Agenda Item No: 13.A

STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** May 20, 2021

Staff Contact: Melanie Bruketta, Human Resources Director

Agenda Title: For Possible Action: Discussion and possible action regarding proposed health and vision 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 with a 3% rate decrease and continued funding of health savings accounts for active employees in Fiscal Year ("FY") 2022 in the annual amount of $2,079.48 (employee only), $3,171.36 (employee plus spouse), $3,034.50 (employee plus children) and $4,297.56 (employee plus family); and (2) vision insurance benefits through Kansas City Life as a two-year contract matching the current rates paid by the City. (Melanie Bruketta, mbruketta@carson.org)

Staff Summary: This item is for the Board of Supervisors to consider the approval of contracts with benefit providers for health and vision insurance for City employees and retirees.

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

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Proposed Motion

I move to approve the benefits contracts as presented and to authorize the Mayor to sign the documents.

Board's Strategic Goal

Organizational Culture

Previous Action

The Board of Supervisors approved the health insurance plan for FY 2021 at the May 7, 2020 meeting. Contracts for dental and life benefits do not need to be renewed this year.

Background/Issues & Analysis

The City's contract for health insurance through Hometown Health expires on June 30, 2021. The City's combined medical and prescription adjusted claims loss ratio was 82% this past year, a four percent increase over the prior 12 months. The 82% loss ratio is driven by overall utilization trends and the presence of large claims. The City approved the implementation of a high deductible plan three years ago which has contributed to keeping the loss ratio low. Standard underwriting practices would call for an approximate 3% 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, the City was able to negotiate a three percent decrease in the rates.

The City's contract for vision insurance through EyeMed expires on June 30, 2021. EyeMed asked for an 8% increase based on an 84% loss ratio. It subsequently lowered it's request to a 7% increase. City staff requested that the City's insurance broker market vision insurance. The City received a quote from Kansas

City Life to match the City's current rates with EyeMed. Kansas City Life uses the VSP network which is not only a better provider network than EyeMed, but also dropped the insured's copay from $20.00 to $10.00 and increased the frame and contact lense allowance from $140 to $150.

The City's Insurance Committee met on March 25, 2021, and Human Resources received no objections to the proposed recommendations.

Applicable Statute, Code, Policy, Rule or Regulation
NRS 244.143(2)(e), 244.146(1)(a), and 332.115(1)(f)

Financial Information
Is there a fiscal impact? Yes

If yes, account name/number: Group Insurance Fund - Medical and Vision Premiums 5700706-506301. Health insurance decrease of 3% and vision insurance with no rate change.

Is it currently budgeted? Yes

Explanation of Fiscal Impact: The health insurance premiums will decrease by 3% from last year and the vision insurance premiums will not change from last year. Both have been built into the FY 2022 tentative budget.

Alternatives
Do not approve one or more of the proposed contracts and direct staff to negotiate further.

Attachments:
LP Benefit Reporting Package.pdf

HHP Subscription Agreement.pdf

Kansas City Vision.pdf

Open Enrollment PowerPoint.pdf

Vision.pdf

Group Application- Vision_R.pdf

Board Action Taken:

Motion: ________________ 1) ________________ Aye/Nay
2) ________________ __________
____
____
____
____

____
(Vote Recorded By)

Benefit Program Reporting Package

Prepared For:

Claims data through: January 2021

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Section 1: Claims Data Review - Current and Prior Period
Medical
Dental
Vision

Section 2: Medical Claims vs Premium Graph

Section 3: Dental Claims vs Premium Graph

Medical & Pharmacy Performance

Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical Claims	Rx Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Rolling 12 Months - Current									
Feb-20	737	1,496	$633,195	$859	$335,134	$91,487	$426,621	$579	67%
Mar-20	734	1,491	$635,553	$866	$374,542	$74,593	$449,135	$612	71%
Apr-20	735	1,495	$632,993	$861	$373,974	$106,228	$480,202	$653	76%
May-20	741	1,502	$632,906	$854	$656,321	$102,484	$758,805	$1,024	120%
Jun-20	744	1,501	$633,423	$851	$339,676	$99,510	$439,186	$590	69%
Jul-20	744	1,494	$631,483	$849	$402,616	$85,749	$488,365	$656	77%
Aug-20	743	1,507	$634,987	$855	$421,725	$99,535	$521,260	$702	82%
Sep-20	738	1,499	$631,773	$856	$322,138	$84,898	$407,036	$552	64%
Oct-20	734	1,503	$631,600	$860	$700,441	$144,974	$845,415	$1,152	134%
Nov-20	740	1,514	$638,174	$862	$310,028	$103,234	$413,262	$558	65%
Dec-20	739	1,511	$639,387	$865	$422,039	$105,197	$527,236	$713	82%
Jan-21	741	1,513	$645,002	$870	$354,682	$111,073	$465,755	$629	72%
Total	**8,870**	**18,026**	**$7,620,477**	-	**$5,013,316**	**$1,208,961**	**$6,222,277**	-	**82%**
Average	**739**	**1,502**	**$635,040**	$859	**$417,776**	**$100,747**	**$518,523**	$701	**82%**

Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical Claims	Rx Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Rolling 12 Months - Prior									
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	$94,233	$372,209	$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	1,463	$621,904	$859	$347,072	$93,210	$440,282	$608	71%
Jan-20	729	1,478	$623,542	$855	$373,239	$180,405	$553,644	$759	89%
Total	**8,638**	**17,336**	**$7,605,360**		**$4,526,232**	**$1,434,327**	**$5,960,559**		**78%**
Average	**720**	**1,445**	**$633,780**	$880	**$377,186**	**$119,527**	**$496,713**	$690	**78%**

Current / Prior	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Medical Claims	Rx Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Average	739	1,502	$635,040	$859	$417,776	$100,747	$518,523	$701	82%
Average	720	1,445	$633,780	$880	$377,186	$119,527	$496,713	$690	78%
Changes:	2.7%	4.0%	0.2%	-2.4%	10.8%	-15.7%	4.4%	1.7%	4.2%

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
Feb-20	737	1,496	$49,842	$68	$49,116	$49,116	$67	99%
Mar-20	734	1,491	$49,609	$68	$32,859	$32,859	$45	66%
Apr-20	735	1,495	$49,627	$68	$14,964	$14,964	$20	30%
May-20	741	1,502	$49,880	$67	$21,304	$21,304	$29	43%
Jun-20	744	1,501	$50,060	$67	$32,002	$32,002	$43	64%
Jul-20	744	1,494	$46,254	$62	$21,033	$21,033	$28	45%
Aug-20	743	1,507	$46,425	$62	$46,763	$46,763	$63	101%
Sep-20	738	1,499	$46,273	$63	$35,424	$35,424	$48	77%
Oct-20	734	1,503	$46,273	$63	$50,403	$50,403	$69	109%
Nov-20	740	1,514	$46,632	$63	$35,347	$35,347	$48	76%
Dec-20	739	1,511	$46,660	$63	$57,200	$57,200	$77	123%
Jan-21	741	1,513	$47,090	$64	$44,700	$44,700	$60	95%
Total	**8,870**	**18,026**	**$574,626**	-	**$441,116**	**$441,116**	-	77%
Average	**739**	**1,502**	**$47,885**	$65	**$36,760**	**$36,760**	$50	77%

Rolling 12 Months - Prior

Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Dental Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
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	$48,323	$67	$45,248	$45,248	$63	94%
Jul-19	717	1,433	$48,274	$67	$38,319	$38,319	$53	79%
Aug-19	717	1,436	$48,351	$67	$43,386	$43,386	$61	90%
Sep-19	719	1,449	$48,600	$68	$36,417	$36,417	$51	75%
Oct-19	719	1,455	$48,600	$68	$47,652	$47,652	$66	98%
Nov-19	720	1,457	$48,545	$67	$46,163	$46,163	$64	95%
Dec-19	724	1,463	$48,747	$67	$33,381	$33,381	$46	68%
Jan-20	729	1,478	$49,284	$68	$49,895	$49,895	$68	101%
Total	**8,638**	**17,336**	**$581,141**	-	**$525,690**	**$525,690**	-	90%
Average	**720**	**1,445**	**$48,428**	$67	**$43,807**	**$43,807**	$61	90%

Current / Prior	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Dental Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Average	739	1,502	47,885	65	36,760	36,760	50	77%
Average	720	1,445	48,428	67	43,807	43,807	61	90%
Changes:	2.7%	4.0%	-1.1%	-3.7%	-16.1%	-16.1%	-18.3%	-15.1%

Vision Performance

Rolling 12 Months - Current								
Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Vision Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Feb-20	737	1,496	$4,661	$6	$3,257	$3,257	$4	70%
Mar-20	734	1,491	$4,645	$6	$2,768	$2,768	$4	60%
Apr-20	735	1,495	$4,653	$6	$2,258	$2,258	$3	49%
May-20	741	1,502	$4,698	$6	$2,765	$2,765	$4	59%
Jun-20	744	1,501	$4,658	$6	$3,637	$3,637	$5	78%
Jul-20	744	1,494	$4,651	$6	$4,823	$4,823	$6	104%
Aug-20	743	1,507	$4,663	$6	$3,795	$3,795	$5	81%
Sep-20	738	1,499	$4,656	$6	$5,263	$5,263	$7	113%
Oct-20	734	1,503	$4,676	$6	$4,676	$4,676	$6	100%
Nov-20	740	1,514	$4,710	$6	$4,275	$4,275	$6	91%
Dec-20	739	1,511	$4,731	$6	$4,879	$4,879	$7	103%
Jan-21	741	1,513	$4,732	$6	$4,759	$4,759	$6	101%
Total	8,870	18,026	$56,134		$47,155	$47,155		84%
Average	739	1,502	$4,678	$6	$3,930	$3,930	$5	84%

Rolling 12 Months - Prior								
Month/ Year	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Vision Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Feb-19	719	1,429	$4,505	$6	$3,266	$3,266	$5	73%
Mar-19	718	1,432	$4,505	$6	$3,564	$3,564	$5	79%
Apr-19	717	1,429	$4,503	$6	$4,318	$4,318	$6	96%
May-19	720	1,437	$4,518	$6	$3,042	$3,042	$4	67%
Jun-19	719	1,438	$4,499	$6	$2,195	$2,195	$3	49%
Jul-19	717	1,433	$4,582	$6	$3,556	$3,556	$5	78%
Aug-19	717	1,436	$4,539	$6	$4,674	$4,674	$7	103%
Sep-19	719	1,449	$4,546	$6	$5,780	$5,780	$8	127%
Oct-19	719	1,455	$4,553	$6	$5,372	$5,372	$7	118%
Nov-19	720	1,457	$4,557	$6	$3,220	$3,220	$4	71%
Dec-19	724	1,463	$4,569	$6	$3,213	$3,213	$4	70%
Jan-20	729	1,478	$4,629	$6	$4,984	$4,984	$7	108%
Total	8,638	17,336	$54,505		$47,184	$47,184		87%
Average	720	1,445	$4,542	$6	$3,932	$3,932	$5	87%

Current / Prior	Subscribers	Members	Policy Premium	Subscribers Composite Premium	Vision Claims	Total Claims	Subscriber Composite Claims*	Paid Loss Ratio
Average	739	1,502	4,678	6	3,930	3,930	5	84%
Average	720	1,445	4,542	6	3,932	3,932	5	87%
Changes	2.7%	4.0%	3.0%	0.3%	-0.1%	-0.1%	-2.7%	-3.0%

Market Survey Analysis

Prepared for

Carson City

Presented By:

LP Insurance Services

Employee Benefits Division

Effective: July 1, 2021

LP Insurance Services, LLC

License #710906

INSURANCE BROKERS * EMPLOYEE BENEFIT CONSULTANTS

Carson City

Response To Bid

CARRIERS CONTACTED	BID RESPONSE	%OVER/UNDER CURRENT
Medical		
Hometown Health	Current/Renewal	-3.00%
Dental		
Cigna	Current	Renews 2022
Vision		
EyeMed	Current/Renewal	6.99%
Kansas City Life	Presented	0.00%
Best Life	Presented	4.13%
Renaissance	Presented	7.57%
Guardian	Not Competitive	11.05%
MES	Not Competitive	11.83%
Standard	Not Competitive	23.90%
Lincoln	Declined to Quote	-
Met Life	Declined to Quote	-
Principal	Declined to Quote	-
Anthem	Declined to Quote	-
Life		
Kansas City Life	Current	Renews 2022

