Agenda Item No: 16.B

STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** June 17, 2021

Staff Contact: Melanie Bruketta, Human Resources Director

Agenda Title: For Possible Action: Discussion and possible action regarding: (1) rescission of the Board of Supervisor's ("Board") May 20, 2021 approval of the health insurance benefits agreement between Carson City and Hometown Health for Fiscal Year ("FY") 2022; (2) authorization for the City Manager to sign and issue written notice of that rescission to Hometown Health; and (3) approval of an agreement with Anthem Blue Cross and Blue Shield ("Anthem") for the provision of health insurance coverage to City employees and retirees for FY 2022 at a 3% decrease in rates as compared to FY 2021. (Melanie Bruketta, mbruketta@carson.org)

Staff Summary: On May 20, 2021 the Board approved a one-year agreement with Hometown Health to provide City employees and retirees health insurance benefits for FY 2022 at a 3% rate decrease from FY 2021 rates. Following that approval from the Board, Hometown Health notified City employees that certain medical providers previously designated as in-network providers, including Carson Tahoe Health, would likely not be in-network providers in FY 2022. Hometown Health has agreed to mutual rescission of the parties' agreement due to this anticipated change in coverage.

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

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Proposed Motion

I move to rescind this Board's May 20, 2021 approval of the Hometown Health agreement, approve the Anthem health insurance contract for Fiscal Year 2022, and authorize the City Manager to sign and issue the necessary documents to effectuate the Hometown Health rescission and execution of the Anthem health insurance agreement.

Board's Strategic Goal

Organizational Culture

Previous Action

The Board approved a health insurance benefits contract with Hometown Health at its May 20, 2021 meeting.

Background/Issues & Analysis

The City's combined medical and prescription adjusted claims loss ratio was 82% in FY 2021, 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 of about 5%-9% and taxes of approximately 4%. However, the City was able to negotiate a 3% decrease in the rates for FY 2022 with Hometown Health and, subsequently, Anthem.

On May 20, 2021, the Board approved a health insurance contract with Hometown Health for FY 2022 with a 3% decrease in premium costs. The Board also approved the contribution rates the City would make to those employees who are on the high deductible plan and approved a new vision plan with Kansas City Life.

Following that May 20, 2021 meeting, Hometown Health notified individual insureds by letter that recent negotiations with Carson Tahoe Hospital caused Hometown Health to believe that for FY 2022, Carson Tahoe Regional Medical Center, Carson Tahoe Medical Group, and Carson Tahoe Continuing Care Hospital would all be out-of-network providers. This change resulted in a substantial and unexpected reduction in Hometown Health's in-network providers; therefore, staff in Human Resources began working with LP Insurance, the City's broker, to find acceptable, alternative coverage. Anthem, which has a larger provider network than Hometown Health, agreed to accept the one-year contract at the same rates and with the same benefit terms provided in the Hometown Health agreement.

Approval of this item today will not change the approved HSA funding rate for the high deductible plan or the Board's May 20, 2021 approval of the vision insurance contract between the City and Kansas City Life.

Applicable Statute, Code, Policy, Rule or Regulation
NRS 244.143(2)(e), 244.146(1) 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%

Is it currently budgeted? Yes

Explanation of Fiscal Impact: The health insurance premiums will decrease by 3% from last year and has been built into the FY 2022 final budget.

Alternatives
Do not approve the proposed contract and direct staff to negotiate further.

Attachments:
NV LGGC- Carson City.pdf

Anthem Premium Comp Chart.pdf

Carson SOB BS 7_v1.docx

SOB_CARSON CITY_Custom Health Savings Account PPO Plan 22E_5VWE.docx

Proposal Signature Page.pdf

Carson Wellness.pdf

B) CIQ_Fillable.pdf

A) Employer App PPO_Fillable.pdf

Board Action Taken:

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

_____
(Vote Recorded By)

Employer Contract

This Employer Contract ("Contract") is entered into by and between Carson City ("Employer") and Rocky Mountain Hospital and Medical Service, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem") (individually referred to as "Party" and together collectively referred to as the "Parties") upon the following terms and conditions:

ARTICLE 1 – PURPOSE

Employer has requested Anthem to provide health insurance coverage to its eligible employees or other individuals as described in the Booklet. Upon Anthem's receipt and acceptance of Employer's signed application and payment of the first premium, this Contract will be deemed executed by the Employer. This Contract supersedes any prior agreements between the Parties regarding the subject matter of this Contract. Anthem's standard policies and procedures, as they may be amended from time to time, will be used in the performance of services specified in this Contract and the provision of benefits contained in the Booklet.

