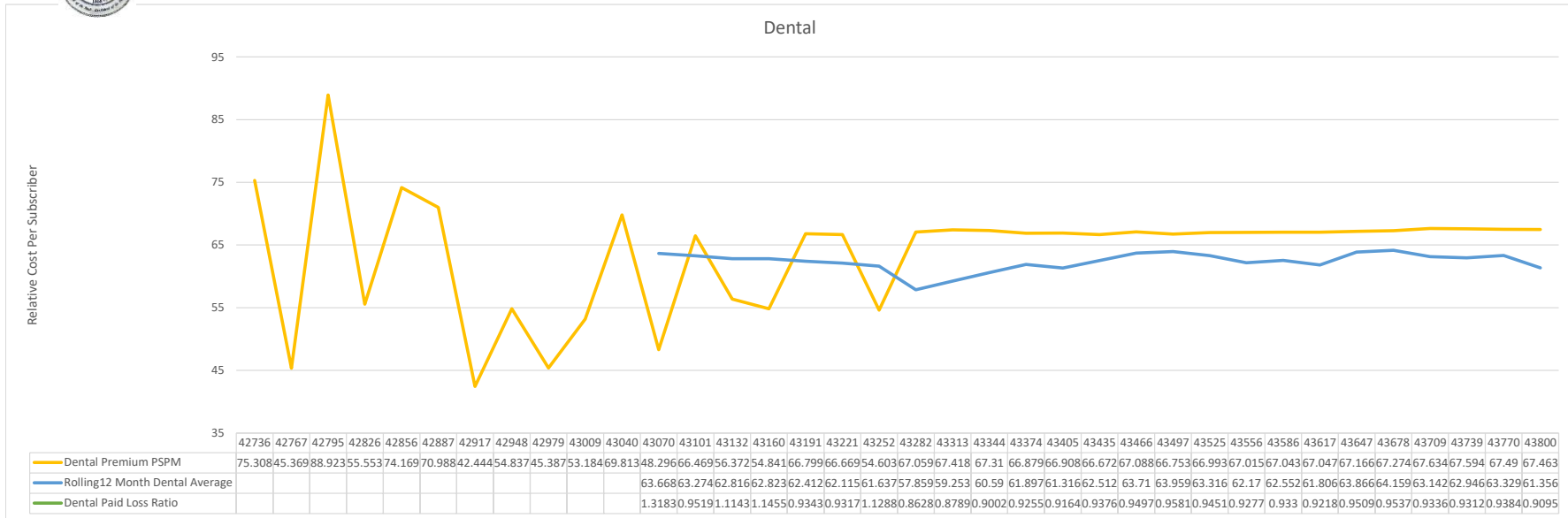
Rolling 12 Months - Current								
Month/Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Dental Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Jan-19	720	1,434	\$48,303	\$67	\$59,822	\$59,822	\$83	124%
Feb-19	719	1,429	\$47,995	\$67	\$50,659	\$50,659	\$70	106%
Mar-19	718	1,432	\$48,101	\$67	\$43,183	\$43,183	\$60	90%
Apr-19	717	1,429	\$48,049	\$67	\$38,973	\$38,973	\$54	81%
May-19	720	1,437	\$48,271	\$67	\$52,413	\$52,413	\$73	109%
Jun-19	719	1,438	\$48,207	\$67	\$41,821	\$41,821	\$58	87%
Jul-19	717	1,433	\$48,158	\$67	\$34,370	\$34,370	\$48	71%
Aug-19	717	1,436	\$48,235	\$67	\$50,273	\$50,273	\$70	104%
Sep-19	719	1,449	\$48,629	\$68	\$35,552	\$35,552	\$49	73%
Oct-19	719	1,455	\$48,600	\$68	\$46,243	\$46,243	\$64	95%
Nov-19	720	1,457	\$48,593	\$67	\$48,235	\$48,235	\$67	99%
Dec-19	731	1,483	\$49,267	\$67	\$36,478	\$36,478	\$50	74%
Total	8,636	17,312	\$580,409	-	\$538,022	\$538,022	-	93%
Average	720	1,443	\$48,367	\$67	\$44,835	\$44,835	\$62	93%

Rolling 12 Months - Prior								
Month/Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Dental Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Jan-18	712	1,426	\$47,326	\$66	\$49,042	\$49,042	\$69	104%
Feb-18	712	1,421	\$40,137	\$56	\$48,083	\$48,083	\$68	120%
Mar-18	718	1,424	\$39,376	\$55	\$48,698	\$48,698	\$68	124%
Apr-18	721	1,435	\$48,162	\$67	\$49,057	\$49,057	\$68	102%
May-18	717	1,439	\$47,802	\$67	\$48,947	\$48,947	\$68	102%
Jun-18	716	1,432	\$39,096	\$55	\$48,043	\$48,043	\$67	123%
Jul-18	713	1,426	\$47,813	\$67	\$16,427	\$16,427	\$23	34%
Aug-18	713	1,435	\$48,069	\$67	\$47,496	\$47,496	\$67	99%
Sep-18	710	1,424	\$47,790	\$67	\$43,724	\$43,724	\$62	91%
Oct-18	709	1,409	\$47,418	\$67	\$47,300	\$47,300	\$67	100%
Nov-18	711	1,413	\$47,571	\$67	\$44,365	\$44,365	\$62	93%
Dec-18	717	1,422	\$47,804	\$67	\$44,482	\$44,482	\$62	93%
Total	8,569	17,106	\$548,363	-	\$535,664	\$535,664	-	98%
Average	714	1,426	\$45,697	\$64	\$44,639	\$44,639	\$63	98%

Current / Prior	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Dental Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Average	720	1,443	48,367	67	44,835	44,835	62	93%
Average	714	1,426	45,697	64	44,639	44,639	63	98%
Changes:	0.8%	1.2%	5.8%	5.0%	0.4%	0.4%	-0.3%	-5.1%



Rolling 12 Dental Claims vs Paid Premium



Market Survey Analysis

Prepared for

Carson City

Presented By:

LP Insurance Services
Employee Benefits Division



Effective: July 1, 2020

LP Insurance Services, LLC
License #710906

INSURANCE BROKERS * EMPLOYEE BENEFIT CONSULTANTS

**Carson City
Response To Bid**

<u>CARRIERS CONTACTED</u>	<u>BID RESPONSE</u>	<u>%Over/Under current</u>
<u>Medical</u>		
Hometown Health	Current/Renewal	0.0%
<u>Dental</u>		
Anthem	Current/Renewal	5.0%
Cigna	Presented	-6.8%
Standard	Presented	-5.0%
Met Life	Uncompetitive Network	-9.3%
Best Life	Not Competitive	N/A
Kansas City Life	Not Competitive	N/A
Mutual of Omaha	Not Competitive	N/A
Reliance Standard	Not Competitive	N/A
UNUM	Not Competitive	N/A
Guardian	Not Competitive	N/A
Humana	Retirees Not Included	N/A
Ameritas	Declined to Quote	N/A
Delta	Declined to Quote	N/A
Lincoln	Declined to Quote	N/A
Principal	Declined to Quote	N/A
<u>Vision</u>		
EyeMed	Current (Rate Guarantee)	-
<u>Life</u>		
Anthem	Current/Renewal	0.0%
Kansas City Life	Quote Presented	-18.0%
Mutual of Omaha	Quote Presented	-16.0%
Renaissance	Quote Presented	-6.0%
Standard	Not Competitive	N/A
Lincoln Financial	Declined to Quote	N/A
Met Life	Declined to Quote	N/A
Principal	Declined to Quote	N/A
Reliance Standard	Declined to Quote	N/A
UNUM	Declined to Quote	N/A

Carson City
Medical Benefits & Cost Comparison

Carrier
Network
Individual Calendar Year Deductible
Family Calendar Year Deductible
Individual Calendar Year Out of Pocket Max.
Family Calendar Year Out of Pocket Max.
Primary Physician Copay
Specialist Physician Copay
Emergency Room
Urgent Care Center
Lab, X-Ray (Non-Hospital)
MRI, PET, CT Scans (Non-Hospital)
Outpatient Surgery
Inpatient Hospitalization
In Network Prescription Benefit:
Tier I
Tier II
Tier III
Rates: (Actives & Early Retirees)
Employee
Employee + Spouse
Employee + Children
Family
Rates: (Retired with Medicare)
Retiree w/ Medicare (A&B)
Retiree + Spouse, both w/ Medicare (A&B)
Retiree + Spouse, one w/ Medicare (A&B)
Retiree + Child(ren), w/ Medicare (A&B)
Retiree + Family, both w/ Medicare (A&B)
Retiree + Family, one w/ Medicare (A&B)
Monthly Premium
Annual Premium
\$ over/(under) current
% over/(under) current
Monthly HSA Funding
Annual HSA Funding
Monthly Premium w/ HSA Funding
Annual Premium w/ HSA Funding
Monthly Premium
Annual Premium

Current & Renewal					
		Hometown \$2700 PPO HSA		Hometown \$1500 PPO	
		In-Network	Out-Network	In-Network	Out-Network
		\$2,700 → \$2,800	\$5,400 → \$5,600	\$1,500	\$5,000
		\$5,400 → \$5,600	\$10,800 → \$11,200	\$4,500	\$15,000
		\$2,700 → \$2,800	\$10,000	\$6,000	\$12,000
		\$5,400 → \$5,600	\$20,000	\$12,000	\$24,000
		0% (d)	30% (d)	\$40	50% (d)
		0% (d)	30% (d)	\$60	50% (d)
		0% (d)	0% (d)	\$150	\$150
		0% (d)	0% (d)	\$50	\$50
		0% (d)	30% (d)	\$0, \$60	50% (d)
		0% (d)	30% (d)	\$100	50% (d)
		0% (d)	30% (d)	\$500	50% (d)
		0% (d)	30% (d)	\$1,500 (d)	50% (d)
					\$15
					\$40
					\$60 + Ancillary Charge
		Current	Renewal	Current	Renewal
	90	\$389.95	\$389.95	245	\$568.60
	21	\$799.52	\$799.52	77	\$1,165.78
	33	\$748.21	\$748.21	71	\$1,090.96
	44	\$1,221.97	\$1,221.97	88	\$1,781.74
	188			481	
	0	\$286.46	\$286.46	46	\$417.73
	0	\$608.03	\$608.03	7	\$886.61
	0	\$718.53	\$718.53	1	\$1,047.79
	0	\$741.70	\$741.70	0	\$1,081.50
	0	\$741.00	\$741.00	0	\$1,080.55
	0	\$861.49	\$861.49	2	\$1,256.14
	0			56	
		\$130,343	\$130,343		\$492,305
		\$1,564,116	\$1,564,116		\$5,907,663
			\$0		\$0
			0.0%		0.0%
		\$46,639	\$46,639	-	-
		\$559,663	\$559,663	-	-
		\$176,982	\$176,982	\$492,305	\$492,305
		\$2,123,779	\$2,123,779	\$5,907,663	\$5,907,663.12
		Both Plans (with HSA Funding)			
		\$669,287			
		\$8,031,442			