Carson City

Medical Benefits & Cost Comparison

		Current & Renewal				
Carrier		Hometown $2,800 PPO HSA			Hometown $1,500 PPO	
Network		Hometown Health PPO			Hometown Health PPO	
		In-Network	Out-Network		In-Network	Out-Network
Individual Calendar Year Deductible		$2,800	$5,600		$1,500	$5,000
Family Calendar Year Deductible		$5,600	$11,200		$4,500	$15,000
Individual Calendar Year Out of Pocket Max.		$2,800	$10,000		$6,000	$12,000
Family Calendar Year Out of Pocket Max.		$5,600	$20,000		$12,000	$24,000
Primary Physician Copay		0% (d)	30% (d)		$40	50% (d)
Specialist Physician Copay		0% (d)	30% (d)		$60	50% (d)
Emergency Room		0% (d)	0% (d)		$150	$150
Urgent Care Center		0% (d)	0% (d)		$50	$50
Lab, X-Ray (Non-Hospital)		0% (d)	30% (d)		$0, $60	50% (d)
MRI, PET, CT Scans (Non-Hospital)		0% (d)	30% (d)		$100	50% (d)
Outpatient Surgery		0% (d)	30% (d)		$500	50% (d)
Inpatient Hospitalization		0% (d)	30% (d)		$1,500 (d)	50% (d)
In Network Prescription Benefit:						
Tier I		0% (d)			$15	
Tier II		0% (d)			$40	
Tier III		0% (d)			$60 + Ancillary Charge	
Rates: (Actives & Early Retirees)		Current	Renewal		Current	Renewal
Employee	95	$389.95	$378.25	242	$568.60	$551.54
Employee + Spouse	26	$799.52	$775.53	72	$1,185.78	$1,180.80
Employee + Children	40	$748.21	$725.76	75	$1,090.96	$1,058.22
Family	50	$1,221.97	$1,185.30	88	$1,781.74	$1,728.27
	200			477		
Rates: (Retired with Medicare)						
Retiree w/ Medicare (A&B)	0	$286.40	$277.86	39	$417.73	$405.19
Retiree + Spouse, both w/ Medicare (A&B)	0	$608.03	$589.78	5	$886.61	$860.00
Retiree + Spouse, one w/ Medicare (A&B)	0	$718.53	$696.97	7	$1,047.79	$1,016.35
Retiree + Child(ren), w/ Medicare (A&B)	0	$741.70	$719.44	0	$1,081.50	$1,049.05
Retiree + Family, both w/ Medicare (A&B)	0	$741.00	$718.76	1	$1,080.55	$1,048.12
Retiree + Family, one w/ Medicare (A&B)	0	$861.49	$835.64	1	$1,256.14	$1,218.45
	0			53		
Monthly Premium		$148,080	$143,634		$490,548	$475,828
Annual Premium		$1,776,957	$1,723,637		$5,886,579	$5,709,936
$ over/(under) current			-$53,320			-$176,643
% over/(under) current			-3.00%			-3.00%
Monthly HSA Funding		$51,009	$51,009		-	-
Annual HSA Funding		$612,105	$612,105		-	-
Monthly Premium w/ HSA Funding		$199,089	$194,645		$490,548	$475,828
Annual Premium w/ HSA Funding		$2,389,062	$2,335,742		$5,886,579	$5,709,936
		Current - Both Plans (with HSA)			Renewal Both Plans (with HSA)	
Monthly Premium		$689,637			$670,473	
Annual Premium		$8,275,641			$8,045,678	
		Current - Both Plans (with HSA)			Renewal Both Plans (with HSA)	
$ over/(under) current		-			-$229,963	
% over/(under) current		-			-2.8%	

Additional Services: $3,500 Wellness Credit; InBody Testing

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Carson City

Dental Benefits & Cost Comparison

Carrier		Cigna
Network		Cigna
		In-Network
Reimbursement		Neg. Fee
Individual Calendar Year Deductible		$50
Family Calendar Year Deductible		$150
Coverage Level:		
Preventive		0%
Basic		20% (d)
Major		45% (d)
Orthodontia		50%
Coverage:		
Cleaning Frequency		3 Every 12 Mo.
Composite Fillings		Anterior & Posterior
Crowns		Major
Endo and Perio		Basic
Oral Surgery		Basic
Implants		Major
Calendar Year Maximum		$2,000
Orthodontia Lifetime Maximum		$1,500
Missing Tooth Provision		Yes
Roll-Over Benefits		No
Waiting Periods (timely applicants):		
Basic		None
Major		None
Rates:		Current
Employee Only	380	$45.47
Employee + Spouse	107	$63.95
Employee + Child(ren)	104	$80.86
Family	135	$99.35
	726	
Monthly Premium		$45,943
Annual Premium		$551,315
Rate Guarantee		Renews 7/1/2022

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Carson City
Vision Benefits & Cost Comparison

Carrier		EyeMed			Kansas City Life	Best Life	Renaissance
Network			Access		VSP Choice	Insight	VSP Choice
			In-Network		In-Network	In-Network	In-Network
Frequency:							
Eye Exam			Every 12 months		Every 12 months	Every 12 months	Every 12 months
Lenses			Every 12 months		Every 12 months	Every 12 months	Every 12 months
Frames			Every 24 months		Every 24 months	Every 24 months	Every 24 months
Schedule of Benefits:							
Vision Exam			$20 copay		$10 copay	$10 copay	$20 copay
Single Vision Lenses			$25 copay		$25 copay	$25 copay	$25 copay
Bifocal Lenses			$25 copay		$25 copay	$25 copay	$25 copay
Trifocal Lenses			$25 copay		$25 copay	$25 copay	$25 copay
Frames			$140 allowance		$150 allowance	$130 allowance	$150 allowance
Contact Lenses - Elective			$140 allowance		$150 allowance	$130 allowance	$150 allowance
Rates:		Current	Initial	Revised	Proposed	Proposed	Proposed
Employee	392	$3.85	$4.16	$4.12	$3.85	$4.15	$4.14
Employee + Spouse	105	$7.33	$7.92	$7.84	$7.33	$8.29	$7.89
Employee + Children	111	$7.71	$8.33	$8.25	$7.71	$8.17	$8.29
Family	136	$11.34	$12.25	$12.13	$11.34	$10.78	$12.20
	744						
Monthly Premium		$4,677	$5,053	$5,004	$4,677	$4,870	$5,031
Annual Premium		$56,123	$60,635	$60,044	$56,123	$58,442	$60,369
$ above/(below) current		-	$4,513	$3,921	$0	$2,320	$4,246
% above/(below) current		-	8.04%	6.99%	0.00%	4.13%	7.57%
Rate Guarantee			48 months		24 months	24 months	24 months

Carson City

Life/AD&D Benefits & Cost Comparison

Carrier	**Kansas City Life**
Eligibility	Active and Retired Employees
Benefit Amount:	
Class 1: Unclassified & Elected Members	$35,000
Class 2: Sheriff Personnel	$50,000
Class 3: Active Fire Members	$50,000
Class 4: All Other Active Members	$20,000
Class 5: Retirees	$10,000
Class 6: Surviving Spouses	$500, No AD&D
Dependents, Class 1-5:	
Spouse	$500
Child	$500
Plan Features:	
Accelerated Death Benefit	80%
Portability	Included
Waiver of Premium	Included
Travel Assistance	Included
Benefit Reduces To:	
at age 65	None
at age 70	65%
at age 75	65%
Rates:	**Current**
Volume	$20,696,500
Life/AD&D per $1,000	$0.205
Dep Life per Unit	$0.300
Est. Monthly Premium	**$4,243**
Est. Annual Premium	**$50,913**
Rate Guarantee	**Renews 7/1/2022**

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 is no longer employed by the Group or otherwise does not meet membership requirements. The Group agrees that no person will be kept on the Group's payroll or otherwise be represented as a Member for the sole purpose of obtaining or maintaining coverage under the Contract. The Group agrees to observe the terms of this Agreement and hold Hometown Health harmless for all costs and fees incurred or associated with such an ineligible individual, including, without limitation, attorney fees and liability incurred in the defense of any claim or suit brought at any time by a person ineligible for coverage.

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

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

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

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

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

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

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

SECTION V. MEMBER ELIGIBILITY

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

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

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

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

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

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

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

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

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

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

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

Following the loss of eligibility of an individual, Hometown Health will allow continued coverage for such individual only if eligible under COBRA, such individual is notified of their continuation rights by the employer and if the individual has elected and paid for the continued coverage to the extent required by COBRA. The Group further understands and agrees that any notice, collection of premium or communication about continuation coverage will be the responsibility of the Group (or employee 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 F MLA 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.

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

SECTION VI. PREMIUM CHARGES

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

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.

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

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

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

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

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

SECTION VII. BENEFIT CHANGES

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

If any change to the benefits or the payment amount is unacceptable to the Group the Group will have

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

SECTION VIII. ENROLLMENT

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

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

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

SECTION IX. GROUP CONTRIBUTION

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

SECTION X. INELIGIBLE MEMBER

Group shall receive a credit for premiums paid, or be relieved of liability for unpaid but accrued premium, if Group gives Hometown Health notice of the ineligibility no later than sixty (60) days after the date

eligibility ceased; provided, however, that Hometown Health has not provided or arranged for covered health services for the Member after the Member's eligibility ceased and Hometown Health received notice of ineligibility. Notwithstanding the above or Hometown Health's receipt and acceptance of a premium payment on behalf of an ineligible Member, Hometown Health may refund such premium payment(s) to Group and hold the Member liable for the fee-for-service equivalent for any services or benefits received during the period for which the Member was not eligible for coverage.

SECTION XI. NOTICE

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

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

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

SECTION XII. TERMINATION OF AGREEMENT BY HOMETOWN HEALTH

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

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

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

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

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

(5) If the Group does not remit to Hometown Health any assessment billed for Hometown health or any similar state or federal program,

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

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

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

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

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

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

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

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

SECTION XIII. TERMINATION BY GROUP

The Group may terminate this Agreement upon thirty (30) days written notice to Hometown Health for the

reasons listed below. In no case will Hometown Health be obligated to terminate this Agreement in fewer than thirty (30) days.

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

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

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

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 tbe 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. 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.

(h) 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

(i) 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, normal 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: 20 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	$551.54
Subscriber Plus Spouse	$1,130.80
Subscriber Plus Child	$1,058.22
Subscriber Plus Children	$1,058.22
Subscriber Plus Family	$1,728.27

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of Carson City, Nevada under this Agreement by and between Hometown Health and Carson City, Nevada shall become effective as of 12:01 AM on 7/1/2021, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2022, or unless otherwise terminated as allowed herein.

The undersigned representative of Carson City, Nevada 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

David M Hansen
CEO, Hometown Health

3/3/2021
Date

Carson City, Nevada
BY

(Authorized Signature of Group)

Date

Section XVI. COVERAGE

Medical Benefit Plan:	20 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	$405.19
Retiree & Spouse (One w/ Medicare)	$1,016.35
Retiree & Spouse (Both w/ Medicare)	$860.00
Retiree & Child (Retiree w/ Medicare)	$1,049.05
Retiree & Children (Retiree w/ Medicare)	$1,049.05
Family (Retiree or Spouse w/ Medicare)	$1,218.45
Family (Retiree & Spouse w/ Medicare)	$1,048.12

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

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Hometown Health
BY

David M Hansen
CEO, Hometown Health

3/3/2021
Date

Carson City, Nevada
BY

(Authorized Signature of Group)

Date

Section XVI. COVERAGE

Medical Benefit Plan:	20 LG PPO HD-NA CINS E D2800X2 HSA A1
Rx Benefit:	RX 0%/0%/0%/0%
Renown Occ Health:	N

Section XVII. PREMIUM RATE SCHEDULE

TYPE OF COVERAGE	Total Premium
Individual Subscriber	$378.25
Subscriber Plus Spouse	$775.53
Subscriber Plus Child	$725.76
Subscriber Plus Children	$725.76
Subscriber Plus Family	$1,185.30

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of Carson City, Nevada under this Agreement by and between Hometown Health and Carson City, Nevada shall become effective as of 12:01 AM on 7/1/2021, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2022, or unless otherwise terminated as allowed herein.