ARTICLE 2 – DEFINITIONS

In this Contract, the following terms will have the meanings shown below. Capitalized terms used in this Contract that are not defined below are defined in the Booklet.

A. **Anniversary Date**. The date indicated in Schedule A that this Contract will renew.

B. **Booklet**. The Certificate of Coverage that describes the medical or other health care benefits provided by Anthem, including any amendments or schedules.

C. **Contract**. The entire agreement between the Parties including: (1) this Contract and any amendments and schedules; (2) the Booklet and any amendments; (3) the Employer application; and, (4) any individual enrollment information, as each may be updated from time to time.

D. **Plan Participant.** Actively employed individuals, owners, partners or other individual union members, association members or other Plan participants designated by Employer who meet the eligibility criteria in the Booklet and any additional eligibility criteria indicated on Schedule A. These individuals must complete any probationary period required by the Employer and satisfy Anthem's underwriting rules, consistent with applicable laws. Retirees are also eligible for coverage under this Contract, if indicated on Schedule A.

E. **Employer Health Plan or Plan**. A benefits plan established by the Employer as described in the plan documents, which includes this Contract and the Booklet.

F. **Member.** An individual, including the Subscriber and any dependents, that meets the eligibility criteria and has enrolled for coverage under this Contract.

G. **Subscriber.** An employee or Plan Participant in whose name any membership is established that meets the eligibility criteria and has enrolled for coverage under this Contract.

ARTICLE 3 – OBLIGATIONS OF ANTHEM

A. Anthem will provide medical or other health care benefits under the terms of this Contract and the Booklet. Anthem will not provide benefits for health care services provided: (1) before a Member's first day of coverage under this Contract; (2) after the termination of coverage; or, (3) during any period that full premium has not been paid, except as required by law.

B. Anthem will provide either electronic or paper copy of materials such as Booklets, ID cards and provider directories, as permitted under applicable law. Employer will assist in the distribution of materials if requested by Anthem. Anthem will provide paper copies of electronic materials, upon request.

C. Anthem will process the enrollment of eligible individuals, subject to the terms of this Contract and receipt of applicable premium. Anthem will maintain current Member eligibility information submitted by Employer.

D. Anthem will process claims, including investigating and reviewing the claims according to Anthem's standards, to determine what amount, if any, is due and payable according to the terms and conditions of this Contract and the Booklet. Anthem has the right to make benefit payments to either Providers or Members as described in the Booklet. Anthem will coordinate benefits with other payors, including Medicare. Anthem will give notice in writing when a claim for benefits has been denied. The notice will provide the reasons for the denial and the right to an appeal of the denial under the terms of the Booklet.

E. Anthem is responsible for pursuing recoveries of claim payments as appropriate. Anthem shall determine which recoveries it will pursue. However, Anthem will not pursue a recovery if the cost of collection is likely to exceed the recovery amount, or if the recovery is prohibited by law or an agreement with a Provider or other vendor.

F. Employer is responsible for complying with Employee Retirement Income Security Act ("ERISA") reporting requirements, as applicable; however, Anthem will provide Employer available data necessary for preparation of the ERISA Form 5500, if and to the extent applicable. The Booklet provided by Anthem does not satisfy all requirements of ERISA for a Summary Plan Description, but may be incorporated into the Summary Plan Description issued by Employer. Anthem is under no obligation to provide any other type of data reports to Employer, except as otherwise agreed to by the Parties or required by law.

G. In addition to the benefits described in the Booklet, Anthem may make available to the Employer value-added services such as discounts, memberships, mobile phone minutes, credit protection or identity theft protection services to Members. These value-added services are not insured benefits under this Contract and can be discontinued at any time and without notice. Anthem may also facilitate the provision of wellness programs offered by Employer and Employer will pay any fees for these wellness programs, if indicated in Schedule B. Depending on the program or benefits elected by Employer, Anthem may offer a wellness engagement credit to Employer when certain requirements set by Anthem are met, as indicated in Schedule C.