City of Carson City
Dental Benefits & Cost Comparison

Carrier	Anthem		Cigna		Standard		Met Life		Met Life	
Network	DDS, Prime		Cigna		DDS, Ameritas		Met Life		Met Life	
	<u>In-Network</u>	<u>Out-Network</u>	<u>In-Network</u>	<u>Out-Network</u>	<u>In-Network</u>	<u>Out-Network</u>	<u>In-Network</u>	<u>Out-Network</u>	<u>In-Network</u>	<u>Out-Network</u>
Reimbursement	Neg. Fee	MAC	Neg. Fee	MAC	Neg. Fee	MAC	Neg. Fee	MAC	Neg. Fee	MAC
Individual Calendar Year Deductible	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Family Calendar Year Deductible	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Coverage Level:										
Preventive	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Basic	20% (d)	20% (d)	20% (d)	20% (d)	20% (d)	20% (d)	20% (d)	20% (d)	20% (d)	20% (d)
Major	45% (d)	45% (d)	45% (d)	45% (d)	45% (d)	45% (d)	45% (d)	45% (d)	45% (d)	45% (d)
Orthodontia	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Coverage:										
Cleaning Frequency	3 every 12 months		3 Every 12 Mo.		3 Every 12 Mo.		3 Every 12 Mo.		3 Every 12 Mo.	
Composite Fillings	Anterior Only		Anterior & Posterior		Anterior Only		Anterior Only		Anterior Only	
Crowns	Major		Major		Major		Major		Major	
Endo and Perio	Basic		Basic		Basic		Basic		Basic	
Oral Surgery	Basic		Basic		Basic		Basic		Basic	
Implants	Major		Major		Major		Major		Major	
Calendar Year Maximum	\$2,000		\$2,000		\$2,000		\$2,250 <i>Applies to Basic/Major Only</i>		\$3,000 \$2,500 <i>Applies to Basic/Major Only</i>	
Orthodontia Lifetime Maximum	\$1,500		\$1,500		\$1,500		\$1,500		\$1,500	
Missing Tooth Provision	Yes		Yes		Yes		Yes		Yes	
Roll-Over Benefits	Yes		No		Yes		No		No	
Waiting Periods (timely applicants):										
Basic	None		None		None		None		None	
Major	None		None		None		None		None	
Rates:	Current	Renewal	Proposed	Proposed	Proposed	Proposed	Proposed	Proposed	Proposed	Proposed
Employee Only	380	\$48.31	\$50.73	\$45.03	\$45.47	\$45.89	\$46.98	\$43.82	\$44.83	\$44.83
Employee + Spouse	107	\$67.95	\$71.35	\$63.34	\$63.95	\$64.56	\$66.09	\$61.63	\$63.06	\$63.06
Employee + Child(ren)	104	\$85.92	\$90.22	\$80.09	\$80.86	\$81.62	\$83.55	\$77.93	\$79.73	\$79.73
Family	135	\$105.56	\$110.84	\$98.40	\$99.35	\$100.28	\$102.65	\$95.74	\$97.96	\$97.96
	726									
Monthly Premium	\$48,815	\$51,258	\$45,502	\$45,943	\$46,372	\$47,471	\$44,276	\$45,299	\$45,299	\$45,299
Annual Premium	\$585,777	\$615,098	\$546,026	\$551,315	\$556,469	\$569,652	\$531,308	\$543,592	\$543,592	\$543,592
\$ over/(under) current	-	\$29,321	-\$39,751	-\$34,461	-\$29,308	-\$16,125	-\$54,469	-\$42,185	-\$42,185	-\$42,185
% over/(under) current	-	5.0%	-6.79%	-5.88%	-5.00%	-2.75%	-9.30%	-7.20%	-7.20%	-7.20%
Rate Guarantee		12 months	12 months	24 months	12 months	24 months	12 months	12 months	12 months	12 months
	8% Rate Cap on 2021 Renewal				Rollover amounts will be honored		5% Rate Cap on 2021 & 2022 Renewal		5% Rate Cap on 2021 & 2022 Renewal	

**Carson City
Top Dental Providers Comparison by Carrier**

DENTIST NAME	Anthem		Metlife		Cigna		Standard	
	In Network	Out Network	In Network	Out Network	In Network	Out Network	In Network	Out Network
Snell-Killam Aimee N	X		X		X		X	
Carman Gregory B	X		X		X		X	
Schofield Matthew Paul	X			X	X		X	
Horgan Benjamin T	X		X		X		X	
Marvel Jamie L	X			X		X	X	
Coombs Ryan P	X			X	X		X	
Nelson Marc A	X			X	X		X	
Parsons Heather M	X		X		X			X
Kiggins Justin D	X		X		X		X	
Funke Mark D	X			X	X		X	
Peterson Kevin M	X			X	X		X	
Aglietti Gary C	X			X	X		X	
Unruh Thomas C	X			X	X			X
Acevedo Jason R	X		X		X			X
West Ronald D	X		X		X		X	
Almaraz Michael G	X			X	X		X	
Hardman Paul D	X			X	X		X	
Brewer Shannon R	X			X		X	X	
Euse Clint Leo	X			X	X		X	
Syndergaard Benjamin D	X			X	X		X	
Leonakis George L	X		X			X	X	
Dryden Steven V	X		X		X		X	
Dragon Richard J	X		X		X			X
Parigini Rick		X		X		X		X
Total Top Providers	23	1	10	14	20	4	19	5

Carson City

Life/AD&D Benefits & Cost Comparison

Carrier	Anthem		Kansas City Life	Mutual of Omaha	Renaissance
Eligibility	Active and Retired Employees		Active and Retired Employees	Active and Retired Employees	Active and Retired Employees
Benefit Amount:					
Class 1: Unclassified & Elected Members	\$35,000		\$35,000	\$35,000	\$35,000
Class 2: Sheriff Personnel	\$50,000		\$50,000	\$50,000	\$50,000
Class 3: Active Fire Members	\$50,000		\$50,000	\$50,000	\$50,000
Class 4: All Other Active Members	\$20,000		\$20,000	\$20,000	\$20,000
Class 5: Retirees	\$10,000		\$10,000	\$10,000	\$10,000
Class 6: Surviving Spouses	\$500, No AD&D		\$500, No AD&D	\$500, No AD&D	\$500, No AD&D
Dependents, Class 1-5:					
Spouse	\$500		\$500	\$500	\$500
Child	\$500		\$500	\$500	\$500
Plan Features:					
Accelerated Death Benefit	80%		80%	80%	80%
Portability	Included		Included	Included	Included
Waiver of Premium	Included		Included	Included	Included
Travel Assistance	Included		Included	Included	Included
Benefit Reduces To:					
at age 65	None		None	None	None
at age 70	65%		65%	65%	65%
at age 75	65%		65%	65%	65%
Rates:	Current	Renewal	Proposed	Proposed	Proposed
Volume	\$20,696,500	\$20,696,500	\$20,696,500	\$20,696,500	\$20,696,500
Life/AD&D per \$1,000	\$0.250	\$0.250	\$0.205	\$0.210	\$0.235
Dep Life per Unit	\$0.300	\$0.300	\$0.300	\$0.300	\$0.300
Est. Monthly Premium	\$5,174	\$5,174	\$4,243	\$4,346	\$4,864
Est. Annual Premium	\$62,090	\$62,090	\$50,913	\$52,155	\$58,364
\$ over/(under) current	-	\$0	-\$11,176	-\$9,934	-\$3,725
% over/(under) current	-	0.0%	-18.00%	-16.00%	-6.00%
Rate Guarantee		12 months	24 months	24 months	24 months



**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.
- (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 where 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 to 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 after 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: 2020 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 7/1/2020, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2021, 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

City of Carson City
 BY

Sam King
 CEO, Hometown Health

(Authorized Signature of Group)

_____ Date

_____ Date

Section XVI. COVERAGE

Medical Benefit Plan: 2020 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 7/1/2020, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2021, or unless otherwise terminated as allowed herein.

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Hometown Health
 BY

City of Carson City
 BY

Sam King
 CEO, Hometown Health

(Authorized Signature of Group)

 Date

 Date

Section XVI. COVERAGE

Medical Benefit Plan: 2020 LG PPO HD-NA CINS D2800X2
 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

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Hometown Health
 BY

City of Carson City
 BY

Sam King
 CEO, Hometown Health

(Authorized Signature of Group)

_____ Date

_____ Date

Section XVI. COVERAGE

Medical Benefit Plan: 2020 LG PPO HD-NA CINS D2800X2
 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 7/1/2020, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2021, 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

City of Carson City
 BY

Sam King
 CEO, Hometown Health

(Authorized Signature of Group)

 Date

 Date

Hometown Health

10315 Profesional Circle~ Reno, Nevada 89521 (775) 982-3100 www.hometownhealth.com

GROUP APPLICATION - INFORMATION DOCUMENT

This document will be requested to be reviewed annually at the health plan renewal period

1. FULL LEGAL NAME OF CONTRACT HOLDER (Include punctuation and abbreviations):

Carson City, Nevada

1a. Federal Tax ID #: 886000189

1b. IRS Section 125: YES NO

2. ADDRESS:

201 N Carson St Suite 4 Carson City NV 89701
Location Address Street City State Zip Code

Same as above

Mailing Address (If different) Street or PO Box City State Zip Code

2a. Telephone: 775-283-7088

2b. Fax: 775-887-2067

2c. Email: mbruketta@carson.org

3. NAME / TITLE OF OWNER, GENERAL MANAGER OR CEO:

Name Title

3a. Telephone: 3b. Fax: 3c. Email:

4. COMPANY BILLING NAME AND ADDRESS (If different from legal name noted above):

Jacque Cassinelli
Name Street City State Zip Code

4a. Mailing Address (If different) 4b. Telephone # 4c. Fax #
775-283-7043 77-887-2067

5. BUSINESS INDUSTRY OR NATURE OF BUSINESS:

Local Government

6. NAICS CODE: (If available):

6a. MEMBER OF BANN: YES NO

7. COMPANY TYPE:

Corporation LLC Non-Profit Partnership Political Subdivision S-Corp.
 Sole Proprietorship Union Other:

8. YEAR BUSINESS ESTABLISHED: 1858

8a. #Employees (FT & PT): 865 8b. #Employees Eligible To Enroll: 593 8c. #Employees Waiving Enrollment: 25

8d. Please check appropriate box below to indicate your organization's size*: **Mandatory Insurer Reporting Law-Section 111 of Public Law 110-173**

Less than 20 full- or part-time employees*

20 to 99 full- or part-time employees*

100 or more full- or part-time employees*

* If organization is part of a multi-employer plan (a group of plans), please count employees in other groups/plans also.