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

Hometown Health
BY

David M Hansen
CEO, Hometown Health

3/3/2021
Date

Carson City, Nevada
BY

(Authorized Signature of Group)

Date

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Section XVI. COVERAGE

Medical Benefit Plan: 20 LG PPO HD-NA CINS E D2800X2 HSA A1
Rx Benefit: RX 0%/0%/0%/0%
Renown Occ Health: N

Section XVII. PREMIUM RATE SCHEDULE

TYPE OF COVERAGE	Total Premium
Retiree w/ Medicare	$277.86
Retiree & Spouse (One w/ Medicare)	$696.97
Retiree & Spouse (Both w/ Medicare)	$589.78
Retiree & Child (Retiree w/ Medicare)	$719.44
Retiree & Children (Retiree w/ Medicare)	$719.44
Family (Retiree or Spouse w/ Medicare)	$835.64
Family (Retiree & Spouse w/ Medicare)	$718.761

Note: These rates include all ACA fees.

Section XVIII. TERM OF AGREEMENT

Coverage for Members of Carson City, Nevada under this Agreement by and between Hometown Health and Carson City, Nevada shall become effective as of 12:01 AM on 7/1/2021, Pacific Standard Time (Contract Effective Date), and remain in effect for 12 consecutive months ending as of 12:00 AM on 6/30/2022, or unless otherwise terminated as allowed herein.

The undersigned representative of Carson City, Nevada 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

David M Hansen
CEO, Hometown Health

3/3/2021
Date

Carson City, Nevada
BY

(Authorized Signature of Group)

Date

Hometown Health Providers Insurance Company, Inc.

Premium Rate Quote

Group Name: CARSON CITY NEVADA
Group Number: 4623
Rate Effective Date: 7/1/2021
Broker: LP Insurance User
Blended Rate Indicator: Yes

Plan		Current Benefit Plan Description*
1	Medical Plan:	2016 PPO 40-CO 1500 A D1500X2 RX $15/$45/$60/20%
	Pharmacy Plan:	Included In Medical
	Vision Plan:	None

Non-Medicare Information	Employee	EE & Spouse	EE & Child	EE & Children	Family	Overall Total
Enrollment	171	40	21	46	84	412
Proposed Rate	$ 553.54	$ 1,130.80	$ 1,058.22	$ 1,058.22	$ 1,728.27	$ 184,791.30
Current Rate	$ 568.02	$ 1,165.76	$ 1,090.96	$ 1,090.96	$ 1,781.74	$ 190,491.66

Medicare Information	EE (1 with)	EE & Spouse (1)	EE & Spouse (2)	EE & Child (1)	EE & Children (1)	Family (1)	Family (2)
Enrollment	10	5	7	-	-	1	1
Proposed Rate	$ 409.39	$ 1,018.35	$ 400.00	$ 1,049.05	$ 1,049.05	$ 1,218.48	$ 1,048.12
Current Rate	$ 437.73	$ 1,047.79	$ 386.61	$ 1,081.50	$ 1,081.50	$ 1,256.14	$ 1,080.55

Plan Rate Change: -3.0%

Plan		Current Benefit Plan Description*
2	Medical Plan:	2016 PPO HD-NA CINS E D2500X2 HSA A1,RX 0%/0%/0%/0%
	Pharmacy Plan:	Included In Medical
	Vision Plan:	None

Non-Medicare Information	Employee	EE & Spouse	EE & Child	EE & Children	Family	Overall Total
Enrollment	92	26	17	21	51	207
Proposed Rate	$ 378.25	$ 775.53	$ 725.76	$ 725.76	$ 1,185.30	$ 143,481.57
Current Rate	$ 389.95	$ 799.52	$ 748.21	$ 748.21	$ 1,221.97	$ 148,050.10

Medicare Information	EE (1 with)	EE & Spouse (1)	EE & Spouse (2)	EE & Child (1)	EE & Children (1)	Family (1)	Family (2)
Enrollment	-	-	-	-	-	-	-
Proposed Rate	$ 377.86	$ 696.97	$ 585.76	$ 718.44	$ 718.44	$ 833.64	$ 718.76
Current Rate	$ 389.46	$ 718.53	$ 608.02	$ 741.70	$ 741.70	$ 861.49	$ 741.00

Plan Rate Change: -3.0%

Plan		Current Benefit Plan Description*
3	Medical Plan:	2016 PPO 40-CO 1500 A D1500X2 RX $15/$45/$60/20%
Early Retirees	Pharmacy Plan:	Included In Medical
	Vision Plan:	None

Non-Medicare Information	Employee	EE & Spouse	EE & Child	EE & Children	Family	Overall Total
Enrollment	71	32	4	4	4	115
Proposed Rate	$ 553.54	$ 1,130.80	$ 1,058.22	$ 1,058.22	$ 1,728.27	$ 90,721.33
Current Rate	$ 568.00	$ 1,165.76	$ 1,090.96	$ 1,090.96	$ 1,781.74	$ 93,530.28

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: -3.0%

Plan		Current Benefit Plan Description*
4	Medical Plan:	2016 PPO HD-NA CINS E D2500X2 HSA A1,RX 0%/0%/0%/0%
Early Retirees	Pharmacy Plan:	Included In Medical
	Vision Plan:	None

Non-Medicare Information	Employee	EE & Spouse	EE & Child	EE & Children	Family	Overall Total
Enrollment	1	1	-	-	-	2
Proposed Rate	$ 378.25	$ 775.53	$ 725.76	$ 725.76	$ 1,185.30	$ 1,153.78
Current Rate	$ 389.95	$ 799.52	$ 748.21	$ 748.21	$ 1,221.97	$ 1,189.47

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: -3.0%

Total Enrollment:	739
Total Estimated Monthly Premium:	$ 419,251.17
Total Premium at Current Rate Levels:	$ 432,305.63
Overall Rate Change:	-3.0%

Signature Required for Acceptance			
Authorized Company Representative (please print)	Title	Signature	Date

[illegible fine print]

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

Addendums to Contract Plan Year 2021-2022

Addendum 2 – Wellness/Rehires/Lay-Offs/Military

1. Provided it occurs during the term of this contract, Hometown Health will provide biometric wellness screenings at the 2021 Carson City Health Fair. There will be no cost to Carson City or employees who attend that are enrolled in Hometown Health.

   Hometown Health will provide a 2021 Flu Shot Clinic. There will be no cost to Carson City or its members who are enrolled in Hometown Health.

2. Hometown Health will provide a $3,500 wellness allowance to Carson City to be used for wellness related services not listed in items #1 and #2 above. The wellness vendor, any services, or supplies must be approved prior to purchase. Approval will not be unreasonably withheld by Hometown Health. Hometown Health will remit payment to the approved vendor within 30 days of receipt of invoice. Funds must be spent during the term of this contract.

3. Employees reinstated after a lay-off, suspension, or pursuant to an administrative order or Court order may be entitled to reinstate insurance immediately. Employees who are rehired must wait to reinstate insurance until the 1st of the month following 60 days of employment.

4. Employees placed on Military Leave will have no impact to the employees insurance coverage. The employer and the employee premium payments or obligations, if any, remain consistent with the City Policy for up to a 52-week period. The employee upon deployment may choose to waive insurance coverage and may reinstate insurance coverage on the employee's date of return.

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

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

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:

Name: Melanie Bruketta — Title: HR Director

Address: 201 N Carson St, Suite 4 — City: Carson City — State: NV — Zip Code: 89701

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):

Name: Jacque Cassinelli — Title: HR Generalist

Address: 201 N Carson St, Suite #4 — City: Carson City — State: NV — Zip Code: 89701

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:
☒	☒	☐	☒ Active Employees ☒ Retirees:
☐	☐	☐	☒ Permanent Full Time employees scheduled to work at least 30 hours per week. **Eligible employee means a permanent employee who has a regular working week of 30 or more hours...NRS689C.065
☐	☐	☐	☒ Other: (Attach Explanation) Attachment 1 (AB)
☐	☐	☐	☒ 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:
☒	☒	☐	☐ 1st of Month on or following date of eligible employment Termination of Coverage = Last day of month which employee ceases to be eligible
☐	☐	☐	☒ 1st of Month on or following 60 day(s) of eligible employment (60 days max) Termination of Coverage = Last day of month which employee ceases to be eligible
☐	☐	☐	☐ 1st of Month on or following 1 month of eligible employment Termination of Coverage = Last day of month which employee ceases to be eligible
☐	☐	☐	☐ Additional Information: (Attach Explanation) Termination of Coverage =
☐	☐	☐	**LARGE EMPLOYERS ONLY HAVE THE FOLLOWING ADDITIONAL OPTIONS:** ☐ Date of eligible employment Termination of Coverage = Midnight, the date of termination
☐	☐	☐	☐ ☐ days or ☐ months from date of eligible employment (90 days max) Termination of Coverage = Midnight, the date of termination
☐	☐	☐	☐ 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	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.
C3. PART TIME TO FULL TIME POLICY	C4. REHIRE EMPLOYEE POLICY
(Only applies to large groups)	
☐ Does Not Apply	☐ Does Not Apply
Minimum # of ____ ☐ Days or ☐ Months	If rehired within 12 ☐ Days or ■ Months of termination then Coverage Effective:
Working P/T before going F/T, then Coverage Effective:	**Maximum period for rehire policy is 12 months.**
☐ Date of Full Time Status	Date of Rehire (Only applies to large groups)
☐ 1st of Month following Full Time Status	☐ 1st of Month following Rehire
☐ Other: (Attach Explanation)	☒ Other: (Attach Explanation) Attachment 2 (MB)

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~~ The 1st through the end the month - FULL PREMIUM DUE (MB)

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

Dated this 1st day of April, year 2019

Melanie Bruketta HR Director (Print Name and Title of Company Representative)

Melanie Bruketta (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: Kevin Monaghan

300 E 2nd St, Suite 1300 — Reno — NV — 89501

Address — City — State — Zip Code

Telephone #: 775-996-6000, Ext#___ Fax #: 775-221-8093 Email: Kevin.monaghan@lpins.net

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 1st day of April, year 2019

Kevin Monaghan, ________
(Print Name and Title of Producer)

[signature]
(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 $ Ø 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 and approved by the Carson City Board of Supervisors. (MB)
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): Kevin Monaghan
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 Carson City, NV this 1st day of April, year 2019

Melanie Bruketta
(Print Name and Title of Company Representative)

[signature]
(Signature of Company Representative)

Attachment 1- Group Application

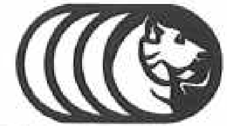
An employee may elect to stay covered under the plan without having to elect COBRA if the employee has an employment contract with the City that states the following:

That upon resignation, retirement or termination, the employee may elect to continue coverage under the City's medical, dental, vision and life insurance plans.

Attachment 2- Group Application

An employee who is rehired with Carson City is eligible to re-enroll in the group insurance plan the first of the month following sixty days of employment from the rehire date.