H. Anthem shall not: (1) adjust premiums based on genetic information; (2) request genetic testing, except to determine medical appropriateness; (3) collect genetic information from a Member in connection with enrollment; or, (4) collect genetic information for any other underwriting purpose.

ARTICLE 4 – OBLIGATIONS OF EMPLOYER

A. Employer will provide initial eligibility information in the format agreed to by the Parties, as well as notice of additions, deletions, and changes to enrollment. If requested by Anthem, Employer agrees to conduct certain transactions electronically, as described and facilitated within the Anthem Employer Access System, including but not limited to entering and updating eligibility information of Plan Participants and receiving, reviewing and paying for invoiced amounts due and other notices given under this Contract. The Employer may, at any time, terminate its consent and conduct such future transactions in paper format, by contacting Anthem's assigned account manager. Requesting paper transactions shall in no way delay or relieve the Employer of its obligations under this Contract. Employer will also provide any information reasonably required by Anthem to administer this Contract, including information regarding: (1) eligibility for enrollment and termination of Members; (2) changes in single or family coverage status; (3) changes due to Medicare eligibility; or, (4) contribution and participation levels.

B. Employer will notify each employee as the employee becomes eligible for enrollment, and will collect and submit to Anthem enrollment or waiver of coverage information. Employer will also keep a record of employees who do not apply. All information provided by Employer to Anthem will be true, accurate and complete to the best of its knowledge. In addition, Employer will provide an open enrollment period as agreed to by the Parties and consistent with state and federal law. In order to facilitate the distribution of materials, Employer will assist with the collection of Subscriber email addresses and Subscriber consents to electronic transaction/communication in accordance with applicable State or Federal electronic transaction laws. Anthem may offer reasonable monetary incentives to Employer in exchange for such assistance.

C. Employer will timely notify Anthem of any Member termination or loss of eligibility for coverage. Anthem may limit retroactive terminations to a maximum of 60 days prior to the date notice is received. Also, if Anthem has provided benefits for individuals no longer eligible, Anthem may collect from Employer any paid claim amounts not otherwise recovered by Anthem.

D. Employer must comply with Anthem's contribution levels, participation levels, and other applicable underwriting rules that are consistent with applicable laws. Employer must also determine and maintain eligibility for the Anthem benefits of the Plan according to the terms of the Booklet and the Anthem Employer administrator manual and any Employer Access or other Anthem computer platform utilized by or on behalf of the Employer. Absent prior written approval from Anthem, the Employer must use the Anthem-approved forms (including but not limited to applications, change forms, waivers, elections and arbitration notices) and retain, in a format capable of audit and reproduction, complete eligibility and enrollment documentation and proof of any required signatures, whether in paper or electronic form. If Employer uses electronic or telephonic enrollment applications in place of enrollment application forms provided by Anthem, Employer warrants and agrees that the enrollment processes and media include an arbitration disclosure provision with language acceptable to Anthem and located immediately before the electronic signature, and that the manner of electronic signature satisfies all legal requirements for an electronic signature.

E. Employer represents that it satisfies the definition of a large Employer under applicable state and federal law and that it will promptly notify Anthem if there is a change in Employer's status as either a large Employer or small Employer, as defined under applicable law. In such event, Employer will provide all information requested by Anthem about its status.

F. If Employer maintains a Grandfathered Health Plan, as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), Employer will not make any changes to such Plan, including changes to Employer contribution levels, without giving Anthem advance written notice of the intent to change such Plan. Also, at Anthem's request, Employer will confirm in writing that it has not made changes to its Plan that would cause the Plan to lose its grandfathered status. If Employer makes changes to a Grandfathered Health Plan without notice to Anthem, the Plan may lose grandfathered status, and significant penalties or fines may be assessed against Employer and Anthem. If Employer makes changes to its Plan and does not provide advance notice to Anthem, Employer agrees to reimburse Anthem for any penalties, fines or other costs assessed against Anthem.