9. DOES YOUR COMPANY OFFER OTHER INSURANCE OPTIONS, NOT ASSOCIATED WITH HOMETOWN HEALTH?: YES NO Example- Dental and/or Vision

9a. If Yes - Coverage Type: Dental & Life Carrier Name: Anthem

Coverage Type: Vision Carrier Name: EyeMed

10. EMPLOYER CONTRIBUTION TO EMPLOYEE AND DEPENDENT PREMIUM:

Enter the Percentage (%) or Dollar (\$) Amount; Minimum is 50% of Employee Premium:

HOURLY: **SALARIED:** **OTHER:** (Please specify) See attached contribution sheet per CBOs

EE: EE: EE:

DEP: DEP: DEP:

Area for Hometown Health use:

EFFECTIVE DATE:

PARENT CODE:

GROUP INFORMATION

A. COMPANY INFORMATION:

1a. COMPANY NAME Carson City, NV

B. COMPANY BENEFIT ADMINISTRATOR(S):

1b. CORPORATE CONTACT:

Melanie Bruketta

HR Director

Name

Title

201 N Carson St, Suite 4

Carson City NV

89701

Address

City

State

Zip Code

Telephone #: 775-283-7088, Ext#

Fax #: 775-887-2067

Email: mbruketta@carson.org

1a. Receives Contract / Renewal Notices

1b. Receives Hometown Health Employer Newsletter

2b. LOCAL CONTACT (If same as Corporate Contact, leave blank):

Jacque Cassinelli

HR Generalist

Name

Title

201 N Carson St, Suite #4

Carson City NV

89701

Address

City

State

Zip Code

Telephone #: 775-283-7043, Ext#

Fax #: 775-887-2067

Email: jcassinelli@carson.org

2a. Receives Contract / Renewal Notices

2b. Received Hometown Health Employer Newsletter

3b. PREMIUM BILLING CONTACT (If different than Contacts listed above):

Name

Title

Address

City

State

Zip Code

Telephone #: _____, ext# _____ Fax #: _____ Email: _____

4b. OTHER COMPANY CONTACTS (If applicable):

Name

Title

Telephone #: _____, ext# _____ Fax #: _____ Email: _____

GROUP ELIGIBILITY AND PAYMENT PROVISIONS

Please return with renewal/new packet

A: COMPANY NAME: Carson City, NV

Group Size: 720

Check category in each Provisions Sections: "B" Eligibility Status, "C" Commencement of Coverage

B: ELIGIBILITY STATUS (check all categories applicable):

SALARIED	HOURLY	OTHER (Please list)	B1. ELIGIBLE EMPLOYEES:
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Active Employees <input checked="" type="checkbox"/> Retirees:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Permanent Full Time employees scheduled to work at least <u>30</u> hours per week. <small>**Eligible employee means a permanent employee who has a regular working week of 30 or more hours.../NRS689C.065</small>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Other: (Attach Explanation) see Attachment 1
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Leave of Absence:

B2. DEPENDENT POLICY:

- Employee Only (available for Employers with fewer than 50 fulltime equivalent Employees)
- Employees and dependent children
- Employees, spouse and dependent children
- Employees, spouses, domestic partners and dependent children

C: Commencement of Coverage (Check all categories applicable):

Eligible employment begins on:

- Date of Hire (default) OR
- Following a reasonable and bona fide employment-based orientation period of 60 days (not to exceed 30 days). By selecting this box you attest that the orientation period you require is both reasonable and bona fide.

Eligible employment also begins when a part time employee begins to work full time.

SALARIED	HOURLY	OTHER (Please list)	C1 NEWLY ELIGIBLE EMPLOYEES EFFECTIVE FOR COVERAGE:
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1st of Month on or following date of eligible employment Termination of Coverage = Last day of month which employee ceases to be eligible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 1st of Month on or following <u>60</u> day(s) of eligible employment (60 days max) Termination of Coverage = Last day of month which employee ceases to be eligible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1st of Month on or following 1 month of eligible employment Termination of Coverage = Last day of month which employee ceases to be eligible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Additional Information: (Attach Explanation) Termination of Coverage =
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>LARGE EMPLOYERS ONLY HAVE THE FOLLOWING ADDITIONAL OPTIONS:</u> <input type="checkbox"/> Date of eligible employment Termination of Coverage = Midnight, the date of termination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <u> </u> days or <input type="checkbox"/> months from date of eligible employment (90 days max) Termination of Coverage = Midnight, the date of termination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: (Attach Explanation) Termination of Coverage =

C2. NEWLY ELIGIBLE DEPENDENTS Births and Loss of Coverage will always be date of event

- 1st of Month following Date of Eligibility/Event
- Date of Eligibility/Event
- Other: _____

If this section is not addressed, policy will default to Newly Eligible Employee Provision

C3. PART TIME TO FULL TIME POLICY
(Only applies to large groups)

Does Not Apply
Minimum # of _____ Days or Months

Working P/T before going F/T, then Coverage Effective:

Date of Full Time Status
 1st of Month following Full Time Status
 Other: (Attach Explanation)

If this section is not addressed, policy will default to Newly Eligible Employee Provision - only applies to employees covered prior to termination with current carrier.

C4. REHIRE EMPLOYEE POLICY

Does Not Apply
If rehired within 12 Days or Months of termination then Coverage Effective:

Maximum period for rehire policy is 12 months.

Date of Rehire (Only applies to large groups)
 1st of Month following Rehire
 Other: (Attach Explanation)

PAYMENT PROVISIONS

D. PAYMENT PROVISIONS:

FULL MONTHLY PREMIUM

If commencement of coverage falls on:

- * The 1st through the 15th of the month - FULL PREMIUM DUE
- * The 16th through the end the month - NO PREMIUM DUE

If termination of coverage falls on:

- * ~~The 1st through the 14th of the month - NO PREMIUM DUE~~
- * ~~The 15th~~ through the end the month - FULL PREMIUM DUE

The 1st

MB

Updates and revisions to these provisions can ONLY be made at renewal date of health plan(s) and must be approved by carrier. All Changes must be submitted in writing. Authorized signature required below for approval of current provisions or changes made.

Dated this _____ day of _____, year _____

(Print Name and Title of Company Representative)

(Signature of Company Representative)

Primary Contact and email: Jacque Cassinelli; jcassinelli@carson.org

Secondary Contact and email: Melanie Bruketta; mbruketta@carson.org

Notes:

This area for internal use only-

Renewal Effective Date _____

Date _____ SSR _____ Section Chg'd _____ Eff. Date _____

PRODUCER STATEMENT

(This section must be completed by Producer/Agency)

NOTE: Producer of Record must maintain a current State of Nevada Insurance Division License on file with our office. We must have appointed Producer through the State of Nevada Insurance Division prior to any payment of commission.

1. PRODUCER OF RECORD:

Company / Agency: LP Insurance Services

Producer Name:

300 E 2nd St, Suite 1300 Reno NV 89501
Address City State Zip Code

Telephone #: 775-996-6000, Ext# Fax #: 775-221-8093 Email:

IRS Tax ID #: 27-3054238

2. SECOND PRODUCER OF RECORD (If applicable):

Company / Agency:

Producer Name:

Address City State Zip Code

Telephone #: , Ext# Fax #: Email:

IRS Tax ID #:

COMMISSIONS:

Standard Net of Commissions None *Split *Split Arrangement: Other

*If commissions are split or otherwise distributed, include a complete description of arrangements and information on ALL producers.

Must include IRS Tax ID #

New Producer? Yes No Producer must be appointed by Hometown Health

We/I certify that all information contained in this application is correct, to the best of my knowledge.

We/I also certify that:

- 1. This is a bona-fide business establishment, qualified association or trust.
2. This group meets all participation requirements
3. Coverage, enrollment provisions, eligibility requirements, benefits limitations and exclusions were fully explained and understood by the applicant/employer.
4. I/We know of no reason why coverage should not be offered and recommend that it be offered.
5. I am the Producer of Record representing this group/company.

Dated at this day of, year

(Print Name and Title of Producer)

(Signature of Producer)

EMPLOYERS STATEMENT

Company Name: Carson City, NV

- 1. I wish to enroll the above named company as a group account with:
 Hometown Health Plan (HMO) *Hometown Health Providers Insurance Co.* (PPO)
- 2. I understand and agree to abide by the eligibility rules applicable to employee enrollment as provided in the Evidence of Coverage (EOC).
- 3. I understand the participating requirements for specific coverage(s) and that those requirements must be met and maintained in order for the group to remain eligible for coverage.
- 4. I understand and agree to abide by the following prepayment requirement: Monthly prepayment fees are due and payable, in full, by the first day of the calendar month for which services are provided. Premium is delinquent if not received by the 15th of the month. Coverage will terminate on the last day of the month retroactive to the month for which payment is not received. Any other payment arrangements require our prior approval.
- 5. The group herewith tenders \$ _____ and, in consideration of approval of the application, promises to pay any balance necessary to constitute the full initial payment for group benefits herein identified. It is understood that we have the right to accept or reject application. Coverage will not commence until the application has been accepted.
- 6. I understand that the Group Subscription Agreement (GSA) that includes the EOC, provides specific guidelines for administration of coverage.
- 7. The Group appoints the following Company / Agency as Producer of Record:
Company / Agency (PRINT): LP Insurance Services

Producer Name (PRINT): _____
- 8. To the best of our knowledge and belief, the information provided by the group is true and, along with the group application, is the basis for issuance of coverage and will become a part of the GSA.

Dated at _____ this _____ day of _____, year _____

(Print Name and Title of Company Representative)

(Signature of Company Representative)

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.