Group Vision Proposal provided by Kansas City Life Insurance Company



KANSAS CITY LIFE

GROUP BENEFITS

Proposed For: Carson City
Effective Date: 7/1/2021
Eligibility: Full-time active employees working a minimum of 30 hours per week
Dependent Eligibility: Spouse and unmarried children up to age 26 – could vary depending on state requirements

VSP In-Network Benefits	
Eye Examination	Covered in full after $10 copayment, every 12 months.
Materials	$25 copayment (applicable to spectacle lenses, frames or contact lenses)
Spectacle lenses	Standard single-vision, lined bifocal, lined trifocal, and lenticular lenses every 12 months.
Frames	$150 retail allowance toward any frame every 24 months.
Elective contact lenses (in lieu of eyeglasses)	$150 allowance for contact lenses, fitting and evaluation, every 12 months.
Necessary contact lenses (in lieu of eyeglasses)	Covered in full after $25 copayment every 12 months.
Out-Of-Network Reimbursement Schedule – Visit *www.vsp.com* for details, if you plan to see a provider other than a VSP network provider.	
Eye examination up to $45; frames up to $70; spectacle lenses (per pair) up to: single vision $30, lined bifocal $50, lined trifocal $65, lenticular $100. Elective contacts up to $105, necessary contacts up to $210.	

Monthly Rates

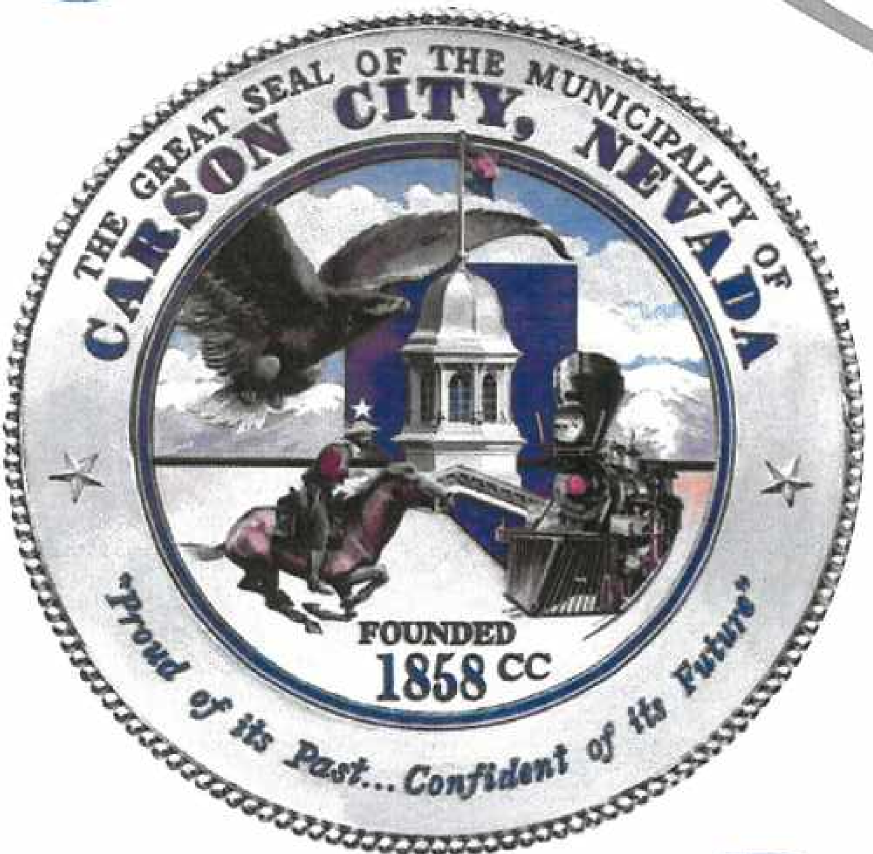
Employee Only:	$ 3.85
Employee + Spouse:	$ 7.33
Employee + Child/ren:	$ 7.71
Family:	$ 11.34

- Rates are guaranteed for 24 months following the effective date.
- Proposal assumes coverage is 100% employer-paid and requires all eligible employees to enroll.
- Net of Commission.
- VSP providers may be found at: *www.vsp.com*
- Groups must be in business a minimum of one year.
- If fewer than 10 employees are enrolled a $15 monthly administrative fee will apply.

This is a brief description only and is not a contract. The Group Master Policy will determine all rights and benefits. For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force or discontinued, see your agent or write to the Company. The policy is cancellable or renewable at the option of the Company. The Company has the right to increase the premium rates. Coverage is not available in all states. Policy and certificate referenced: PJ147/CJ147. This proposal is complete and valid only when attached to form 12270.

VSP is a registered trademark of Vision Service Plan.

Questions regarding this proposal should be directed to Scott Gilroy (x8609 or Scott.Gilroy@kclife.com) or Katie Werner. (x8882 or Katie.Werner@kclife.com).
Our toll free number is (877)266-6767.

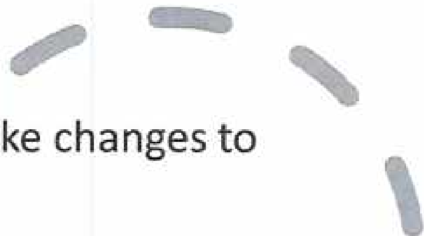


Carson City Open Enrollment

Plan Year: 2021 - 2022

Open Enrollment

- Once a year opportunity to make changes to your benefits
- Medical
  - No plan changes
  - Reduced rates
- Dental
  - No changes
- Vision
  - Moving to Kansas City Life
  - Enhanced benefits



Vocab Review

IN-NETWORK VS
OUT-OF-NETWORK

CONTRACTED
RATES

DEDUCTIBLE

OUT-OF-POCKET
MAXIMUM

COPAY

COINSURANCE

Inpatient Hospital Stay –
$30,000 contracted rate

MRI of the knee –
$1,000 contracted rate

Urgent care
$200 contracted rate

Blood work
$80 contracted rate

Bonus Question – I am covering my family. What is my out-of-pocket maximum?

Medical: Hometown Health $1,500 PPO		
	In-Network	Out-of-Network
Annual Deductible	$1,500 individual $4,500 family	$5,000 individual $15,000 family
Annual Out-of-Pocket Maximum	$6,000 individual $12,000 family	$12,000 individual $24,000 family
Primary Office Visit	$40	50% after deductible
Specialist Office Visit	$60	50% after deductible
Preventive Care	No Charge	No Charge
Routine Lab and X-Ray (Free-Standing)	$0, $60	50% after deductible
MRI, PET, CT Scans (Free Standing)	$100	50% after deductible
Inpatient Hospitalization	$1,500 after deductible	50% after deductible
Outpatient Hospitalization	$500	50% after deductible
Emergency Room Visit	$150	$150
Urgent Care Visit	$50	$50
Prescription Drugs	30 day supply	
Annual Deductible	None	
• Tier 1	$15	
• Tier 2	$40	
• Tier 3	$60	

Inpatient Hospital Stay – $30,000 contracted rate

MRI of the knee – $1,000 contracted rate

Urgent care $200 contracted rate

Blood work $80 contracted rate

Bonus Question – I am covering my family. What is my out-of-pocket maximum?

Medical: Hometown Health $2,800 HSA		
	In-Network	Out-of-Network
Annual Deductible	$2,800 individual $5,600 family	$5,400 individual $10,800 family
Annual Out-of-Pocket Maximum	$2,800 individual $5,600 family	$10,000 individual $20,000 family
Primary Office Visit	0% after deductible	30% after deductible
Specialist Office Visit	0% after deductible	30% after deductible
Preventive Care	No Charge	No Charge
Routine Lab and X-Ray (Free-Standing)	0% after deductible	30% after deductible
MRI, PET, CT Scans (Free Standing)	0% after deductible	30% after deductible
Inpatient Hospitalization	0% after deductible	30% after deductible
Outpatient Hospitalization	0% after deductible	30% after deductible
Emergency Room Visit	0% after deductible	0% after deductible
Urgent Care Visit	0% after deductible	30% after deductible
Prescription Drugs	30 day supply	
Annual Deductible	Applies	
• Tier 1	$0 after deductible	
• Tier 2	$0 after deductible	
• Tier 3	$0 after deductible	

Bank Account

- Tax-Free Contributions
- Tax-Free Spending
- Tax-Free Growth

You own the account

- All contributions are yours
- Take it with you if you leave
- You decide how to spend your money

Money rolls over

- Never lose it unless you spend

City Contributions (annually)

	Per paycheck	Annually
• Employee	$86.65	$2,079.48
• Employee + Spouse	$132.14	$3,171.36
• Employee + Child(ren)	$126.44	$3,034.50
• Employee + Family	$179.07	$4,297.56

Additional Employee Contributions

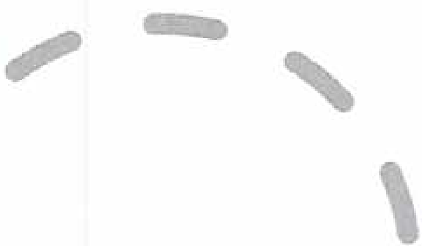
	Per paycheck	Annually
• Employee	$63.35	$1,520.52
• Employee + Spouse	$167.86	$4,028.64
• Employee + Child(ren)	$173.56	$4,165.50
• Employee + Family	$120.93	$2,902.44

Contributions are slightly lower than last year

Eligibility

- Must be enrolled in the High Deductible PPO Plan
- Cannot have other coverage that is not a *qualified high deductible plan*

- Medical, dental, vision
  - Yourself
  - Qualified tax dependents
- Medicare premiums



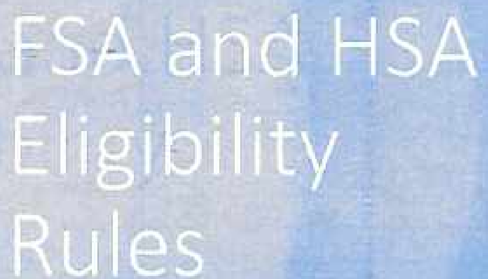
Save your receipts!

Flexible Spending Account

- Healthcare
  - $2,750 Annual Election
  - Medical, dental, vision
  - Cannot have an HSA
- Dependent Care
  - $5,000 Annual Election
  - Childcare for dependents up to age 13
  - Available to anyone

Best for KNOWN expenses

USE IT OR LOSE IT!



FSA and HSA Eligibility Rules

- You cannot have a healthcare FSA and an HSA at the same time
- If you would like to enroll in the HSA, you **MUST spend all of your FSA funds AND submit all reimbursements before June 30th**
- You can still have a dependent care FSA and an HSA at the same time

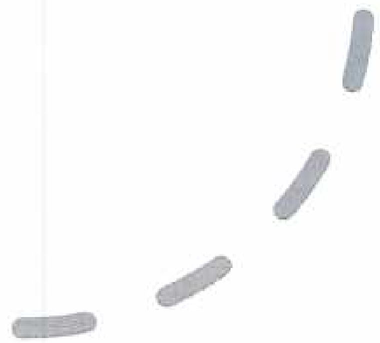
Plan considerations

- Moving to the HSA ?
  - Cash flow considerations
  - Prescription costs
  - How do I use my healthcare?
- Moving to the PPO?
  - Premium cost vs healthcare costs

Remember, deductible credit will carry over from plan to plan if you make a change during open enrollment

Important Hometown Health Reminders

- Labs
  - MUST use Renown Labs in Washoe County
  - Use LabCorp outside of Washoe County
- Advanced Imaging
  - No prior authorization is required by HHP
  - Provider/facility may still request it
- Teladoc
  - $0 copay on PPO Plan
  - $45 copay on HSA Plan
  - Register today (Teladoc.com)



Preventive cleaning-
$200 contracted rate

Filling –
$150 contracted rate

Crown
$1,000 contracted rate

Bonus Questions – What should I do before getting any work done?

Dental: Cigna	
	In-Network
Annual Maximum	$2,000
Orthodontia Lifetime Maximum	$1,500
Calendar Year Deductible	
• **Individual**	$50
• **Family**	$150
Preventive Services (Cleaning, Exams, X-Rays)	0% no deductible
Basic Services (Extractions, Fillings, Periodontics, Root Canals)	20% after deductible
Major Services (Crowns/ Onlays, Dentures, Bridges)	45% after deductible
Orthodontia	50% no deductible

New carrier and new network

Frequencies reset based on date of last service

Vision: Kansas City Life - VSP	
	In-Network
Exam Copay	$10
Materials Copay	$25
Frequency	Exam & Lenses every 12 months
	Frames every 24 Months
Examination	Covered in full after copay
Lenses	Covered in full after copay
Frames	Up to $150 allowed
Elective Contact Lenses	Up to $150 allowed

Aetna Resources For Living℠

Employee Assistance Program

To access services:

1-800-955-6422

resourcesforliving.com
Username: Carsoncity
Password: EAP

Carson City

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home.