G. Employer agrees to receive electronic copies of Booklets, ID cards, provider directories, and other documents as may be provided by Anthem and understands that at any time it can contact Anthem to request a paper copy. The Employer agrees to timely distribute and deliver to its Plan Participants and dependents, such documents and the Summary of Benefits and Coverage ("SBC") provided by Anthem as are required by federal law. The SBC must be provided with open enrollment materials or, if Employer does not hold an open enrollment, at least 30 days prior to the Anniversary Date. Employer will issue an updated SBC if the benefits change between the time of original distribution and the effective date of coverage. SBCs must also be provided to new enrollees and special enrollees. Employer may distribute the SBC either electronically or by paper, subject to the requirements of applicable law. If requested by Anthem, Employer will certify its compliance with the SBC distribution requirements. Employer agrees to reimburse Anthem for any penalties, fines or other costs assessed against Anthem, if Employer fails to comply with these requirements.

Employer will timely notify Anthem of requested benefit changes prior to the Anniversary Date. A request for benefit changes after the renewal of this Contract may delay the effective date of the benefit changes by at least 60 days and require a notice of material modification.

In order to facilitate the distribution of such materials and related items, Employer will assist with the collection of Subscriber email addresses and Subscriber consents to electronic transaction/communication in accordance with applicable State or Federal electronic transaction laws. Anthem may offer reasonable monetary incentives to Employer in exchange for such assistance.

H. Employer is responsible for all applicable requirements pertaining to COBRA, unless otherwise agreed to in writing by Anthem. If Anthem has agreed to perform any COBRA administration duties on behalf of Employer, such arrangement will be described in a separate agreement.

I. If Employer offers multiple benefit plans insured by more than one carrier, Employer will offer Anthem coverage to all employees at terms and contribution levels that are no less favorable than those offered by other carriers.

J. The waiting period elected by Employer may not exceed 90 days.

K. Employer's designated agent, producer, broker, agency, brokerage, general agency and their respective employees currently on file with Anthem (Agent) are authorized to access Employer's health plan information, including protected health information, on behalf of Employer's health plan through Anthem's employer access system or any other access points Anthem may offer. This information may include, but is not limited to, detail about Members, plan selections and bills/invoices. The Agent is also authorized to make changes to Employer's information on behalf of Employer, including but not limited to adding/deleting plans and Members and changing

Member demographic information. The Agent will administer all information in accordance with the provisions of the Contract, and Employer will be responsible for the activities of the Agent. If Employer's Agent on file changes, these authorizations will apply with respect to the successor Agent. The Agent is required to maintain original documentation and will make such documentation available to Anthem upon request.

ARTICLE 5 – CHANGES TO CONTRACT AND BOOKLET

A. Anthem may modify the terms of the Booklet by giving at least 60 days advance written notice prior to the Anniversary Date of this Contract. Employer can also propose changes to the terms of the Booklet at any time by giving written notice of any such requested change to Anthem. The effective date of such requested changes to the Booklet shall be agreed to by the Parties. In addition, Anthem may modify the terms of this Contract, other than the terms of the Booklet and the premium rates, by giving 30 days advance written notice to Employer of such changes.

B. Anthem may change the premium rates or other amounts due under this Contract by providing written notice to Employer at least 60 days before the effective date of such change, except as otherwise required by law. However, such notice requirement will not apply to changes in premium rates that are the result of changes in benefit provisions requested by Employer.

C. An amendment to this Contract will not be effective unless signed by an officer of Anthem. If any change to the Contract or the Booklet, including premium amounts, is unacceptable to Employer, Employer has the right to terminate coverage under this Contract by giving written notice of termination to Anthem before the effective date of the change. Payment of the new amount in the event of a premium rate change, or continued payment of the current amounts in the event of a Contract or Booklet change only, will constitute acceptance of the change by Employer, without the necessity of securing Employer's signature on the schedule or amendment. The schedule or amendment will then become a part of this Contract.

ARTICLE 6 – PREMIUM AND GRACE PERIOD

A. The premium rates for coverage under this Contract are provided in Schedule B. Premium rates are based on the data provided by Employer, consistent with applicable laws. Anthem may retroactively modify the premium rates if the data provided is inaccurate or new data is submitted that varies from the data previously provided to Anthem.

B. The full invoice amount, including premium, taxes, fees or assessments, must be paid in advance by Employer on or before the invoice due date. Anthem does not have an obligation to accept a partial payment. Employer must make payments regardless of any contributions to those payments by Subscribers. Even if Employer has not received an invoice from Anthem, Employer is still obligated to pay, at a minimum, the prior invoice amount.