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	<u>Member Responsibility</u>	
	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
<i>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.</i>		
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
<i>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.</i>		
Physician Office Visits		
Primary Care (PCP) Office Visits (<i>Does not include imaging, surgery and other services.</i>)	\$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 (<i>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.</i>)	\$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%
<i>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.</i>		
Preventive Screenings		
Mammography screening	\$0	CYD then 50%
Papanicolaou (Pap) test	\$0	CYD then 50%
Prostate Specific Antigen (PSA) screen	\$0	CYD then 50%
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%



Benefit Summary Table		
Benefit Category	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
Hospital Facility Services		
Acute care hospital admission	CYD then \$1500 per Admit	CYD then 50%
Inpatient delivery, postpartum care and newborn care services	CYD then \$1500 per Admit	CYD then 50%
Outpatient observation (<i>generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria</i>)	\$500	CYD then 50%
Skilled nursing facility (limited to 100 days per Calendar Year)	CYD then \$1500 per Admit	CYD then 50%
Rehabilitation facility (limited to 60 days per Calendar Year)	CYD then \$1500 per Admit	CYD then 50%
<p><i>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.</i></p> <p><i>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.</i></p>		
Urgent Care and Emergency Services		
Virtual Visits for Urgent Care Services (<i>available only through Hometown Health's preferred virtual visit provider</i>)	\$0	Not Available Out-of-Network
Urgent Care Services (<i>includes Out-of-Area Out-of-Network Urgent Care Center Services; Out-of-Network Providers may balance bill you for the amount charged in excess of the Allowed Amount</i>)	\$50	\$50
Emergency Room Services (<i>Copayment is waived if admitted; Out-of-Network Providers may charge for amounts greater than the Allowed Amount</i>)	\$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%



Benefit Summary Table		
Benefit Category	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
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 (<i>except Specialty Imaging and Diagnostic Testing</i>)	\$40	CYD then 50%
Services provided in a Specialty Care Physician office (<i>except Specialty Imaging and Diagnostic Testing</i>)	\$60	CYD then 50%
Laboratory Services		
General laboratory services (<i>unless covered under ACA preventive guidelines</i>)	\$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%
<i>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.</i>		
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and pulmonary rehabilitation (<i>Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.</i>)	\$10	CYD then 50%
Wound therapy in an outpatient hospital or outpatient facility setting (<i>For wound therapy in an office based setting, see the Physician Office Visit section of this Benefit Summary Table.</i>)	\$60	CYD then 50%
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 (<i>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.</i>)	\$60	CYD then 50%
Port Wine Stain Removal	\$60	CYD then 50%
<i>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.</i>		
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 (<i>if admitted, see the acute care hospital admission cost sharing in the Hospital Services section above.</i>)	\$500	CYD then 50%
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	\$500	CYD then 50%
Bariatric Surgery (<i>Limited to one Medically Necessary gastric restrictive surgery per lifetime.</i>)	CYD then \$1500	CYD then 50%
Diagnostic and/or therapeutic endoscopy	\$200	CYD then 50%
<i>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.</i>		



Benefit Summary Table		
Benefit Category	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) <i>(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.)</i>	CYD then \$60	CYD then 50%
Orthopedic and prosthetic devices <i>(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)</i>	CYD then \$60	CYD then 50%
Ostomy supplies <i>(Limited to 30 days of therapeutic supplies per month. Ostomy supplies require Prior Authorization.)</i>	CYD then \$60	CYD then 50%
Special Food Products <i>(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Calendar Year. Prior Authorization required.)</i>	CYD then \$60	CYD then 50%
<i>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.</i>		
Alcohol and Substance-Abuse Treatment		
Inpatient treatment	CYD then \$1500 per Admit	CYD then 50%
Outpatient treatment – specialist	\$40	CYD then 50%
Withdrawal treatment – inpatient	CYD then \$1500 per Admit	CYD then 50%
Withdrawal treatment – outpatient	\$40	CYD then 50%
<i>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.</i>		
Mental Health		
Inpatient Medically Necessary services for mental health disorders	CYD then \$1500 per Admit	CYD then 50%
Mental health outpatient and office visits	\$40	CYD then 50%
Applied Behavioral Therapy for the treatment of Autism <i>(Limited to 1,250 hours (approximately 260 visits) of therapy for habilitation and 1,250 hours (approximately 260 visits) of therapy for rehabilitation per Calendar Year.)</i>	\$60	CYD then 50%
<i>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.</i>		



Benefit Summary Table		
Benefit Category	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
Other Medical Services		
Kidney dialysis received at home or in an outpatient or office setting <i>(for kidney dialysis received in an inpatient facility, see the inpatient facility benefit line.)</i>	\$60	CYD then 50%
Spinal manipulations performed by a chiropractor or other physician <i>(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime .)</i>	\$60	CYD then 50%
Alternative Care including acupuncture services <i>(Limited to \$1,000 maximum benefit per Calendar Year.)</i>	\$60	CYD then 50%
Home health care <i>(Limited to 30 visits per Calendar Year; May provide for private duty nursing in the home; Prior Authorization required.)</i>	\$60	CYD then 50%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. <i>(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)</i>	\$60	CYD then 50%
Temporomandibular Joint (TMJ) Disorder Services <i>(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.)</i>		
<i>Office based services (excluding surgical services)</i>	\$60	CYD then 50%
<i>All other services (including surgical services)</i>	CYD then \$1500 per Admit	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 <i>(Limited to a lifetime benefit maximum of 185 days) :</i>		
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. b. Outpatient counseling of the Member and his or her immediate family (limited to 5 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. Hospice care providing nursing care for a maximum of five (5) inpatient days or (5) outpatient visits per ninety (90) days of home hospice care. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical.		
<i>Office based services</i>	\$60	CYD then 50%
<i>All other services</i>	CYD then \$1500 per Admit	CYD then 50%
Any other covered medical service not listed in the Schedule of Benefit	CYD then \$0	CYD then 50%



Benefit Summary Table		
Benefit Category Benefit Tier Level	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
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 <i>(as described in the Preventive Services section of the EOC .)</i>	\$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%
<i>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).</i>		
Pharmacy Benefits - Enhanced		
Tier 1 – Generic Drugs <i>Member Responsibility reflects up to 30-day supply per fill.</i>	\$15	N/A
Tier 2 – Preferred Brand Drugs – <i>may also include select Generic drugs. Refer to the EOC for ancillary charge.</i> <i>Member Responsibility reflects up to 30-day supply per fill.</i>	\$40	N/A
Tier 2 – Preferred Brand Oral Oncological Drugs <i>(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.)</i> <i>Member Responsibility reflects up to 30-day supply per fill.</i>	\$40	N/A
Tier 3 – Non-Preferred Brand or Generic Drugs <i>Member Responsibility reflects up to 30-day supply per fill.</i>	\$60 plus the Ancillary Charge	N/A
Tier 4 – Specialty Pharmaceutical Drugs – <i>may also include non- preferred high cost Generic drugs. Specialty Pharmaceuticals require Prior Authorization.</i> <i>Most Specialty Pharmaceuticals must be obtained through a specialty Pharmacy designated by Hometown Health and are limited to a 30-day supply per fill.</i>	20%	N/A
Tier 5 – Preventive Drugs <i>(prescribed in accordance with the U.S. Preventive Task Force Recommendations A & B; excludes select Brand Drug formulations with an available Generic Drug alternative)</i> <i>Member Responsibility reflects up to 30-day supply per fill.</i>	\$0	N/A
<i>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.</i>		

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 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	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
Calendar Year Deductibles		
Combined Medical & Pharmacy Calendar Year Deductible (CYD) Individual	\$2,800	\$5,600
Combined Medical & Pharmacy Calendar Year Deductible (CYD) Family	\$5,600	\$11,200
<i>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.</i>		
Calendar Year Out-of-Pocket Maximums		
Individual Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	\$2,800	\$5,600
Family Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	\$5,600	\$11,200
<i>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.</i>		
Physician Office Visits		
Primary Care (PCP) Office Visits (<i>Does not include imaging, surgery and other services.</i>)	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 (<i>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.</i>)	\$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	CYD then 0%	CYD then 30%
<i>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.</i>		
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%
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%



Benefit Summary Table		
Benefit Category Benefit Tier Level	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
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 (<i>generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria</i>)	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%
<p><u>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.</u></p> <p><i>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.</i></p>		
Urgent Care and Emergency Services		
Virtual Visits for Urgent Care Services (<i>available only through Hometown Health's preferred virtual visit provider</i>)	CYD then 0%	Not Available Out-of-Network
Urgent Care Services (<i>includes Out-of-Area Out-of-Network Urgent Care Center Services; Out-of-Network Providers may balance bill you for the amount charged in excess of the Allowed Amount</i>)	CYD then 0%	CYD then 0%
Emergency Room Services (<i>Copayment is waived if admitted; Out-of-Network Providers may charge for amounts greater than the Allowed Amount</i>)	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		
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%



Benefit Summary Table		
Benefit Category Benefit Tier Level	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
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 (<i>except Specialty Imaging and Diagnostic Testing</i>)	CYD then 0%	CYD then 30%
Services provided in a Specialty Care Physician office (<i>except Specialty Imaging and Diagnostic Testing</i>)	CYD then 0%	CYD then 30%
Laboratory Services		
General laboratory services (<i>unless covered under ACA preventive guidelines</i>)	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%
<i>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.</i>		
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and pulmonary rehabilitation (<i>Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.</i>)	CYD then 0%	CYD then 30%
Wound therapy in an outpatient hospital or outpatient facility setting (<i>For wound therapy in an office based setting, see the Physician Office Visit section of this Benefit Summary Table.</i>)	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 (<i>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.</i>)	CYD then 0%	CYD then 30%
Port Wine Stain Removal	CYD then 0%	CYD then 30%
<i>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.</i>		
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 (<i>if admitted, see the acute care hospital admission cost sharing in the Hospital Services section above.</i>)	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 (<i>Limited to one Medically Necessary gastric restrictive surgery per lifetime.</i>)	CYD then 0%	CYD then 30%
Diagnostic and/or therapeutic endoscopy	CYD then 0%	CYD then 30%
<i>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.</i>		



Benefit Summary Table		
Benefit Category	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) <i>(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.)</i>	CYD then 0%	CYD then 30%
Orthopedic and prosthetic devices <i>(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)</i>	CYD then 0%	CYD then 30%
Ostomy supplies <i>(Limited to 30 days of therapeutic supplies per month. Ostomy supplies require Prior Authorization.)</i>	CYD then 0%	CYD then 30%
Special Food Products <i>(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Calendar Year. Prior Authorization required.)</i>	CYD then 0%	CYD then 30%
<i>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.</i>		
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%
<i>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.</i>		
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 <i>(Limited to 1,250 hours (approximately 260 visits) of therapy for habilitation and 1,250 hours (approximately 260 visits) of therapy for rehabilitation per Calendar Year.)</i>	CYD then 0%	CYD then 30%
<i>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.</i>		

Benefit Summary Table		
Benefit Category	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
Other Medical Services		
Kidney dialysis received at home or in an outpatient or office setting <i>(for kidney dialysis received in an inpatient facility, see the inpatient facility benefit line.)</i>	CYD then 0%	CYD then 30%
Spinal manipulations performed by a chiropractor or other physician <i>(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime .)</i>	CYD then 0%	CYD then 30%
Alternative Care including acupuncture services <i>(Limited to \$1,000 maximum benefit per Calendar Year.)</i>	CYD then 0%	CYD then 30%
Home health care <i>(Limited to 30 visits per Calendar Year; May provide for private duty nursing in the home; Prior Authorization required.)</i>	CYD then 0%	CYD then 30%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. <i>(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)</i>	CYD then 0%	CYD then 30%
Temporomandibular Joint (TMJ) Disorder Services <i>(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.)</i>		
<i>Office based services (excluding surgical services)</i>	CYD then 0%	CYD then 30%
<i>All other services (including surgical services)</i>	CYD then 0%	CYD then 30%
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 <i>(Limited to a lifetime benefit maximum of 185 days)</i> : 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. b. Outpatient counseling of the Member and his or her immediate family (limited to 5 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. Hospice care providing nursing care for a maximum of five (5) inpatient days or (5) outpatient visits per ninety (90) days of home hospice care. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical.		
<i>Office based services</i>	CYD then 0%	CYD then 30%
<i>All other services (including surgical services)</i>	CYD then 0%	CYD then 30%
Any other covered medical service not listed in the Schedule of Benefit	CYD then 0%	CYD then 30%