Services are confidential and available 24 hours a day, 7 days a week.

Next Steps

- Enrollments are due May 28th
- Complete enrollments in ESS
- Cannot make any changes after open enrollment ends without a qualifying event

Employee Self Service

Benefits

Life Events

Certifications

Employee Notifications

Pay/Tax Information

Performance Evaluations

Personal Information

Time Off

Select "Benefits" on the left hand menu

Benefits

New Hire Benefit Enrollment

You must complete this enrollment by 7/21/2020. After you choose your benefits, please click "Continue" to re and submit them.

Benefit	Current Election	Current Election	
PPO INSURANCE PLAN	No Election Made	Election Not Made	Decline Benefit | Make New Election
HIGH DEDUCTIBLE INSURANCE PLAN	No Election Made	Election Not Made	Decline Benefit | Make New Election
HEALTH SAVINGS ACCOUNT	No Election Made	Election Not Made	Enrollment in this section requires enrollment ir HIGH DEDUCTIBLE INSURANCE PLAN

Continue

All costs are per pay period. Your estimated total cost per pay period is **$0.00**.

Benefits

New Hire Benefit Enrollment

You must complete this enrollment by 7/21/2020. After you choose your benefits, please click "Continue" to review and submit them.

Benefit	Current Election	Current Election	
PPO INSURANCE PLAN	No Election Made	Election Not Made	Decline benefit | Make New Election
HIGH DEDUCTIBLE INSURANCE PLAN	No Election Made	Election Not Made	Decline benefit | Make New Election
HEALTH SAVINGS ACCOUNT	No Election Made	Election Not Made	Enrollment in this section requires enrollment in HIGH DEDUCTIBLE INSURANCE PLAN

Continue

Benefits

New Hire Benefit Enrollment

You must complete this enrollment by 7/21/2020. After you choose your benefits, please click "Continue" to review and submit them.

Benefit	Current Election	Current Election	
PPO INSURANCE PLAN	No Election Made	Declined	Change New Election
HIGH DEDUCTIBLE INSURANCE PLAN	No Election Made	Election Not Made	Decline benefit | Make New Election
HEALTH SAVINGS ACCOUNT	No Election Made	Election Not Made	Enrollment in this section requires enrollment in HIGH DEDUCTIBLE INSURANCE PLAN

Continue

Here is where you can make your insurance choices.

Remember that if you want to choose Health Savings Account you will need to enroll in the High Deductible Plan first. Once you do this then the options for HSA will then be there.

For example, Richard wants to choose the HSA Plan so he will "Decline Benefit" on the PPO Insurance Plan and click "Make New Election" on the High Deductible Insurance Plan (see blue arrows).

If you are adding dependents, you will be taken to this screen. You will do this for each one of your dependents. Please be sure you include each dependents correct social security number. Once you are done adding your dependents you will click on "Continue".

Add a new dependent

First name *

Middle name

Last name *

Suffix

Date of birth *

Gender

Relationship *

Handicapped

SSN # (include dashes)

Save Cancel

e must be added for at least 2 dependents.

Benefits

New Hire Benefit Enrollment

You must complete this enrollment by 7/21/2020. After you choose your benefits, please click "Continue" to review submit them.

Benefit	Current Election	Current Election	
PPO INSURANCE PLAN	No Election Made	Declined	Change New Election
HIGH DEDUCTIBLE INSURANCE PLAN	No Election Made	HIGH DEDUCTIBLE FAMILY CCEA **$448.53 | details**	Decline benefit | Change New Election
HEALTH SAVINGS ACCOUNT	No Election Made	Election Not Made	Decline benefit | Make New Election

Continue

All costs are per pay period. Your estimated total cost per pay period is **$448.53**.

After hitting Continue you should now be at this screen. Notice at the bottom you are now seeing the price per pay period that your insurance is going to cost you. Now because Richard chose High Deductible he will also have to enroll into HSA. Click on "Make New Election" (see blue arrow).

You should now be at this screen where you need to choose an option. Remember, please read each one thoroughly, you will be choosing the same thing that you chose for the High Deductible Plan. Richard chose High Deductible Family so he will now choose "HSA Family". And then click Continue.

Employee Self Service
Benefits
Life Events
Certifications
Employee Notifications
Pay/Tax Information
Performance Evaluations
Personal Information
Time Off

Benefits

HEALTH SAVINGS ACCOUNT

Must be enrolled in High Deductible plan to enroll in health savings account.

HSA SELF
Annual Costs: Employer Cost $2,143.68
Pay Period Costs: Employer Cost $89.32
Monthly Cost: $0.00
Amount : 0

HSA CHILD
Annual Costs: Employer Cost $3,128.40
Pay Period Costs: Employer Cost $130.35
Monthly Cost: $0.00
Amount : 0

HSA SPOUSE
Annual Costs: Employer Cost $3,269.52
Pay Period Costs: Employer Cost $136.23
Monthly Cost: $0.00
Amount : 0

HSA FAMILY
Annual Costs: Employer Cost $4,430.64
Pay Period Costs: Employer Cost $184.61
Monthly Cost: $0.00
Amount : 0

I Decline

Continue Cancel

Employee Self Service
Benefits
Life Events
Certifications
Employee Notifications
Pay/Tax Information
Performance Evaluations
Personal Information
Time Off

Benefits

New Hire Benefit Enrollment

You must complete this enrollment by 7/21/2020. After you choose your benefits, please click submit them.

Benefit	Current Election	Current Election	
PPO INSURANCE PLAN	No Election Made	Declined	Change New Election
HIGH DEDUCTIBLE INSURANCE PLAN	No Election Made	HIGH DEDUCTIBLE FAMILY CCEA **$448.53 | details**	Decline benefit | Change
HEALTH SAVINGS ACCOUNT	No Election Made	HSA FAMILY **details**	Decline benefit | Change

Continue

All costs are per pay period. Your estimated total cost per pay period is **$448.53**.

Once you are back to the Main Screen you should review your choices again. You can always go back in to each choice by choosing "Change New Election". If everything looks good then you will click Continue.

Now that you are on this screen you again can review your choices, if you need to make any changes you can always click on "Modify". You will also notice that Richard needs to upload his HSA Contributions Form because he chose an HSA account. You will now need to click on the "Resources Tab" that looks like a folded piece a paper at the top right corner (see blue arrow above).

Review your enrollment

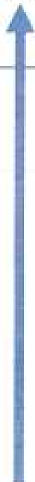
Review

PPO INSURANCE PLAN	
ELECTION - Declined	
Monthly Cost	$0.00
Attachment	Please complete the HSA contributions form in the resource center in ESS. Choose File No file chosen

HIGH DEDUCTIBLE INSURANCE PLAN	
ELECTION - HIGH DEDUCTIBLE FAMILY CCEA	
JAMES RICHARDSON	
ROSY RICHARDSON	
SUSAN RICHARDSON	
Pay Period Employee Cost	$448.53
Pay Period Employer Cost	$895.64
Annual Employee Cost	$10,764.72
Annual Employer Cost	$21,495.36
Monthly Cost	$897.06

HEALTH SAVINGS ACCOUNT	
ELECTION - HSA FAMILY	
Pay Period Employer Cost	$184.61
Annual Employer Cost	$4,430.64
Monthly Cost	$0.00
Election amount	$0.00
TOTAL PAY PERIOD EMPLOYEE COST	**$448.53**
TOTAL ANNUAL EMPLOYEE COST	**$10,764.72**

Submit Choices Modify Cancel



Resources

City Policy & Procedure Manual

KnowledgeCity

Hometown Health (Medical Ins.)

Anthem Dental

EyeMed Vision

Teladoc

HR Simplified- HSA

Self-Appraisal Form

Insurance Waiver Form

HSA Enrollment Form

Please complete the HSA contributions f

.00

SS.

Choos

$448.53

$895.64

You will click on the "HSA Enrollment Form".

Review your enrollment

Employee Self Service

Benefits

Life Events

Certifications

Employee Notifications

Pay/Tax Information

Performance Evaluations

Personal Information

Time Off

Review

PPO INSURANCE PLAN

ELECTION - Declined

Monthly Cost

Attachment

Please complete the HSA contributions form in the resource

Choose File No file chose

HIGH DEDUCTIBLE INSURANCE PLAN

ELECTION - HIGH DEDUCTIBLE FAMILY CCEA

JAMES RICHARDSON

ROSY RICHARDSON

SUSAN RICHARDSON

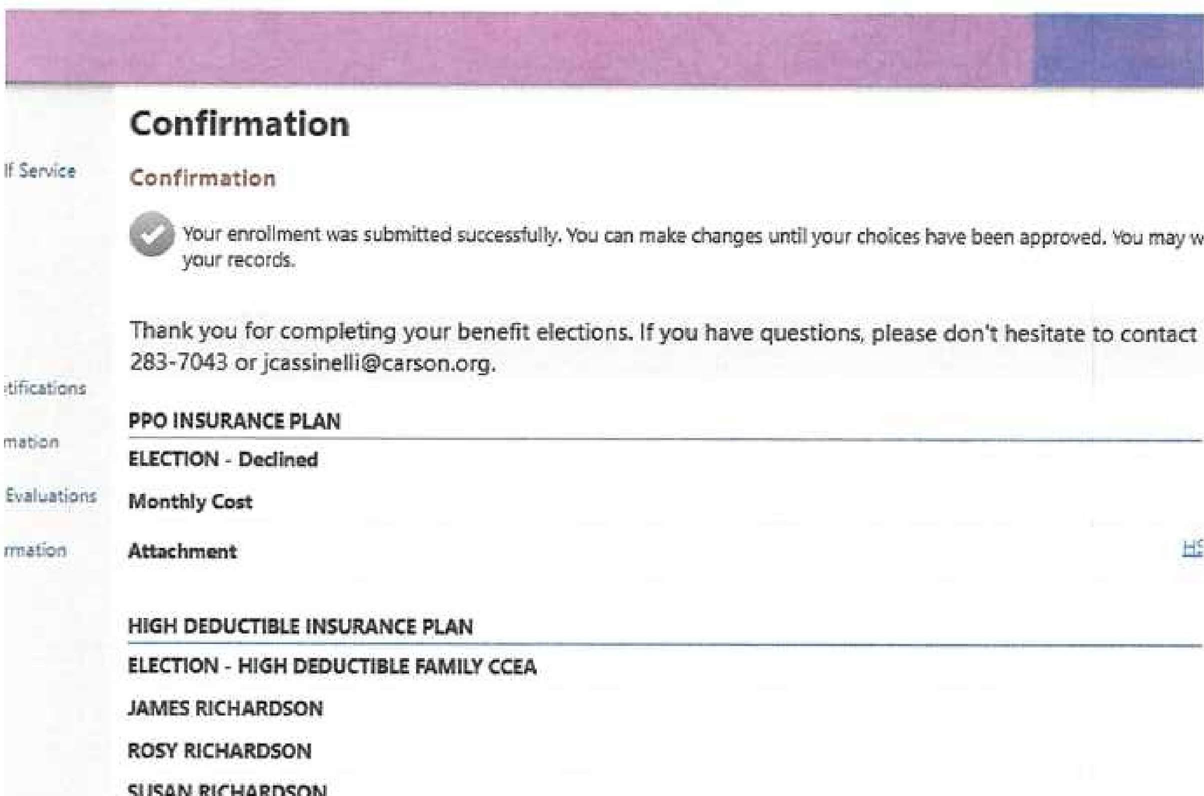
Pay Period Employee Cost

Pay Period Employer Cost

Annual Employee Cost

Annual Employer Cost

You will need to fill out the form and then you will need to attach it back in ESS.



When that is done you will click Submit choices at the bottom of the screen and you should get a confirmation at the end.