C. Employer is entitled to a 31 day period beginning on the invoice due date (the "Grace Period"), for the payment of any premium or other amounts due. If, during the Grace Period, Employer pays the full amounts owed, this Contract will remain in force. Anthem is not obligated to pay any claims incurred during the Grace Period, until the full amount due is received.

D. Anthem may assess additional fees or charges if indicated in Schedule B.

E. For any rebate due and payable by Anthem as a result of the medical loss ratio ("MLR") requirements of PPACA or applicable state law, all such rebates paid will constitute a return of premium. Employer will promptly provide Anthem with any information needed to calculate the rebate amount. Anthem reserves the right to pay the rebate to either Employer or Subscribers.

If Anthem pays the rebate to Employer, Employer will promptly refund to each Subscriber his or her proportional share of the rebate according to the requirements of PPACA. On request, Employer will provide to Anthem documentation required under PPACA of the distribution of the rebate to Subscribers. Employer agrees to provide such documentation within the time frame designated by Anthem.

If Anthem receives a claim relating to the amount of the Subscriber's rebate, Employer will cooperate with Anthem and provide Anthem with information required to investigate the claim. If Anthem is required to pay additional amounts to a Subscriber due to Employer's failure to provide accurate information, make a refund, or refund less than the amount due, Employer must reimburse Anthem for such additional amounts paid. This provision survives the termination of the Contract.

ARTICLE 7 – TERMINATION

A. Employer may terminate this Contract at any time by giving Anthem advance written notice of termination; however, the termination will be effective at the end of the month in which notice is given, except as otherwise agreed to by the Parties. Employer must pay the amounts due for each Subscriber covered through the effective date of termination of this Contract. Unless Employer provides advance notice of termination, this Contract will automatically renew on each Anniversary Date, upon Employer's payment and Anthem's acceptance of premium.

B. The Contract will terminate:

(1) automatically, without notice, on the last day of coverage for which premium and other amounts have been paid, if the Grace Period expires and any amounts due remain unpaid. Anthem's receipt and deposit of a payment through its automatic payment procedures or other procedures will not be deemed acceptance of a late payment or waiver of termination.

(2) with written notice to Employer that the Contract will be terminated due to Employer's failure to comply with Anthem's contribution or participation requirements or Employer's failure to supply information necessary to substantiate the contribution or participation levels.

(3) with written notice to Employer, if Employer commits fraud or makes an intentional misrepresentation of material fact with respect to this Contract.

(4) with written notice to Employer, as required by applicable law, that the Contract will be terminated because Anthem is discontinuing the particular type of health benefits product elected by Employer, Anthem will no longer issue Employer health coverage within the small or large Employer market, or for any other reason permitted by law.

(5) with written notice to Employer, if there is no longer any Subscriber under the Plan who lives or works in Anthem's service area.

(6) as of the date Employer's membership in an association, labor union or other entity applicable to Employer's coverage ceases, or the date that entity's coverage with Anthem ceases.

C. Employer will promptly notify Members that this Contract is or will be terminated, and will provide any notice regarding a Member's right to other coverage. Anthem will not provide benefits coverage for medical services rendered after the effective date of termination, except as otherwise provided in the Booklet or required by law.

D. Anthem reserves the right to cancel coverage with 30 days prior written notice to any Member who engages in material misrepresentation or fraud.

E. If this Contract terminates for nonpayment of an invoice amount due, Employer may request reinstatement of this Contract according to Anthem's policies and procedures, which may include the payment of a reinstatement fee. Anthem will determine whether the Contract will be reinstated, and notify Employer of its decision. If Anthem reinstates the Contract, the coverage will resume as of the date the Contract terminated. If Anthem does not reinstate the Contract, it will return any unearned premium to Employer.

ARTICLE 8 – NOTICES

A. Any required notice under this Contract will be deemed sufficient when made in writing and delivered by first class mail; personal delivery; electronic mail, as permitted by law; or overnight delivery with confirmation capability. Such notice will be deemed to have been given as of the date of the mailing. Anthem will provide notice to Employer's principal place of business as shown on Anthem's records. Employer will provide notice to its designated Anthem representative.

B. If requested by Anthem, Employer will distribute notices and other communications to Members. Employer will notify all Members of the termination of this Contract.