Benefit Summary Table		
Benefit Category Benefit Tier Level	<u>Member Responsibility</u>	
	PPO Network	Out-of- Network
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 <i>(as described in the Preventive Services section of the EOC .)</i>	\$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%
<i>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).</i>		
Pharmacy Benefits - Enhanced		
Tier 1 – Generic Drugs <i>Member Responsibility reflects up to 30-day supply per fill.</i>	CYD then 0%	N/A
Tier 2 – Preferred Brand Drugs – <i>may also include select Generic drugs. Refer to the EOC for ancillary charge.</i> <i>Member Responsibility reflects up to 30-day supply per fill.</i>	CYD then 0%	N/A
Tier 2 – Preferred Brand Oral Oncological Drugs <i>(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.)</i> <i>Member Responsibility reflects up to 30-day supply per fill.</i>	CYD then 0%	N/A
Tier 3 – Non-Preferred Brand or Generic Drugs <i>Member Responsibility reflects up to 30-day supply per fill.</i>	CYD then 0% plus the Ancillary Charge	N/A
Tier 4 – Specialty Pharmaceutical Drugs – <i>may also include non- preferred high cost Generic drugs. Specialty Pharmaceuticals require Prior Authorization.</i> <i>Most Specialty Pharmaceuticals must be obtained through a specialty Pharmacy designated by Hometown Health and are limited to a 30-day supply per fill.</i>	CYD then 0%	N/A
Tier 5 – Preventive Drugs <i>(prescribed in accordance with the U.S. Preventive Task Force Recommendations A & B; excludes select Brand Drug formulations with an available Generic Drug alternative)</i> <i>Member Responsibility reflects up to 30-day supply per fill.</i>	\$0	N/A
<i>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.</i>		

For more information go to www.HometownHealth.com

Hometown Health Providers Insurance Company, Inc.
Premium Rate Quote



Group Name: CARSON CITY NEVADA
 Group Number: 4620
 Rate Effective Date: 7/1/2020
 Broker: LP Insurance User
 Blended Rate Indicator: Yes

Plan	Current Benefit Plan Description*	Non-Medicare Information	Employee	EE & Spouse	EE & Child	EE & Children	Family	Overall Total	
1	Medical Plan:	20 LG PPO 40-CO 1500 A D1500X3;RX \$15/\$40/\$60/20%	Enrollment	181	42	18	46	85	
	Pharmacy Plan:	Included in Medical	Proposed Rate \$	568.60	1,165.78	1,090.96	1,090.96	1,781.74	
	Vision Plan:	None	Current Rate \$	568.60	1,165.78	1,090.96	1,090.96	1,781.74	
	Medicare Information		EE (1 with)	EE & Spouse (1)	EE & Spouse (2)	EE & Child (1)	EE & Children (1)	Family (1)	Family (2)
	Enrollment	46	1	7	2	-	-	-	
	Proposed Rate \$	417.73	1,047.79	886.61	1,081.50	1,081.50	1,256.14	1,080.55	
	Current Rate \$	417.73	1,047.79	886.61	1,081.50	1,081.50	1,256.14	1,080.55	
Plan Rate Change:								0.0%	
2	Medical Plan:	20 LG PPO HD-NA CINS E D2800X2 HSA A1;RX 0%/0%/0%/0%	Enrollment	89	20	16	17	44	
	Pharmacy Plan:	Included in Medical	Proposed Rate \$	389.95	799.52	748.21	748.21	1,221.97	
	Vision Plan:	None	Current Rate \$	389.95	799.52	748.21	748.21	1,221.97	
	Medicare Information		EE (1 with)	EE & Spouse (1)	EE & Spouse (2)	EE & Child (1)	EE & Children (1)	Family (1)	Family (2)
	Enrollment	-	-	-	-	-	-	-	
	Proposed Rate \$	286.46	718.53	608.03	741.70	741.70	861.49	741.00	
	Current Rate \$	286.46	718.53	608.03	741.70	741.70	861.49	741.00	
Plan Rate Change:								0.0%	
3	Medical Plan:	20 LG PPO 40-CO 1500 A D1500X3;RX \$15/\$40/\$60/20%	Enrollment	64	35	3	4	3	
	Pharmacy Plan:	Included in Medical	Proposed Rate \$	568.60	1,165.78	1,090.96	1,090.96	1,781.74	
	Vision Plan:	None	Current Rate \$	568.60	1,165.78	1,090.96	1,090.96	1,781.74	
	Medicare Information		EE (1 with)	EE & Spouse (1)	EE & Spouse (2)	EE & Child (1)	EE & Children (1)	Family (1)	Family (2)
	Enrollment	-	-	-	-	-	-	-	
	Proposed Rate \$	-	-	-	-	-	-	-	
	Current Rate \$	-	-	-	-	-	-	-	
Plan Rate Change:								0.0%	
4	Medical Plan:	20 LG PPO HD-NA CINS E D2800X2 HSA A1;RX 0%/0%/0%/0%	Enrollment	1	1	-	-	-	
	Pharmacy Plan:	Included in Medical	Proposed Rate \$	389.95	799.52	748.21	748.21	1,221.97	
	Vision Plan:	None	Current Rate \$	389.95	799.52	748.21	748.21	1,221.97	
	Medicare Information		EE (1 with)	EE & Spouse (1)	EE & Spouse (2)	EE & Child (1)	EE & Children (1)	Family (1)	Family (2)
	Enrollment	-	-	-	-	-	-	-	
	Proposed Rate \$	-	-	-	-	-	-	-	
	Current Rate \$	-	-	-	-	-	-	-	
Plan Rate Change:								0.0%	
Total Enrollment:								725	
Total Estimated Monthly Premium:								\$ 622,648.29	
Total Premium at Current Rate Levels:								\$ 622,648.29	
Overall Rate Change:								0.0%	

Signature Required for Acceptance

Authorized Company Representative (please print)	Title	Signature	Date
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Blended rates are applicable only when renewing with current plans.

This renewal of premium rates is based on information reviewed as of the date of this quote.
 Rates may be adjusted based on final enrollment and/or new or differing information discovered within seventy days after the Effective Date.
 Vision benefits are offered by EyeMed. EyeMed is solely responsible for providing vision benefits provided under their vision benefit plans.
 Certain combinations of plans may not be sold together and may be subject to additional charges.
 A final binding rate quote and contract, if approved by Hometown Health, will be delivered to a Company representative authorized to accept health insurance contracts.
 All insurance contracts have a duration of twelve months unless otherwise stated.
 Key benefits listed above do not constitute a comprehensive list of benefits and are listed as a reference only. Coinsurance benefits are applied after all associated deductibles have been paid.
 Certain limits and exclusions not described above may apply. Refer to the Evidence of Coverage and Summary of Benefits for a more detailed description of the benefits for each plan.
 In the event of a conflict between this information and the final binding contract, the binding contract will prevail.

Please fax (775-982-3747) or return to Hometown Health 30 days prior to the Effective Date.

Hometown Health Providers Insurance Company, Inc.
Claims Report



Group Name: CARSON CITY NEVADA
Group Number: 4620
Report Date: 1/30/2020

Loss Ratio Summary

Month	Subscribers	Members	Medical Incurred (completed)	Pharmacy Incurred (completed)	Total Incurred (completed)	Premium	Loss Ratio
201907	717	1,433	\$276,023	\$81,131	\$357,155	\$616,149	58.0%
201908	717	1,436	\$297,295	\$84,752	\$382,047	\$623,641	61.3%
201909	719	1,449	\$317,539	\$120,120	\$437,659	\$617,286	70.9%
201910	719	1,455	\$330,067	\$110,854	\$440,921	\$627,764	70.2%
201911	720	1,457	\$370,317	\$95,414	\$465,731	\$622,112	74.9%
Total	3,592	7,230	\$1,591,241	\$492,271	\$2,083,512	\$3,106,951	67.1%

Large Claim Summary

Claims incurred from 201907 to 201911 in excess of \$25,000

Incurred Amount	Principle Diagnosis
\$97,236	MALIGNANT NEOPLASM OF UNSPECIFIED KIDNEY, EXCEPT RENAL PELVIS
\$88,867	CROHN'S DISEASE, UNSPECIFIED, WITHOUT COMPLICATIONS
\$62,514	SPINAL STENOSIS, LUMBAR REGION WITH NEUROGENIC CLAUDICATION
\$59,550	SPRAIN OF ANTERIOR CRUCIATE LIGAMENT OF LEFT KNEE, INITIAL ENCOUNTER
\$45,275	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE WITHOUT PSYCHOTIC FEATURES
\$40,118	SEPSIS, UNSPECIFIED ORGANISM
\$37,248	ATYPICAL ATRIAL FLUTTER
\$33,365	TECFIDERA DR 240 MG CAPSULE
\$32,863	TECFIDERA DR 240 MG CAPSULE
\$26,454	OTHER NONRHEUMATIC AORTIC VALVE DISORDERS
\$25,820	ENCOUNTER FOR ADJUSTMENT AND MANAGEMENT OF AUTOMATIC IMPLANTABLE CARDIAC DEFIBRILLATOR

Administrative Summary

Account Name: Carson City

Account Number: 3343597

General Account Section

Account Info

Effective Date: 07/01/2020
Original Effective Date: 07/01/2020
Renewal Date: 07/01/2021
Tax ID Number: 88-6000189
Contract Situs State: NV
SIC Code: 9111
Section125: Yes

Subsidiaries

Subsidiary/Affiliated Companies: _____

Other Contract States

<u>State abbreviation and name</u>	<u>Product</u>
TX Texas	DPPO

Booklets

Elects to Receive Insurance Documents Electronically? Yes

*Note: For ASO, there is an optional service charge for printing and distribution.

Booklet Name (For Cover): Carson City, NV, A Consolidated Municipality

Separate Booklet for each Benefit Option? Yes

Non Standard Booklet (Optional Service Charge Applied Per Booklet): No

Renewal

Client is requesting new booklets/certificates No

Client is requesting certificate riders No

Comments:

Administrative Summary

ID Card

Client Name On ID Card(Optional): Carson City, NV

Is Client using their own company logo on ID cards? No

Client Specific Features (Optional Service Charges apply): No

If yes, specify _____

For Customer Service the default 800 number is 1-800-CIGNA24 (1-800-244-6224).