Group Insurance Benefits

DRAFT

Carson City

Group Vision Insurance

Class 01

DRAFT

Nevada Life and Health Insurance Guaranty Association

Nevada Guaranty Association Summary Document

Effective January 1, 2020

Residents of Nevada who purchase life insurance, annuities, health insurance, or Health Maintenance Organization (HMO) insurance should know that the insurance companies licensed in this State to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Association). The purpose of the Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations and becomes insolvent. If this should happen, the Association assesses its other member insurance companies for the money to pay the claims of the insured persons who live in this State and, in some cases, to keep coverage in force. This valuable extra protection provided by these insurers through the Association is not unlimited, however, as noted in the **bold** written information below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Nevada Life and Health Insurance Guaranty Association may not provide coverage for certain types of policies, however, if coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Association when selecting an insurance company or when selecting an insurance policy.

Coverage is NOT provided for a policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus. Insurance companies are required by law to deliver this notice to you. However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation, or to induce the purchase of any kind of insurance policy.

The State law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. Below is a brief summary of this law's coverages, exclusions, and limits. The summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act, or the rights or obligations of the Association. Anyone may obtain additional information from the Association or file a complaint with the Nevada Commissioner of Insurance, at the applicable address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association.

The Nevada Life and Health Insurance Guaranty Association
4600 Kietzke Lane, Suite O-269
Reno, Nevada 89502

(Business and Mailing address)
Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, Nevada 89706

Generally, individuals will be protected by the Association if they live in this State and **hold a life, health, or HMO insurance contract, or an annuity, or if they are insured under a group insurance contract issued by a member insurer.** The beneficiaries, payees, or assignees of the insured persons are protected as well, if they live in another state.

DRAFT

MAXIMUM BENEFIT LIMITS
(For any one policyholder per company no matter how many policies you have)

Life Insurance: $300,000 or $100,000 for cash surrenders

Annuities: $250,000 or $250,000 for cash surrenders, including structured settlement annuities

Disability Income Insurance: $300,000

Long Term Care: $300,000

Basic Hospital, Medical and Surgical Insurance or Major Medical Insurance and HMOs (Known as Health Benefit Plans as defined in NRS 687B.470); For any one person: $100,000, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or an aggregate of $500,000 in benefits, including benefits for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees, or other persons, the Association will not pay more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in NRS 686C, the maximum allowed is an aggregate of $250,000 regardless of the number of contracts issued by any one member company.

EXCLUSIONS FROM COVERAGE

Not covered by the Nevada Guaranty Association:

If they are eligible for protection under the law by another State Guaranty Association;

The Insurer is not authorized to do business in the State of Nevada;

If the policy was insured by a fraternal benefit society, a mandatory state pooling plan, or a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

Any policy or portion of a policy which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

Where interest rate yields exceed an average rate;

Credits given in connection with the administration of a policy by a group contract holder;

Any dividends;

Employers' plans to the extent they are self-funded (not insured by an insurance company or administered by an insurance company);

Unallocated annuity contracts (which give rights to group contract holders, and not to individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code and the Nevada Revised Statute 686C.130; or

Medicare or Medicare Advantage contracts.

FOR MORE INFORMATION AND ANSWERS TO MOST ASKED QUESTIONS, PLEASE VISIT THE ASSOCIATION'S WEB SITE:
www.nvlifega.org

DRAFT

DRAFT

Certificate of Vision Insurance

Kansas City Life Insurance Company certifies that in accordance with and subject to the terms of the Group Master Policy, the Insured Individual is insured for the coverage described in this certificate. The Group Master Policy provides the coverage described in this certificate for certain Insured Individuals covered under the Policy.

This certificate describes the Vision Insurance coverage provided by the Group Master Policy. This certificate supersedes and replaces any which may have been issued to You previously.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, Kansas City, Missouri 64111.

Secretary	President, CEO and Chairman

Guide to Certificate Provisions

Schedule of Benefits 3

Plan Benefits 3

Definition of Certain Terms 6

Eligibility and Effective Dates 7

Termination Provisions 9

Benefits Payable 10

Covered Vision Expenses 10

Limitations and Exclusions 11

Coordination of Benefits ("COB") 11

Claim Provisions 15

DRAFT

Schedule of Benefits

Policyholder:
Carson City

Group Number:
[XXXXX]

Classes of Eligible Individuals

All full-time employees in active employment in the United States with the Employer working a minimum of 30 hours per week.

You must be an Employee of the Employer in an eligible class.

Temporary and seasonal workers are excluded from coverage. Persons who are not legal residents or citizens of the United States are not eligible for coverage.

Probationary Waiting Period: As noted in Your Employer's Group Vision Insurance Policy

Plan Benefits

	FREQUENCY OF USE
Eye Examination	Once every 12 months beginning with the first date of service
Materials **Lenses**	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) Once every 12 months beginning with the first date of service
Materials **Frame**	Once every 24 months beginning with the first date of service

	COPAYMENT
Eye Examination	$10.00 shall be payable by the Covered Person at the time of examination
Materials	$25.00 shall be payable by the Covered Person at the time when materials are purchased

Any Copayments required under this plan shall be the responsibility of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed plan Allowances, annual maximum benefits, or any other stated plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

A Covered Person may use the Provider of their choice for the following covered vision services. Plan Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

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Plan Benefits
(Continued)

In-Network Provider Services: To utilize Plan Benefits, Covered Persons may select an In-Network Provider, schedule an appointment, and inform the doctor's office that they are Covered Persons of VSP. The In-Network Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from an In-Network Provider without Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Out-of-Network Provider.

Out-of-Network Provider Services: When Covered Persons elect to utilize the services of an Out-of-Network Provider, benefit payments for services from such Out-of-Network Provider will be determined according to the Plan's Out-of-Network Provider benefit fee schedule if Out-of-Network Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Out-of-Network Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of our Plan Benefits. If Covered Person is eligible for and obtains Plan Benefits from an Out-of-Network Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed by Us in accordance with the Out-of-Network Provider Reimbursement Schedule shown below, less any applicable Copayments.

COVERED SERVICES AND MATERIALS	IN-NETWORK BENEFITS (Using an In-Network Provider)	OUT-OF-NETWORK BENEFITS (Using an Out-of-Network Provider) Reimbursement Schedule
Eye Examination Comprehensive examination of visual functions and prescription of corrective eyewear.	Covered in full less any applicable Copayment	Up to $45.00 Allowance
Lenses	**(Glass or plastic Single Vision, Lined Bifocal, Lined Trifocal or Lenticular)** Covered in full less any applicable Copayment Polycarbonate lenses are covered in full for dependent children up to age 26.	**Single Vision** Up to $30.00 Allowance **Lined Bifocal** Up to $50.00 Allowance **Lined Trifocal** Up to $65.00 Allowance **Lenticular** Up to $100.00 Allowance
Frames	Covered up to $150.00 Allowance less any applicable Copayment The In-Network Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.	Covered up to $70.00 Allowance
Elective Contact Lenses Contact Lenses are provided in place of spectacle lens and frame benefits available herein.	Covered up to $150.00 Allowance less any applicable Copayment The Elective Contact Lens Allowance applies to materials only.	Covered up to $105.00 Allowance The Elective Contact Lens Allowance applies to materials only.

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Plan Benefits
(Continued)

COVERED SERVICES AND MATERIALS	IN-NETWORK BENEFITS (Using an In-Network Provider)	OUT-OF-NETWORK BENEFITS (Using an Out-of-Network Provider) Reimbursement Schedule
Necessary Contact Lenses Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor. Contact Lenses are provided in place of spectacle lens and frame benefits available herein.	Covered in full less any applicable Copayment	Covered up to $210.00 Allowance
Low Vision Professional services for severe visual problems not correctable with regular lenses, including: Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.	**Supplemental Testing** Covered in full* Includes evaluation, diagnosis and prescription of vision aids where indicated. **Supplemental Aids** 75% of In-Network Provider's fee, up to $1,000.00* *Maximum benefit for all Low Vision services and materials is $1,000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.	**Supplemental Testing** Up to $125.00* Includes evaluation, diagnosis and prescription of vision aids where indicated. **Supplemental Aids** 75% of Provider's fee, up to $1,000.00* *Maximum benefit for all Low Vision services and materials is $1,000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

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Definition of Certain Terms

Actively-at-Work
You will be considered to be actively-at-work with Your Employer on a day, which is one of Your Employer's scheduled workdays if You are performing, in the usual way, all of the regular duties of Your job on a full time basis on that day. You will be deemed to be actively-at-work on a day, which is not one of Your Employer's scheduled workdays, only if You were actively-at-work on the preceding scheduled workday.

Active Full-time Employee
An employee who works the minimum number of regularly scheduled hours for the Employer indicated on the Schedule of Benefits. An Employee is not someone who is temporary or seasonal; who is a consultant to the Employer; who is a subcontractor or independent contractor; or who is a member of the board of directors of the Employer. Owners, partners and sole proprietors are considered to be Employees only if they work the minimum number of regularly scheduled hours for the Employer.

Allowance
The flat dollar amount payable under this Policy for eye examinations, the fitting of eyeglasses, or Materials received and/or purchased by the Covered Person.

Annual Enrollment Period
The period of time, established by the Employer, during which You have an opportunity to select Your benefits and Your Dependent's benefits for the coming year.

Benefit Authorization
A process used to confirm eligibility of a Covered Person and identify those Plan Benefits to which Covered Person is entitled.

Copayments
Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

Covered Person
All individuals and dependents whose insurance is in force under the policy.

Eligibility Date
The date a full-time employee in an eligible class satisfies the probationary waiting period shown in Section 1. Policy Data.

Enrollment, Enrollment Form
The written request for enrollment in the plan of insurance by an eligible person on a form acceptable to Us.

In-Network Provider
An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Covered Persons.

Insured Individual
An individual whose insurance is in force under the terms of the Policy.

Insured Dependent
A Spouse or Child(ren) whose insurance is in force under the terms of the Policy.

Kansas City Life
Kansas City Life Insurance Company, a Missouri corporation, with its Home Office located at 3520 Broadway, Kansas City, Missouri 64111 and the telephone number is (816) 753-7000.

Life Event
Life Event means one of the following: 1) Your marriage or divorce; 2) the death of Your spouse; 3) the birth or adoption of Your child; 4) the death of Your child; 5) a change in the employment status of Your spouse; or 6) a change in Your employment status.

Materials
Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Policy.

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Out-of-Network Provider
Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons.

Plan Benefits
The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy.

Policy
The contract of insurance made by Kansas City Life and the Policyholder.

Policyholder
The firm or other organization in whose name the Policy is issued. The term Policyholder will include only those Subsidiaries, Divisions, and Affiliates listed in the Policy.

We, Us, and Our
Kansas City Life Insurance Company also referred to as Kansas City Life.

You/Your
The individual who is insured under this plan. The words "You" and "Your" with respect to any benefits, rights and privileges outlined in this certificate, refer to the employee.

Eligibility and Effective Dates

Who can be insured?
All members of the eligible classes shown on the Schedule of Benefits can be insured.

When am I eligible to be insured?
You are eligible to be insured on the latest of:

1) the policy effective date;
2) the date You become a member of an eligible class shown on the Schedule of Benefits; or
3) the date You complete the probationary waiting period (if any).

The probationary waiting period may differ for current and new Insured Individuals. The probationary waiting periods are shown in the Vision Insurance Policy.

When does my insurance begin?
To become insured, You must complete, sign, and submit an enrollment form to the Policyholder within 31 days of Your eligibility date.

Your insurance begins on the first day of the policy month, which coincides with, or next follows the date You are first eligible, but only if You are a member of an eligible class on the date insurance is to begin.

If You are not a member of an eligible class on the date insurance is to begin, insurance will begin on the first day of the policy month following Your entry into an eligible class.

When am I eligible for insurance for my dependents?
You are eligible for insurance for Your dependents on the later of:

1) the date You are eligible to be insured; or
2) the date You acquire an eligible dependent.