ARTICLE 9 – LIMITATION ON ACTIONS AND GOVERNING LAW

A. No action may be brought to recover benefits for any service covered under this Contract unless the required notice or proof of claim has been given to Anthem within the time frame required under the Booklet, and such action is commenced no earlier than 60 days and no later than 3 years following the date that the notice or proof of claim has or should have been provided to Anthem.

B. Except to the extent preempted by ERISA or any other applicable federal law, this Contract will be governed by and construed according to the laws of Nevada. All claims or actions arising under this Contract will be heard in a court of competent jurisdiction in Nevada.

ARTICLE 10 – NO WAIVER

No failure or delay by either Party to exercise any right or to enforce any obligation under this Contract, in whole or in part, will operate as a waiver to enforce compliance with such right or obligation in the future. No course of dealing between Employer and Anthem will operate as a waiver of any right or obligation under this Contract.

ARTICLE 11 – ASSIGNMENT

Neither Party may assign all or part of this Contract without first obtaining the written consent of the other Party. However, subject to applicable laws, Anthem may assign all or part of its duties and obligations to: (1) another qualified insurance carrier under an assumption reinsurance arrangement; (2) any affiliate or successor in interest of Anthem; or, (3) another qualified insurance carrier surviving a merger, reorganization, sale, or similar event involving Anthem or Anthem's assets. Any assignee under this Contract must continue to fulfill all Contract obligations.

ARTICLE 12 – SERVICE MARKS

This Contract constitutes a contract solely between Employer and Anthem. Anthem is an independent corporation operating under a license with the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield Plans, permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the State of Nevada. Anthem is not contracting as the agent of the Association. Employer has not entered into this Contract based upon representations by any person other than Anthem. No person, entity, or organization other than Anthem will be held accountable or liable to Employer for any of Anthem's obligations provided under this Contract. This paragraph will not create any additional obligations on the part of Anthem, other than those obligations contained in this Contract.

ARTICLE 13 – CONTRACT ADMINISTRATION

A. Anthem has the discretionary authority to construe the Contract and any disputed or doubtful terms of the Contract, and to determine eligibility for benefits under the Contract. Anthem also has the discretionary authority to resolve all questions arising under the Booklet and to establish and amend the policies and procedures with regard to the administration of benefits under the Booklet. In addition, Anthem has all powers necessary or appropriate to carry out its duties in connection with the performance of services under this Contract. Anthem's authority to determine eligibility for benefits shall be exercised consistently with the provisions of the Contract, the Booklet, Provider agreements, and applicable law.

B. Anthem may waive or modify any referral, authorization, or certification requirements, benefit limits, or other processes contained in the Booklet if such waiver is in the best interest of the Member or will facilitate effective and efficient claims administration.

C. Anthem may institute, from time to time, pilot or test programs regarding disease management, utilization management, case management or wellness initiatives. A pilot or test program may impact some, but not all Members. Anthem reserves the right to discontinue a pilot or test program at any time without notice.

D. Anthem will have sole responsibility for resolving appeals from claim decisions, consistent with state and federal law. If Employer receives a question or complaint regarding benefits under this Contract, Employer will advise the Member to contact Anthem.

E. All statements made by Employer and any Member will be considered representations and not warranties. A written statement may not be used by Anthem to void the coverage unless a copy has first been provided to the Employer or Member, as applicable.

F. Anthem assumes only those responsibilities that are expressly stated in this Contract. Nothing contained in this Contract will be construed to deem Anthem as Plan Sponsor, Plan Administrator or a Named Fiduciary for purposes of ERISA.

G. Anthem may delegate any of its responsibilities under this Contract without the consent of Employer. Anthem shall remain responsible to Employer for fulfilling its obligations under this Contract.

ARTICLE 14 – RELATIONSHIP OF THE PARTIES

Employer and Anthem are separate legal entities. Nothing in this Contract will cause either Party to be deemed a partner, agent or representatives of the other Party. Neither Party will have the expressed or implied right or authority to assume or create any obligation on behalf of the other Party.

ARTICLE 15 – INTERPLAN PROGRAMS

Out-of-Area Services

Overview
Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area,") the claim for those services may be processed through one of these Inter- Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Anthem Service Area, Members obtain care from Providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. We remain responsible for fulfilling our contractual obligations to you. Anthem's payment practices in both instances are described below.