Client-Specific 1-800 Number? No Optional service charges apply for client-specific 800 numbers.

HIPAA

HIPAA Levels Selected: For NonASO - (Yes PHI / Yes SHI)

CignaAccess.com - Employer Tools

Report and Statistics Applications:

Eligibility Reports - Yes

Banking Reports (must use Chase or Citibank) - No

Financial Experience Reports - No

Online Enrollment powered by Choicelinx - No

CARBS (Cigna Account Receivable and Billing System PDF) Yes

Employee Support Applications:

Eligibility Maintenance Tool - Yes

Eligibility and Benefit - Yes

Claim Inquiry (only PHI is selected) - Yes

Member Materials - Yes

IRS 1095 Submission Report - Yes

IRS Name and SSN Mismatch Report - Yes

Administrator information:

Primary Administrator: Jacque Cassinelli

Restrict Delegation (Eligibility Maintenance Tool/Claim Inquiry) Yes

Conversion

Conversion Privileges Provision: No

If yes, please specify by state and product: _____

General Account Information Comments

Other Insurance Carriers:

Medical

Hometown Health

www.hometownhealth.com

Vision

Eyemed

www.eyemed.com

24 Month Rate Guarentee until 07/01/2022

Revision Date 03/31/2020

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Administrative Summary

Administrative Summary

Contacts

Type: Broker

Name/Address

Maria Ibarra
(Title)
LP Insurance Services, Inc.
300 E. 2nd Street
Suite 1300
Reno, NV 89501

Email/Main Phone/Cell/Fax

Email: Maria.Ibarra@lpins.net
Main: Extn:
Cell:
Fax:
HIPAA Contact? Yes

Role(s):

Type: Broker

Name/Address

Diana Davis
(Title)
LP Insurance Services, Inc.
300 E. 2nd Street
Suite 1300
Reno, NV 89501

Email/Main Phone/Cell/Fax

Email: Diana.Davis@lpins.net
Main: Extn:
Cell:
Fax:
HIPAA Contact? Yes

Role(s):

Type: Broker

Name/Address

Bridget Brundige
Employee Benefits
LP Insurance Services, Inc.
300 E. 2nd Street
Suite 1300
Reno, NV 89501

Email/Main Phone/Cell/Fax

Email: bridget.brundige@lpins.net
Main: (775) 221-8092 Extn:
Cell:
Fax: (775) 221-8093
HIPAA Contact? Yes

Role(s):

Type: Client

Name/Address

Jacque Cassinelli
HR Generalist
Carson City
201 N Carson St
Carson City, NV 89701

Email/Main Phone/Cell/Fax

Email: jcassinelli@carson.org
Main: (775) 283-7043 Extn:
Cell:
Fax: (775) 887-2067
HIPAA Contact? Yes

Role(s):

CIGNA Access
Main

Type: Client

Name/Address

Melanie Bruketta
HR Director
Carson City
201 N Carson St
Carson City, NV 89701

Email/Main Phone/Cell/Fax

Email: MBruketta@Carson.org
Main: (775) 283-7088 Extn:
Cell:
Fax:
HIPAA Contact? Yes

Role(s):

Revision Date 03/31/2020

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Administrative Summary

Eligibility Section

Active Employees

Employee Groups: _____

Employment Status

Full time: Yes Part time: No Other: No

Comments: _____

Minimum Hour Requirement (Active Service Hours)

Waive actively at work requirement for the initial group of employees Yes

Retirees

Retirees covered? Yes

Retiree Under 65 (pre-retirement age): Under 65

Retiree Over 65 (post-retirement age): Over 65

Retiree Definition: As Defined by Employer

Other comments : _____

Upon retirement, coverages non-Medicare eligible retirees will be eligible for: _____

Upon retirement, coverages Medicare eligible retirees will be eligible for: _____

Split eligibility? No

Retiree Submission Level: Separate Retiree Only Branch (std.)

General Eligibility

Waiting Period For Initial Group: No Waiting Period

Waiting Period For New Hires: 1st of Mo. Following 60 Days from Date of Hire

Annual Open Enrollment Period (Please specify) As Determined by Employer

Packaging of Benefits? No

Eligibility Comments: Active Service Houts: 80 hours per pay period

Dependents

Spouse: Yes

Domestic Partners: Yes Due to Legislation Both Opposite and Same Sex Domestic Partners

Collateral Dependents: No

Children (Selected coverage)

Adopted Child Yes Handicapped Dependent Yes

Dependent Child Yes Newborn Yes

Foster Child No Stepchild Yes

Grandchild No Student Yes

Legal Guardianship Yes

Additional Selections For Dependents:

Active For Retiree

Dep Max Age: 26 26

Administrative Summary

Student Age: 26 26
Married Dep? Yes Yes

Administrative Summary

Continuation of Benefits

Layoff: Other (approval required, specify below)
If "Other", specify: As Determined by Employer
Leave of Absence Other (approval required, specify below)
If "Other", specify: As Determined by Employer

Injury or Sickness

While totally and continually disabled as a result of Yes
the injury or sickness

Surviving Spouse: Yes Comment: If accident happens while they are at work, Retiree
If yes, Specify: Client Driven Option
If legislation, Specify:
Eligibility Submission Choice: Spouse SSN (Std)

Data Transfer

Eligibility Submission Choice

Social Security Number (std.): Yes
Social Security Number and Employee ID No

Manual (specify below)

Yes
Paper Enrollment No
Employee Enrollment and
Maintenance Tool (EMT) No
Standard Eligibility
Spreadsheet (SES) Yes

Automated (specify below)

No
ACE (Cigna's eligibility
layout Non-HIPAA 834) No
HIPAA 834 Version 5010 No
TPV Eligibility File No
(specify vendor)

Cigna Guided Solutions (specify below)

No
Cigna Online Enrollment (OLE) No
Cigna Guided Solutions (CGS) No
Cigna Guided Solutions Client Manager : _____
Employee Classes using Cigna Guided Solutions services _____
(for example, Actives only or Actives and COBRA, or Actives and
Retirees, or New Jersey Actives only):

Termination

Termination Provision

Please select: End of Month
Comments: _____

Dependent Termination Provision

Please select: End of Birth Month

Administrative Summary

Comments: _____

Administrative Summary

Dental Provisions Section

Does Cigna Standard COB Apply? Yes

Comments: _____

History Load Takeover Credit: No
(No is std. If yes, specify load type.)

Please choose all that apply:

Deductible Credit (current year) No

Deductible Credit (prior year) No

Dental Annual Maximum No

Dental Orthodontic Maximum No

Oral Surgery

Will oral surgical procedures be paid under the Dental Plan? Yes
(Std. is "Yes")

Will oral surgical procedures be coordinated with Medical? No

Dental Plan Type (DHMO only): _____

Brush Biopsies

Brush Biopsies are covered (Std.) Yes
Includes both the biopsy and lab charge:

CignaFlex Advantage Offered? No

Dental Plan Information - DPPO, DIND or DEPO

Dental Plan Type: Standard

Dental Late Entrant Frequency: 24 months

Dental Late Entrant Comments:

Missing Tooth Limitation-Waive for initial group? Yes

Missing Tooth Limitation Frequency: 24 months

Missing Tooth Limitation Comments:

Limited Extension of Benefits? Yes

ID Cards? Yes

Dental ID Card Type: Non-Personalized

Dental Provision Comments

Administrative Summary

Dental Census Section

	State	Dental Employees	Dental Indemnity	Dental PPO	Dental EPO	Dental HMO	HMO Available?	Insurance State	TN Met
AZ	Arizona	1	.	x	.	.	Yes	No	No
CA	California	5	.	x	.	.	Yes	No	No
FL	Florida	2	.	x	.	.	Yes	No	No
HI	Hawaii	1	.	x	.	.	No	No	No
NV	Nevada	621	.	x	.	.	Yes	Yes	No
TX	Texas	1	.	x	.	.	Yes	No	No
UT	Utah	1	.	x	.	.	Yes	Yes	No
	Total	<u>632</u>							

Administrative Summary

Financial Section

Contributions

Employee Contributions - Employee:	<u>Yes</u>	Employee Contributions - Dependent:	<u>Yes</u>
Employer Contribution Percentage:	<u>99</u>	Employer Contribution Percentage:	<u>50</u>
DHMO	<u>No</u>	DHMO	<u>No</u>
PPO	<u>Yes</u>	PPO	<u>Yes</u>
EPO	<u>No</u>	EPO	<u>No</u>
Indemnity	<u>No</u>	Indemnity	<u>No</u>

Billing Statement

Number of Bills: 2
Statement Code: 1
Statement Name: Active and COBRA Carson City
Bill Type: Summary
Billing Window: Prior
Bill Date: 20 (Day of month - 1 to 31)
Billing Media: Web&email
Billing Contact: Jacque Cassinelli

Additional Billing Statements

Code: 2 Carson City Retiree
Type: Detail
Window: Prior Payment: Check
Bill Date: 20 HIPAA:
Bill Media: Web&email Contact: Jacque Cassinelli

Other Billing Contacts

Payment Information

Payment Due date: 1st
State For Premium Tax payment: NV

Payment Method

Payment Method: Check

Financial Section Comments

Dental PPO Contributions:
Employee: 99%
Dependent: 50-75% depending on CBA
Retirees: 50-90% depending on length of service and retirement date

Carson City
Guaranteed Cost Funding
Non-Participating
July 01, 2020 - June 30, 2022

Tier	Expected Lives	Current Rates	Sold Rates*
Dental PPO - Plan 1			
Employee Only	316	\$48.31	\$45.47
Employee + Spouse	98	\$67.95	\$63.95
Employee + Child(ren)	92	\$85.92	\$80.86
Employee + Family	123	\$105.56	\$99.35
Annual Cost	629	\$513,763	\$483,537
Percent Change (Sold vs Current)			-5.88%

**The above quoted rates do not include any commissions.*

Total	629	\$513,763	\$483,537
--------------	------------	------------------	------------------

Carson City Experience

Experience 1					
Emps	Premium	Paid Claims	Benefit Adj. Claims	Paid L/R	Incd L/R

EXPERIENCE ANALYSIS

Dec-18	714	\$42,881	44,482		
Jan-19	720	\$48,332	59,822		
Feb-19	718	\$48,044	\$50,659	\$50,659	105.4%
Mar-19	719	\$48,130	\$43,183	\$43,183	89.7%
Apr-19	718	\$48,117	\$38,973	\$38,973	81.0%
May-19	722	\$48,387	\$52,413	\$52,413	108.3%
Jun-19	721	\$48,323	\$41,821	\$41,821	86.5%
Jul-19	718	\$48,255	\$34,370	\$34,370	71.2%
Aug-19	718	\$48,351	\$50,273	\$50,273	104.0%
Sep-19	720	\$48,523	\$35,552	\$35,552	73.3%
Oct-19	720	\$48,600	\$46,243	\$46,243	95.2%
Nov-19	720	\$48,593	\$48,235	\$48,235	99.3%
Dec-19	725	\$48,815	\$27,901	\$27,901	57.2%
Jan-20	731	\$49,267	\$36,478	\$36,478	74.0%
Total	8,628	574,536	506,101	506,101	87.0%
		Change in lives over setback period:	0.8%		
		Average Lives	719		