The date acquired for eligible dependents is as follows:

1) a spouse is deemed acquired on the date of marriage;
2) a natural child is deemed acquired on the date of birth;
3) an adopted child is deemed acquired on the date of placement for the purpose of adoption and continues to be eligible unless the placement is disrupted prior to legal adoption and the child is removed from placement;
4) a stepchild is deemed acquired on the date of marriage to the natural parent; and

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5) a grandchild or other child is deemed acquired on the first date he or she meets the definition of "child" as shown below.

Who are eligible dependents?
Eligible dependents are:

1) Your spouse; and/or
2) each unmarried child who is:
    a) under 26 years of age (until the end of the month in which the child turns age 26);
    b) age 26 or over if the child:
        i) is incapable of earning a living due to mental or physical handicap on the day before reaching the age limit;
        ii) depends on You for more than half of his or her support on that day; and
        iii) remains incapacitated and dependent as described. You must submit proof of incapacity and dependency to Kansas City Life within 31 days after the child reaches the age limit. Kansas City Life can require proof of continued incapacity and dependency but not more than once each year after the two-year period following the child reaching that age limit.

Child includes only:

1) Your natural child or adopted child; and/or
2) Your stepchild, grandchild, or other child who lives with You in a regular parent-child relationship and for whom You (or Your spouse who lives with You) have legal custody ordered by a court of competent jurisdiction.

No one can be insured as a dependent of more than one Insured Individual.

No one on active duty in the Armed Forces of any country can be insured as a dependent.

No one can be insured as a dependent if eligible for insurance as an Insured Individual, except if You and Your spouse can be insured as an Insured Individual, one (and only one) of You may insure the other for vision care expenses.

When does insurance for dependents begin?
To insure Your dependents, You must complete, sign, and submit an enrollment form to the Policyholder within 31 days after Your dependent becomes eligible. Your request must include all Your dependents then eligible.

The dependent's insurance begins for each dependent then eligible on the later of:

1) the date Your insurance begins;
2) the first day of the policy month which coincides with or next follows:
    a) the date You are first eligible for insurance for Your dependents, if You submit the enrollment form on or before the date You are first eligible for insurance for Your dependents;
    b) the date You submit the enrollment form, if You submit the enrollment form within 31 days after the date You are first eligible for insurance for Your dependents;
    c) the first day of the policy month which follows the Annual Enrollment Period; or
    d) the date You submit the enrollment form, if You submit the enrollment form within 31 days of a Life Event.

You cannot apply for insurance or for a change in Your dependent's insurance option at any other time.

You must inform Kansas City Life and the Policyholder in writing when Your last dependent is no longer eligible. The Policyholder has forms available for this purpose. Kansas City Life will not give refunds or credits for Your payment toward the cost of insurance for Your dependents for any period before the later of:

1) the date Your last dependent's insurance ends; or
2) 90 days before the date Kansas City Life is informed.

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Dependents acquired after Your coverage is effective.
Newborns are covered from the date of birth to the next premium due date that is at least 31 days after the child's birth. To continue coverage after this date You must request the coverage in writing and agree to make any required contributions.

All other dependents will be covered from the date of eligibility, if written request and payment of any required premium is submitted within 31 days.

Termination Provisions

When does insurance terminate?
Insurance under the Policy for You or Your dependents will end at 11:59 p.m. on the earliest of:

1) the date the Policy terminates;
2) the date the Policy is amended or changed to end the insurance for the class of eligible individuals to which You belong;
3) the date You cease to be a member of a class for whom insurance is provided;
4) the date that ends the period for which You last made any required payment toward the cost of insurance for You or Your dependents;
5) the date You cease to be actively-at-work as a full-time employee of the employer, if the Policy requires You to be actively-at-work except as provided under a covered leave of absence or temporary layoff;
6) the date Your dependents cease to be eligible;
7) the date, which You or Your dependent enters the Armed Forces, other than for reserve duty of 30 days or less.

If I terminate my coverage when will I be eligible to re-enroll in coverage?
Once You enroll in this coverage, You can't terminate Your vision coverage until the next Annual Enrollment Period. If You terminate Your vision coverage, You can't enroll again until the next Annual Enrollment Period. If Your insurance ends because You fail to make the required premium contribution, You and Your Dependents, if any, will not be eligible until the next Annual Enrollment Period.

Can my coverage continue while I am not actively-at-work?
The Policyholder may (but is not required to) consider You a member of an eligible class (and continue Your insurance) even though You are:

1) put on approved leave of absence;
2) temporarily laid-off and the Policyholder expects to call You back to work.

The Policyholder must treat all Insured Individuals the same for purposes of continuing insurance.

If Your insurance is so continued, it will end on the earliest of:

1) the date the Policyholder notifies Kansas City Life that You are no longer a member of an eligible class; or
2) the date that ends the period for which the Policyholder last paid the premium for You; or
3) the date that ends the maximum continuation period for which the insurance can be continued.

The maximum continuation period is as follows:

- for FMLA or State FML – leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments or by applicable state law
- for temporary lay-off – one month

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Benefits Payable

What benefits are payable?
Subject to all the terms of the Policy, we will pay for covered vision expenses incurred by You and Your Covered Dependents as shown in the Schedule of Benefits. Benefits will be payable after the Covered Person has paid any applicable Copayment. Benefits for certain covered vision expenses may be provided in the form of an Allowance.

We will provide the In-Network Benefits shown in the Schedule of Benefits for covered vision expenses incurred by Covered Persons if the examination is provided by or materials are purchased from an In-Network Provider.

We will provide the Out-of-Network Benefits shown in the Schedule of Benefits for covered vision expenses incurred by Covered Persons if the examination is provided by or materials are purchased from an Out-of-Network Provider. You must pay the entire amount at the time of service, after which the Allowance will be reimbursed to You. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.

Services from an Out-of-Network Provider are in lieu of services from an In-Network Provider.

Are You required to get a Benefit Authorization?
A Benefit Authorization must be obtained before a Covered Person can use Plan Benefits from an In-Network Provider. When a Covered Person seeks Plan Benefits from an In-Network Provider, the Covered Person must schedule an appointment and identify himself/herself as a Covered Person under this policy so the In-Network Provider can obtain a Benefit Authorization from VSP. VSP shall provide a Benefit Authorization to the In-Network Provider to authorize the administration of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Plan Benefits prior to the date the Benefit Authorization expires.

VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Policyholder and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the In-Network Provider that payment will be made to In-Network Provider, irrespective of a later loss of eligibility of the Covered Person, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date.

Covered Vision Expenses

Subject to the Limitations and Exclusions, covered vision expenses include charges made by a Provider for the following vision care services while You or Your Dependents, if any, are insured for these benefits. The benefits payable under the Policy vary depending upon which Provider rendered the services.

Covered vision expenses include expenses for eye examinations and Materials shown in the Schedule of Benefits.

Eye Examination
Comprehensive examination of visual functions and prescription of corrective eyewear.

Eye examinations from an In-Network Provider are subject to the Copayment shown in the Schedule of Benefits. The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Us before the examination takes place. The Provider will submit the Covered Person's claim directly to Us.

Benefits under the Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in the Plan Description or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

Materials
1) Lenses – Glass or plastic single vision, lined bifocal, lined trifocal or lenticular. Polycarbonate lenses are covered in full for dependent children up to age 26.

2) Frames – If vision correction is recommended by a Provider, Covered Vision Expenses will include the fitting of eyeglasses and follow-up adjustments.

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3) Contact Lenses – Elective Contact Lenses and Necessary Contact Lenses. Necessary Contact Lenses are prescribed by the Provider when a specific criterion is met to correct extreme visual acuity problems that cannot be corrected with regular lenses. Contact Lenses are provided in place of spectacle lens and frame benefits.

The above materials are subject to the Copayment for In-Network Benefits shown in the Schedule of Benefits.

Frames and lenses from an Out-of-Network Provider are payable up to the Allowance shown in the Schedule of Benefits for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in the Schedule of Benefits.

Low Vision Program
Low Vision services are prescribed by the Provider when specific criterion is met for professional services for severe visual problems not correctable with regular lenses. Supplemental testing includes evaluation, diagnosis and prescription of visual aids where indicated. Benefits are payable up to the Allowance, subject to the maximum shown in the Schedule of Benefits for the Covered Vision Expense.

Limitations and Exclusions

What are the limitations and exclusions?
Benefits will not be paid for and the term "Covered Vision Expenses" will not include charges for:

1) Services and/or materials not specifically included in the Schedule of Benefits as covered Plan Benefits.
2) Plano lenses (lenses with refractive correction of less than ± .50 diopter).
3) Two pair of glasses instead of bifocals.
4) Replacement of lenses, frames and/or contact lenses furnished under this Policy which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5) Orthoptics or vision training and any associated supplemental testing.
6) Medical or surgical treatment of the eyes.
7) Contact lens insurance policies or service agreements.
8) Refitting of contact lenses after the initial (90-day) fitting period.
9) Contact lens modification, polishing or cleaning.
10) Services or materials furnished to a Covered Person before the Effective Date of the Policy or after the date a Covered Person's Insurance ends.
11) Services or materials obtained while outside the United States, except for emergency vision care.
12) Eye examinations or corrective eyewear required by an Employer as a condition of employment.

Coordination of Benefits ("COB")

This coordination of benefits (COB) provision applies to **this plan** when a Covered Person has health care coverage under more than one **plan**. **Plan** and **this plan** are defined here. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of **this plan** are determined before or after those of another **plan**. The benefits of **this plan**:

a) Shall not be reduced when, under the order of benefit determination rules, **this plan** determines its benefits before another **plan**; but
b) May be reduced when, under the order of benefits determination rules, another **plan** determines its benefits first.

DEFINITIONS

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Plan is any of these which provides benefits or services for vision care:

a) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.

b) Coverage under a governmental **plan** or coverage required or provided by law. This does not include a state **plan** under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act).

Each contract or other arrangement for coverage under (a) or (b) is a separate **plan**. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate **plan**.

This plan is the part of the group contract that provides benefits for vision care expenses.

Primary plan/secondary plan. The order of benefit determination rules state whether **this plan** is a **primary plan** or **secondary plan** as to another **plan** covering the person. When **this plan** is a **primary plan**, its benefits are determined before those of the other **plan** and without considering the other **plan's** benefits. When **this plan** is a **secondary plan**, its benefits are determined after those of the other **plan** and may be reduced because of the other **plan's** benefits. When there are more than two **plans** covering the person, **this plan** may be a **primary plan** as to one or more other **plans** and may be a **secondary plan** as to a different **plan(s)**.

Allowable expense means a necessary, reasonable, and customary item of expense for vision care, when the item of expense is covered at least in part by one or more **plans** covering the person for whom the claim is made. When benefits are reduced under a **primary plan** because a covered person does not comply with the **plan** provisions, the amount of that reduction will not be considered an **allowable expense**. An example of these provisions is preferred provider arrangements.

Claim determination period means a calendar or plan year. However, it does not include any part of a year during which a person has no coverage under **this plan** or any part of a year before the date this COB provision or similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

GENERAL

When there is a basis for a claim under **this plan** and another **plan**. **This plan** is a **secondary plan** which has its benefits determined after those of the other **plan**, unless:

a) The other **plan** has rules coordinating its benefits with those of **this plan**; and

b) Both those rules and **this plan's** rules require that **this plan's** benefits be determined before those of the other **plan**.