If the plan you are purchasing is an HMO plan, Anthem covers only limited healthcare services received outside of Anthem's Service Area. The Benefit Booklet describes what those services are. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. Providers providing such Covered Services may be considered nonparticipating providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs obtained from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area Anthem serves, the Host Blue will be responsible for contracting and handling all interactions with its participating providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim
Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to Anthem by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Anthem by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider

refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Anthem in determining your premiums.

B. Negotiated Arrangements

As an alternative to the BlueCard Program, claims for Covered Services may be processed through a negotiated account arrangement with one or more Host Blues. If Anthem has arranged with one or more Host Blues to provide customized networks or other negotiated arrangements, then the terms of any such arrangement will determine the payment amount. A Member's cost share will be calculated based on the lower of either (i) the billed amount; or (ii) the price that Anthem has negotiated with the Host Blue under the negotiated account arrangement.

C. Special Cases: Value-Based Programs

BlueCard Program

Anthem has included a factor for bulk distributions from Host Blues in the premium for Value-Based Programs when applicable under this Contract.

Negotiated Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Anthem will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Anthem will include any such surcharge, tax or other fee in determining premium.

E. Nonparticipating Providers Outside Anthem Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of our service area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that

the non-participating healthcare provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, Anthem may use other pricing methods, such as billed charges, the pricing Anthem would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount Anthem will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment Anthem makes for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

General Information

If Members are outside the United States (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is not served by a Host Blue. The Benefit Booklet describes what services are covered under the Blue Cross Blue Shield Global Core Program (e.g., emergency only) and how to submit a claim.

ARTICLE 16 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A. All capitalized terms used in this Article have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

B. Anthem may disclose Summary Health Information to Employer for purposes of obtaining premium bids from other carriers or third party payers, or amending or terminating the Plan.

C. Anthem may disclose Personal Health Information ("PHI") to Employer for it to carry out Plan administration functions, but such disclosure may occur only after receipt of certification from Employer that: (1) Employer's Plan documents comply with the privacy requirements of HIPAA; (2) Employer has provided notice to affected individuals as required by HIPAA; and (3) PHI will not be used for the purpose of employment-related actions or other actions not related to administration of benefits under the Plan.

D. Anthem will comply with any additional disclosure restrictions required by state and federal law.

ARTICLE 17 – MISCELLANEOUS

A. Anthem agrees to treat all proprietary information about Employer's operations and its Plan in a confidential manner. Employer agrees to treat all information about Anthem's business operations, discount information, and other proprietary data in a confidential manner. Neither Party will disclose any such information to any other person without the prior written consent of the Party to whom the information pertains. However, Anthem may disclose such information to its legal advisors, lenders, business advisors, and other third parties for commercial or research purposes. Anthem may also make such disclosures as required or appropriate under applicable securities laws. If a Party is required by law to make a disclosure of any proprietary information, the disclosing Party will immediately provide written notice to the other Party detailing the circumstances of and extent of the disclosure.

B. Each Party retains ownership of the materials and processes it develops in connection with the services provided under this Contract, and neither conveys ownership rights in its materials and processes nor acquires ownership rights in the other Party's materials and processes by entering into this Contract or performing its obligations under this Contract. Nothing in this Contract shall impair or limit a Party's right to use and disclose its materials and processes for its own lawful business purposes.

C. By performing the services under this Contract, Anthem is not engaged in the practice of medicine; it merely makes decisions regarding the coverage of services. Providers participating in Anthem networks are not restricted from exercising independent medical judgment regarding the treatment of their patients, regardless of Anthem's coverage determinations.

D. If any provision of this Contract is found to be invalid, illegal or unenforceable under applicable law, order, judgment or settlement, such provision will be excluded from the Contract and the remainder of this Contract will be enforceable and interpreted as if such provision is excluded.

ANTHEM

_____
Mike Murphy
President and General Manager

Effective Date of Employer Contract:
07/01/2021

_____
(Date)

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.

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 HMO's (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 benefit 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 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 gives rights to group contract holders and not to individuals) other than 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

Carson City
07/01/2021

SCHEDULE A

Effective Date of this Addendum is 12:01 a.m. on: 07/01/2021

This Addendum applies to the Employer and its affiliated companies as agreed to in writing by Anthem.