Carson City
Presale - 07/01/20

Imported or Melded?	Carson City	
Name	Projection 1	Total for all Plans
Experience start	2/1/2019	
Experience End	1/31/2020	
Midpoint Months without the insured lag	17.0	
Adjusted to Current Benefit Levels	\$506,101	\$506,101
/ Maturation Factor	1.00	1.00
Mature Experience-Rated Claims	\$506,101	\$506,101
Cumulative Lagged months	2	
Cumulative Lagged Lives	8,628	8,628
PEPM Claim Cost	\$58.66	\$58.66
Annual Trend	5.37%	5.37%
Midpoint Months	19.0	
Compounded Trend	1.0863	1.0863
Trended PEPM Claim Cost	\$63.72	\$63.72
Proposed Benefit Adjustment effective Date of Jul 01, 2020	3.75%	3.75%
Experience Translation Factor Adjustment	0.868	0.868
Trended and Benefit Adjusted PEPM Claim Cost	\$57.38	\$57.38
Manual Claim Cost PEPM	\$56.93	\$56.93
Experience Credibility Factor	100.0%	100.0%
Melded Claim Cost PEPM	\$57.38	\$57.38
Projected Enrollment	629	629
Projected Cumulative Lives - Expected x 12	7,548	7,548
Expected Claims 07/01/20 - 06/30/21	\$433,114	\$433,114
Expenses	9.44%	
Desired Loss Ratio	90.56%	
Experience-Rated Premium Need	\$478,236	\$478,236
Dental Network Access Fees	\$5,284	\$5,284
Total Premium Need	\$483,520	\$483,520
Variance to manual	0.8%	0.8%

PROPOSAL TERMS AND CONDITIONS

A. General Terms of this Proposal

Cigna HealthCare is pleased to present this Proposal for an insured/Administrative Services Only group dental benefit plan (the "Plan") sponsored by Carson City. This proposal is valid for 60 days from its original date of release, 04/01/2020. Any revisions or updates made to this proposal will not renew this valid timeframe unless expressly communicated by Cigna HealthCare.

The information contained in this Proposal by Cigna HealthCare is proprietary and highly confidential. It is being provided with the understanding that it will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of the Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than the employer, its representatives and consultants, and their respective employees who are directly involved in the evaluation process.

Proposal Caveats

Cigna HealthCare may revise or withdraw this Proposal if:

- there is a change to the effective date of the quote
- the policy will not be situated in NV
- the Plan benefits are different than shown in the RFP or benefit modifications are requested
- the census or experience provided by broker/consultant/account is deemed inaccurate

- there is a change in law, regulation, tax rates, or the application of any of these that affects Cigna HealthCare's costs

- enrollment varies by more than +/- 15% from at least one of the following enrollment levels: 629 total enrolled in the Cigna dental plan(s)
- the employer contribution levels are different than shown in the RFP or other than what the quote assumes
- commissions are requested to be different than 0%
- it is requested to interface with a third party vendor
- it is requested to provide optional services beyond those listed here as being included in the quote: None
- administration of the Plan will require more than the following:
 - o Billing lines: 40
 - o Billing and Claim Branch Benefit Options: 10
- Cigna HealthCare is not the exclusive provider of Dental benefits for all of Carson City employees in all worksites

B. Scope and Application of this Proposal

Unless otherwise indicated, this Proposal:

- supersedes and renders null and void any prior Cigna HealthCare offer or proposal with respect to the Plan.
- does not include administration of "run out" claims incurred prior to the effective date.
- all Insured Premium and/or Rates include the cost of the Health Insurance Assessment (PPACA), through 12/31/2020 only. Cigna HealthCare reserves the right to modify quoted rates, as necessary, should there be any changes in future regulation or costs.
- rates guaranteed for a 2 year (24 month) policy period. Guarantee is subject to all terms and conditions outlined in dental caveats.
- Includes the additional Cigna DPPO healthcare professionals for which Cigna HealthCare retains a portion of the savings generated.
- assumes that Cigna HealthCare's standard insurance policy form approved for use in the applicable state by the state insurance regulator will be issued. Because the insurance policy and certificate terms require regulatory approval, there is very little flexibility to change the provisions. The provisions of the insurance policy and certificate will supersede the
- assumes when/if a Cigna HealthCare non-voluntary vision benefit is added to the medical plan, it is added as a rider and always non-accepted, regardless of funding.

Benefit Advisor Fees

Cigna HealthCare may have an agreement with your benefit advisor, under which the benefit advisor may be paid for providing marketplace intelligence or for the performance of administrative services. The qualification for and amount of this payment may be based upon overall business growth and/or retention levels. Any such payment is funded through Cigna HealthCare's general overhead.

The benefit advisor may qualify for incentive payment (monetary or non-monetary) from Cigna HealthCare. For example, the benefit advisor may receive payment based upon new sales, new customer growth or retention. This incentive payment is funded from Cigna HealthCare's general overhead.

Cigna HealthCare sponsors programs to inform benefit advisors about Cigna HealthCare's plan coverage and services (including producer advisory councils). The cost of these events is funded through Cigna HealthCare's general overhead.

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries.

Carson City

Effective Date: July 01, 2020



This is a summary of benefits for your dental plan.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum		
(Class I, II, III, IX Expenses)	\$2000, Class I Applies	\$2000, Class I Applies
Calendar Year Deductible		
Per Individual	\$50	\$50
Per Family	\$150	\$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Non-Routine X-rays	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Space Maintainers (limited to non-orthodontic treatment) Emergency Care to Relieve Pain Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	55%, After Deductible	55%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children and Adults Lifetime Maximum	50%, No Ortho Deductible \$1500	50%, No Ortho Deductible \$1500
Class IX Expenses - Implants		
Subject to the Annual Deductible & Annual Maximum	55%, After Deductible	55%, After Deductible
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge Standard schedule (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Three per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns	Replacement every 5 years
Prosthesis over Implants	1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years.
Dentures and Partials	Replacement every 5 years.
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every two years up to age 16
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for a specified time period; thereafter, considered a Class III expense
Late Entrant Limit	50% coverage on Class III, IV (if applicable), and IX for 12 months
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of \$200 is proposed

Benefit Exclusions:

- * Services performed primarily for cosmetic reasons;
- * Replacement of a lost or stolen appliance;
- * Replacement of a bridge or denture within five years following the date of its original installation;
- * Replacement of a bridge or denture which can be made useable according to accepted dental standards;
- * Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
- * Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- * Bite registrations; precision or semi-precision attachments; splinting;
- * Instruction for plaque control, oral hygiene and diet;
- * Dental services that do not meet common dental standards;
- * Services that are deemed to be medical services;
- * Services and supplies received from a hospital;
- * Charges which the person is not legally required to pay;
- * Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- * Experimental or investigational procedures and treatments;
- * Any injury resulting from, or in the course of, any employment for wage or profit;
- * Any sickness covered under any workers' compensation or similar law;
- * Charges in excess of the reasonable and customary allowances;
- * To the extent that payment is unlawful where the person resides when the expenses are incurred;
- * Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- * For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- * To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- * To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- * In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can access articles on behavioral conditions that impact oral health.

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Prepared by Underwriting.
Cigna DPPO Network (P0010)



Carson City

July 1, 2020

Insurance Coverage Requested:

Dental/Employees and Dep(s)

Dental/Orthodontia

Dental Rates:

Employee (EE):	\$45.47
EE + Spouse:	\$63.95
EE + Children:	\$80.86
EE + Spouse + Children:	\$99.35

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

Signature of Authorized Representative

Title of Authorized Representative

Printed Name



Please complete this worksheet which will allow Kansas City Life Group Benefits to provide you the high-level of service you deserve.

Administrative Details

Legal Name of Group: _____ Carson City _____

Preferred Name of Group to be shown on all correspondence (if different from above):

Main Contact at the Group: _____ Jacque Cassinelli _____

Main Contact Email Address: _____ jcassinelli@carson.org _____

Fax number for Group Contact: _____

Please be advised that electronic versions of the policy, certificate and bill will be provided via email to the contact noted above.

Subsidiaries/ Divisions

No Yes, list here: Active and Retiree

Employee salaries defined as:

- Base Salary
- Base Salary + Commissions which are to be averaged over _____ months
- Base Salary + _____

Note: salaries for groups of 2-9 lives must have a base salary definition only.

Please confirm:

All employees are W-2 K-1 for Owners (if applicable)

Does the group have prior coverage for any lines sold with Kansas City Life?

No Yes – please provide copies of prior carrier booklet or policy.

If coverage is contributory the employee portion of the premium is funded: Pre-Tax Post-tax

Billing Details

Group elects paperless billing (Notification will be sent monthly when the bill is available on the website): Yes No

Group elects to pay future payments via EFT/ACH by completing the appropriate form: Yes No

Group permits the broker of record access to administer the group online via kclgroupbenefits.com. Yes No

For List Billing:

Alphabetical - All employees will be listed alphabetically by last name with one cumulative total generating one bill.

Sort Bill - Employees may be broken into groupings providing subtotals for each group and one grand total generating one bill

Separate Billing - With prior Kansas City Life approval, employees will be separated by billing “locations” generating separate bills by “location”.



KANSAS CITY LIFE

GROUP BENEFITS

Application for Group Insurance

Kansas City Life Insurance Company

3520 Broadway

Kansas City, MO 64111

Legal Name of Applicant (Policyholder)	Federal Tax ID No.
--	--------------------

Nature of Business	Standard Industrial Classification (SIC)	Type of Business
		<input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Other

Street Address, City, State, Zip

Name of Subsidiaries, Divisions, or Affiliates to be Covered

Name and Title of Plan Administrator (Corporate Officer)	Phone No.	E-mail	Fax
--	-----------	--------	-----

Name and Title of Correspondent (Routine Accounting Matters)	Phone No.	E-mail	Fax
--	-----------	--------	-----

Billing Address(es) - If Different From Street Address

Proposed Effective Date of Insurance	Advance Payment of \$_____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.
--------------------------------------	--

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, provide:

<u>Carrier Name</u>	<u>Type of Coverage</u>	<u>Date to be Discontinued</u>
---------------------	-------------------------	--------------------------------

This application must be accompanied by a copy of the inforce carrier policy or certificate with benefit schedule. If Dental, also include a current month's Dental billing from current carrier.