RULES

This plan determines its order of benefits using the first of the following rules which applies:

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a) Nondependent/dependent. The benefits of the **plan** which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the **plan** which covers the person as a dependent;

b) Dependent child/parents not separated or divorced. Except as stated in paragraph (c), when **this plan** and another **plan** cover the same child as a dependent of different persons, called parents:

   i. The benefits of the **plan** of the parent whose birthday falls earlier in a year are determined before those of the **plan** of the parent whose birthday falls later in that year; but

   ii. If both parents have the same birthday, the benefits of the **plan** which covered one (1) parent longer are determined before those of the **plans** which covered the other parent for a shorter period of time. However, if the other **plan** does not have the rule described previously in Rules, (i) or (ii) and if, as a result, the **plans** do not agree on the order of benefits, the rule in the other **plan** will determine the order of benefits.

c) Dependent child/separated or divorced. If two or more **plans** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   i. First, the **plan** of the parent with custody of the child;

   ii. Then, the **plan** of the spouse of the parent with the custody of the child; and

   iii. Finally, the **plan** of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the **plan** of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that **plan** are determined first. The **plan** of the other parent shall be the **secondary plan**. This paragraph does not apply with respect to any **claim determination period** or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d) Joint custody. If the specific terms of a court degree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the **plans** covering the child shall follow the order of benefit determination rules outlined in paragraph (b), above.

e) Active/inactive Enrollee. The benefits of a **plan** which covers a person as an Enrollee who is neither laid off nor retired are determined before those of a **plan** which covers that person as a laid off or retired Enrollee. The same would hold true if a person is a dependent of a person covered as a retiree and an Enrollee. If the other **plan** does not have this rule and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored.

f) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another **plan**, the following shall be the order of benefit determination:

   i. First, the benefits of a **plan** covering the person as an employee, member, or subscriber (or as that person's dependent); and

   ii. Second, the benefits under the continuation coverage. If the other **plan** does not have the rule described here and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored.

g) Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the **plan** which covered an employee, member, or subscriber longer are determined before those of the **plan** which covered that person for the shorter term.

EFFECT ON THE BENEFITS OF THIS PLAN

WHEN THIS SECTION APPLIES

This section applies when, in accordance with the Order of Benefit Determination Rules, **this plan** is a **secondary plan** as to one or more other **plans**. In that event the benefits of **this plan** may be reduced under this section. Other plan(s) are referred to as the “other plans” in “Reduction in this plan’s benefits,” immediately following.

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REDUCTION IN THIS PLAN'S BENEFITS

The benefits of **this plan** will be reduced when the sum of:

(a) The benefits that would be payable for the **allowable expense** under **this plan** in the absence of this COB provision; and

(b) The benefits that would be payable for the **allowable expenses** under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those **allowable expenses** in a **claim determination period**. In that case, the benefits of **this plan** will be reduced so that they and the benefits payable under the other plans do not total more than those **allowable expenses**. When the benefits of **this plan** are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of **this plan**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Kansas City Life Insurance Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Kansas City Life Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **this plan** must give Kansas City Life Insurance Company any facts it needs to pay the claim.

FACILITY OF PAYMENT

A payment made under another **plan** may include an amount which should have been paid under **This Plan**. If it does, Kansas City Life Insurance Company may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under **this plan**. Kansas City Life Insurance Company will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by Kansas City Life Insurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a) The person it has paid or for whom it has paid;

b) Insurance companies; or

c) Other organizations.

Subrogation will not be allowed in any **plan** as distinguished from the rights to recovery.

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Claim Provisions

How do I file a claim?
All claims for benefits should be submitted on Our forms. All claims for Out-of-Network benefits should be submitted on Our forms. You or the Provider should obtain claim forms from the Policyholder or Us. If We fail to provide You with claim forms within 15 days of Your request, You:

1) May submit Your claim in a letter stating the vision expense for which the claim is made.
2) Will be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

When are benefits payable?
Subject to written proof of loss, any benefits payable under the Policy will be paid within 30 days of Our written receipt of such proof of loss, or Our initial notice of decision of claim, if later.

All In-Network benefits will be paid directly to the Provider. Out-of-Network benefits will be paid to You unless You provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of Your death will either be paid to Your beneficiary or to Your estate.

When must a claim be filed to receive benefits?
Written notice of a claim must be given to Us within 180 days after the incurred date of the Covered Vision Expense or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. If an In-Network Provider is used, notice of claim will be given to Us directly by the Provider on behalf of the Covered Person.

No action at law or in equity may be brought to recover under the Policy before 60 days after proof of loss has been filed nor will such action be brought at all unless brought within three years from the end of the time allowed for furnishing proof of loss.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:

1) give the specific reason(s) for the denial;
2) make specific reference to the policy provisions on which the denial is based;
3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?
On any denied claim, You or Your representative may appeal to Us for a full and fair review. You may:

1) request a review upon written application within 180 days of the claim denial;
2) review pertinent documents; and
3) submit issues and documents in writing.

We will make a decision no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific references to the policy provisions on which the decision is based.

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COBRA CONTINUATION OF COVERAGE

(applies only to groups of 20 or more, as defined below)

What is COBRA Continuation?
It is a federal continuation of coverage requirement. Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to any employer (except the federal government and religious organizations) who:

- maintains a group health plan; and
- normally employs 20 or more employees on a typical business day during the preceding calendar year.

For this purpose, "employee" means all owners, partners, and common-law employees (full-time and part-time).

Federal law requires that certain group plans allow qualified persons who would otherwise lose coverage under the plan as a result of a qualifying event, to elect to continue group health coverage after it would otherwise end.

See your Employer for details on this continuation provision. All compliance obligations under COBRA are the responsibility of the Employer and Employee.

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This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review It Carefully.

As used in this notice, "WE" and "OUR" refer to the functions of Kansas City Life Insurance Company and its insurance subsidiaries, Old American Insurance Company and Sunset Life Insurance Company of America, which are covered by federal laws and regulations governing use and disclosure of personally identifiable health information ("protected health information" or "PHI"). The functions which are covered by these rules include: administration of Kansas City Life's group dental and group vision policies. "YOU" means a named insured of a group health insurance policy or an enrollee in the health or dental benefit plan.

Our Duties.
We are required by the Health Insurance Portability and Accountability Act of 1996 to maintain the privacy of your PHI and to provide you with this Notice of our privacy practices and legal duties. We must abide by the terms of this Notice. We reserve the right to change the terms of this notice and to make the new terms effective as to all of the PHI that we maintain about you. In that case we will provide you with a new Notice by mailing it to the address you have last provided us, or with your consent by sending it to you electronically.

Your Rights.
You have a right to access, inspect and copy the PHI we maintain about you. We may impose a reasonable fee where permitted by law.

You have the right to request that we amend your PHI. We may deny your request if we did not create the PHI you want us to amend, or for other reasons. If we do not agree to amend your PHI as you request, you may submit a short statement of dispute and we will include it with your records.

You have the right to an accounting of disclosures we have made of your PHI to others after April 14, 2003, except for disclosures related to your treatment, payment or other health care operations. We may impose a reasonable fee if you make such a request more than once in any 12-month period.

You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to additional restrictions.

You have the right to request that we communicate with you in confidence about your PHI by providing us with an alternate means or location. You must inform us that this is required to avoid endangering you.

If we provide you this Notice by electronic means, you have the right to request a paper copy.

You may exercise any of the rights stated in this section of the Notice by making your request in writing and sending it to us, postage prepaid, at the address shown at the end of this Notice.

Where We Get Your PHI.
We get most health history and treatment information from you or somebody you have authorized to provide it to us. For instance, we get medical information about you in order to pay a health insurance benefit or to pay providers of medical treatment.

Permitted Disclosures of Your PHI.
We are allowed to use and disclose your PHI without your authorization as necessary to conduct or service our business or when disclosure is legally required. For instance, we may use and disclose your PHI as needed to pay claims, set premiums, reinsure policies and underwrite for health care coverage. If you are an enrollee of an employee dental or medical benefit plan, we may disclose limited PHI to your plan's sponsor to permit the sponsor to perform plan administration functions. We may also disclose your PHI when we are required to do so by law (for instance, by subpoena, administrative order or discovery request), or as requested by the U.S. Department of Health and Human Services. If you want us to disclose your PHI to any other person or entity, you must give a written authorization. You may revoke your authorization at any time in writing.

We will not otherwise disclose your PHI to an affiliate or any third party who helps administer our business unless they agree in writing to maintain its confidentiality, use it only as intended and if feasible destroy it when no longer needed.

We do not sell your PHI or disclose it to anyone for purposes unrelated to our services.

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We will comply with applicable health information privacy law of any state which is more stringent than and not pre-empted by federal law.

Complaints.
If you want further information or have any questions about our privacy practices, please contact us using the information provided in this section. You also may submit a written complaint to the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way if you file a complaint.

Contact: Privacy Official, Legal Department, Kansas City Life Insurance Company, PO Box 219139, Kansas City, MO 64121-9139. Or, telephone us at 800-874-5254 ext. 6046.

Questions or Additional Information
Should you have any questions or want additional information about your coverage, this notice, or our privacy practices; please contact KCL Group Administration, PO Box 219425, Kansas City, MO 64121-9425, phone 1-800-874-5254 ext. 6046.

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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.
Carson City, a Consolidated Municipality	886000189

Nature of Business	Standard Industrial Classification (SIC)	Type of Business
City/County Government		☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ LLC ☒ Other

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

Name of Subsidiaries, Divisions, or Affiliates to be Covered

Name and Title of Plan Administrator (Corporate Officer)	Phone No.	E-mail	Fax
Melanie Bruketta - HR Director	775-283-7088	mbruketta@carson.org	

Name and Title of Correspondent (Routine Accounting Matters)	Phone No.	E-mail	Fax
Jacque Cassinelli	775-283-7043	JCassinelli@Carson.org	

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.
7/1/2021	

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

Carrier Name	Type of Coverage	Date to be Discontinued
Eyemed	Vision	6/30/2021

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.)

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

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 05 / 1 to 06 / 30

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 99 % Employee 50-75 % 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	**Voluntary Term Life Insurance**	**Short-Term Disability (STD)**	**Long-Term Disability (LTD)**
☐ All Full-Time Employees working _____ hours/week ☐ Other _____	☐ All Full-Time Employees working _____ hours/week ☐ Other _____	☐ All Full-Time Employees working _____ hours/week ☐ Other _____	☐ All Full-Time Employees working _____ hours/week ☐ Other _____
Dental Insurance	**Vision Insurance**	**Accident Insurance**	**Critical Illness Insurance**
☐ All Full-Time Employees working _____ hours/week ☐ Other _____	☒ All Full-Time Employees working 30 hours/week ☒ Other elected officials, retirees, Carson Water Subconser	☐ All Full-Time Employees working _____ hours/week ☐ Other _____	☐ All Full-Time Employees working _____ hours/week ☐ Other _____

Probationary Waiting Period:

Basic Term Life	**Voluntary Term Life**	**Short-Term Disability (STD)**	**Long-Term Disability (LTD)**
_____ days/months	_____ days/months	_____ days/months	_____ days/months
Dental	**Vision**	**Accident**	**Critical Illness**
_____ days/months	60 days/months	_____ days/months	_____ 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	**Voluntary Life**	**Short-Term Disability**	**Long-Term Disability**
# eligible _____/_____	# eligible _____	# eligible _____	# eligible _____
# enrolled _____/_____	# enrolled _____	# enrolled _____	# enrolled _____

Number of eligible and enrolled individuals (continued):

Dental	Vision	Accident	Critical Illness
# eligible ____	# eligible 787	# eligible ____	# eligible ____
# enrolled ____	# enrolled 756	# enrolled ____	# enrolled ____

Are any individuals currently disabled? ☐ Yes ☐ No If yes, provide:

Full Name	Diagnosis/Prognosis	Estimated Return to Work Date

Are any former employees and/or dependents currently on continuation coverage provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985? ☒ Yes ☐ No If yes, list names of the enrollees, qualifying event, and date of event.

Full Name	Qualifying Event	Date of Event	COBRA End Date
[redacted]	resignation	2/28/2020	8/31/2021

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.

		Dental Insurance	Vision Insurance
1.	Total number of employees on the payroll.		902
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.)		274
3.	Total number of employees who have not completed the probationary waiting period.		10
4.	Number of full-time employees (subtract #2 and #3 from #1).		628

If the employer pays 100% of the employee's cost, skip to number 8 below.

		Dental Insurance	Vision Insurance
5.	Are there other dental plans to be offered concurrently with your Kansas City Life group dental plan? ☐ Yes ☐ 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.		628 (same as #4)
8.	Number of enrolled employees.		586
9.	Number of COBRA participants.		1

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.