Coverage Applied For (Check all that apply.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Basic Term Life Insurance | <input type="checkbox"/> Short-Term Disability (STD) | <input type="checkbox"/> Accident Insurance |
| <input type="checkbox"/> Accidental Death & Dismemberment | <input type="checkbox"/> Long-Term Disability (LTD) | <input type="checkbox"/> On the Job and Off the Job Accident |
| <input type="checkbox"/> Dependent Life Benefit | <input type="checkbox"/> Dental Insurance | <input type="checkbox"/> Off the Job Accident only |
| | <input type="checkbox"/> Vision Insurance | <input type="checkbox"/> Spouse and Child(ren) Coverage |
| <input type="checkbox"/> Voluntary Term Life Insurance | <input type="checkbox"/> Critical Illness Insurance | <input type="checkbox"/> Wellness Benefit |
| <input type="checkbox"/> Accidental Death & Dismemberment | <input type="checkbox"/> Wellness Benefit | <input type="checkbox"/> Hospital Confinement due to Sickness |
| <input type="checkbox"/> Spouse and Children Life Benefit | <input type="checkbox"/> HSA-Compatible (Critical Illness Procedures not included in plan.) | |

Schedule of Benefits

Please attach a copy of the proposal(s) of benefits sold. Only complete the following if benefits applied for are different from those proposed.

Additional Options to be included:

For Accident Insurance Plans: Low Plan Medium Plan High Plan Other

Annual Enrollment period: Month/Day ____/____ to ____/____

Premium

What percentage does the employer contribute towards the premium?

% Basic Term Life % Dependent Life % Voluntary Term Life
 % Short-Term Disability (STD) STD Gross-Up Plan % Long-Term Disability (LTD) LTD Gross-Up Plan

(For Voluntary/Contributory STD and LTD only, is the employee paid portion of premium pre-tax basis or post-tax basis?)

Dental Insurance % Employee % Dependents Vision Insurance % Employee % Dependents
 Accident Insurance % Employee % Dependents Critical Illness Insurance % Employee % Dependents

(For Voluntary/Contributory Accident and Critical Illness only, is the employee paid portion of premium pre-tax basis or post-tax basis?)

Eligibility

Eligible Classes:

Basic Term Life Insurance <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>	Voluntary Term Life Insurance <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>	Short-Term Disability (STD) <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>	Long-Term Disability (LTD) <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>
Dental Insurance <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>	Vision Insurance <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>	Accident Insurance <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>	Critical Illness Insurance <input type="checkbox"/> All Full-Time Employees working <input type="text"/> hours/week <input type="checkbox"/> Other <input type="text"/>

Probationary Waiting Period:

Basic Term Life <input type="text"/> days/months date of hire for employees; 1st of month on or after 60 days for dependents	Voluntary Term Life <input type="text"/> days/months	Short-Term Disability (STD) <input type="text"/> days/months	Long-Term Disability (LTD) <input type="text"/> days/months
Dental <input type="text"/> days/months	Vision <input type="text"/> days/months	Accident <input type="text"/> days/months	Critical Illness <input type="text"/> days/months

If Probationary Waiting Period differs by class, specify here:

Does this apply to current employees hired on or before the effective date? If no, all currently enrolled employees will be covered on the policy effective date regardless of employment date. Yes No

Coverage to be effective the first of the month following completion of probationary waiting period? Yes No

Number of eligible and enrolled individuals:

Basic Life/Dependent Life # eligible <input type="text"/> / <input type="text"/> # enrolled <input type="text"/> / <input type="text"/>	Voluntary Life # eligible <input type="text"/> # enrolled <input type="text"/>	Short-Term Disability # eligible <input type="text"/> # enrolled <input type="text"/>	Long-Term Disability # eligible <input type="text"/> # enrolled <input type="text"/>
--	---	--	---

Number of eligible and enrolled individuals (continued):

Dental	Vision	Accident	Critical Illness
# eligible _____	# eligible _____	# eligible _____	# eligible _____
# enrolled _____	# enrolled _____	# enrolled _____	# enrolled _____
Are any individuals currently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide:			
<u>Full Name</u>	<u>Diagnosis/Prognosis</u>	<u>Estimated Return to Work Date</u>	
Are any former employees and/or dependents currently on continuation coverage provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list names of the enrollees, qualifying event, and date of event.			
<u>Full Name</u>	<u>Qualifying Event</u>	<u>Date of Event</u>	<u>COBRA End Date</u>

Dental / Vision Verification of Eligibility and Enrollment

Participation requirements are a condition of coverage. These requirements may vary depending upon the plan selected. Statements may be used to contest a claim or the validity of the policy only if they are contained in the application. See the policy for further information. Please complete the following section to verify eligibility and enrollment.

	<u>Dental Insurance</u>	<u>Vision Insurance</u>
1. Total number of employees on the payroll.	_____	_____
2. Total number of part-time employees including temporary or seasonal employees. (Employees working less than your group's definition of full-time; minimum of 30 hours per week.)	_____	_____
3. Total number of employees who have not completed the probationary waiting period.	_____	_____
4. Number of full-time employees (subtract #2 and #3 from #1).	_____	_____
If the employer pays 100% of the employee's cost, skip to number 8 below.		
5. Are there other dental plans to be offered concurrently with your Kansas City Life group dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many employees are enrolled in your other dental plans?	_____	Not applicable
6. Total number of employees who have waived because they are covered by their spouse's plan.	_____	Not applicable
7. Number of eligible employees (subtract #5 and #6 from #4). If #5 and #6 combined are more than 50% of #4, underwriting review is required.	_____	(same as #4)
8. Number of enrolled employees.	_____	_____
9. Number of COBRA participants.	_____	_____

For Dental Insurance, this application must be accompanied by a copy of an inforce certificate and benefit schedule, a current month's billing from the current carrier, as well as proof of the effective date for each employee (and dependents, if insured).

Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by Kansas City Life Insurance Company at its Home Office in Kansas City, Missouri.
2. Insurance will be effective with regard to those individuals listed above in the Eligibility Section, on the latest of the following dates: (a) the effective date approved by the Company; (b) the date this application is signed; or (c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this ____ day of _____, 20____.
(City/State) (Month) (Year)

Signature of Writing Agent _____ Agent Code _____

Officer's Signature

Agent's Name and State License ID No. – SSN (Please Print) _____

Please Print Officer's Name

Signature of Other Agent(s) _____ Agent Code _____

Officer's Title

Agent(s) Business Address _____ City, State, Zip _____

Agency _____

Agency Code _____

NOTICE TO ARIZONA APPLICANTS:

Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

NOTICE TO ARKANSAS APPLICANTS:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICES TO COLORADO APPLICANTS:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER FEDERAL LAW. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO, AND CAN BE PURCHASED AS A STAND-ALONE PLAN, OR AS A COVERED BENEFIT IN ANOTHER HEALTH PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE, OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

NOTICE TO ILLINOIS APPLICANTS / NOTICE TO POLICYHOLDER – ILLINOIS RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT

The Illinois Department of Insurance requires that we inform you of Kansas City Life Insurance Company's compliance with the Illinois Religious Freedom Protection and Civil Union Act (the Act). The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections, and benefits that are afforded or recognized by the laws of Illinois to spouses. Therefore, Kansas City Life Insurance Company will administer both existing and newly issued policies and use processes and systems to ensure that parties to a civil union and a marriage are provided identical benefits, protections, and financial security.

Please contact your agent or the Home Office of Kansas City Life Insurance Company if you have questions regarding this notice.

NOTICE TO KENTUCKY APPLICANTS:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE AND WASHINGTON APPLICANTS:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTICE TO NEW MEXICO APPLICANTS IF DENTAL, VISION, ACCIDENT, OR CRITICAL ILLNESS COVERAGE IS APPLIED FOR:

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

NOTICE TO OKLAHOMA APPLICANTS:

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**Group Life Insurance and Accidental Death and Dismemberment (AD&D)
 Provided by Kansas City Life Insurance Company**



KANSAS CITY LIFE

GROUP BENEFITS

Proposed For: Carson City
 Effective Date: 07/01/2020
 Eligibility: All full-time active employees working 30 hours per week & Qualified Retirees (pre-NRS) as well as surviving spouse or former spouse of a deceased retiree.

Plan 1 with dependents - With Everplans*	<u>Life and AD&D Benefit</u>
<u>Life and AD&D</u>	\$35,000
Class 1 - All Unclassified and Elected Employees	
Class 2 - Sheriff, Alternative Sentencing Officers, Juvenile Probation Officers, Marshalls and Bailiffs	\$50,000
Class 3 - All Active Fire Employees	\$50,000
Class 4 - All Other Employees	\$20,000
Class 5 - All Eligible Retirees	\$10,000
*Class 6 - Spouses of Deceased Employees/Retirees	\$500

Dependent Coverage

*Spouse \$500.00 / Child-6 months to 26 years ** \$500.00 / Infant-14 days to 6 months**\$500.00

Estimated Life Volume:	\$20,696,500
Estimated AD&D Volume:	\$20,696,500
Monthly Life Rate per thousand:	\$0.18
Monthly AD&D Rate per thousand:	\$0.025
Total estimated monthly cost:	\$4,242.78

Dependent Rate/Family Unit (covers all eligible): \$0.30

- Rates are guaranteed for 24 Months following the effective date.
- Employee Guarantee Issue (GI) Limit: \$50,000. Dependent Guarantee Issue Limit: \$500.00. Amounts in excess of the GI limit will require satisfactory evidence of insurability.
- Dependent amounts may not exceed 50% of the employee basic amount. Dependents must be performing normal activities and not confined to a hospital on the effective date of coverage.
- Proposal assumes an employer contribution of 100% and requires 100% participation. Proposal assumes employee contribution for dependent life and requires 75% participation of employees with eligible dependents.
- Coverage reduces 35% of the original amount at age 70.
- Coverage ceases at retirement unless eligible for retiree benefits.
- Waiver of premium is included and will terminate on the earliest of age 65 or retirement.
- Accelerated Death Benefit is included for any amount of \$2,500 or more.
- AD&D is 24-hour coverage and includes Seat Belt, Airbag, Repatriation, Day Care, and Education Benefits (Subject to state approval).
- Conversion is included.
- Value Added Services* are included. These services include Beneficiary Companion, Identity Theft Services, Everplans (Life and Legacy Digital Planning Platform), and Travel Assistance.
- "Actively at Work" is required.
- This proposal assumes group has been in business a minimum of one year.
- Rates include flat 0% commission.



KANSAS CITY LIFE

Carson City

July 1, 2020

Insurance Coverage Requested:

Life/Employees and Dep(s)

Life Rates:

Life/AD&D per \$1,000:	\$0.205
Dependent Life per Unit:	\$0.30

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

Signature of Authorized Representative

Title of Authorized Representative

Printed Name