SECTION I – ANNIVERSARY DATE

The Anniversary Date of the Contract shall be: 07/01

SECTION II – ELIGIBILITY

Subscribers who meet the criteria below shall be eligible for coverage under this Contract. To the extent the Employer offers eligibility to family members of a Subscriber, as explained in the criteria below, the family members shall be eligible for coverage if they otherwise meet the definition of Dependent contained in the Booklet. Retiree who meet the eligibility criteria set by the former employer shall be eligible for coverage under this Contract.

Employee and Family, including Spouse
Retiree and their Spouse

See the eligibility rules and criteria set forth in the Employer application.

ANTHEM

Mike Murphy

Mike Murphy
President and General Manager

Effective Date of Employer Contract:

07/01/2021

(Date)

Carson City
07/01/2021

MONTHLY PREMIUM RATES AND PRODUCT(S) ELECTED

SCHEDULE B

Effective Date of this Addendum is 12:01 a.m. on: 07/01/2021

This Addendum applies to the Employer and its affiliated companies as agreed to in writing by Anthem.

The Employer will pay a per Subscriber per month fee calculated by adding the sum of the rates for each of the Member categories set forth in the tables below:

Applicable to the PPO Plan Active:

Plan Participant	$ **551.54**
Plan Participant and spouse	$ **1,130.80**
Plan Participant and child(ren)	$ **1,058.22**
Plan Participant, spouse, and child(ren)	$ **1,728.27**

Applicable to the PPO Plan Medicare:

Plan Participant	$ **405.19**
Plan Participant and spouse (Spouse Non-Medicare Eligible)	$ **1,016.35**
Plan Participant and spouse (Plan Participant and Spouse Medicare Eligible)	$ **860.00**
Plan Participant and child(ren)	$ **1,049.05**
Plan Participant, spouse, and child(ren) (Spouse Non-Medicare Eligible)	$ **1,218.45**
Plan Participant, spouse, and child(ren) (Plan Participant and Spouse Medicare Eligible)	$ **1,048.12**

Applicable to the HSA Plan:

Plan Participant	$ **378.25**
Plan Participant and spouse	$ **775.53**
Plan Participant and child(ren)	$ **725.76**
Plan Participant, spouse, and child(ren)	$ **1,185.30**

Applicable to the HSA Plan Medicare:

Plan Participant	$ **277.86**
Plan Participant and spouse (Spouse Non-Medicare Eligible)	$ **696.97**
Plan Participant and spouse (Plan Participant and Spouse Medicare Eligible)	$ **589.78**
Plan Participant and child(ren)	$ **719.44**
Plan Participant, spouse, and child(ren) (Spouse Non-Medicare Eligible)	$ **835.64**
Plan Participant, spouse, and child(ren) (Plan Participant and Spouse Medicare Eligible)	$ **718.76**

ANTHEM

Mike Murphy
President and General Manager

Effective Date of Employer Contract:

07/01/2021

(Date)

Medical premium comparison

Carson City

Effective July 1, 2021 through June 30, 2022

Quote highlights
Funding type: Fully Insured
Commission level : 0.00%

		Current	Renewal			Quote		
		7/1/2020	7/1/2021			7/1/2021		
		Minimum PPO 1500 $1500/0%/$6000/$40/$150($0/0%/$0/0%/$0/0%/$0/0%)				Anthem PPO - Custom BlueSecure PPO 7	Difference to current	Difference to renewal
	Employees				Employees			
Employee	405	$568.60	$551.54	**Employee**	405	$551.54		
Employee + Spouse	100	$1,165.78	$1,130.80	**Employee + Spouse**	100	$1,130.80		
Employee + Children	102	$1,090.96	$1,058.22	**Employee + Children**	102	$1,058.22		
Employee + Family	107	$1,781.74	$1,728.27	**Employee + Family**	107	$1,728.27		
Monthly total	714	$648,785	$629,317	**Monthly total**	714	$629,317	-$19,468	$0
Annual total		$7,785,421	$7,551,804	**Annual total**		$7,551,804	-$233,617	$0
							-3.00%	0.00%

		Minimum HSA 2800 $2800/0%/$2800/$/$($0/0%/$0/0%/$0/0%/$0/0%)				Anthem PPO - Custom Health Savings Account 22E		
	Employees				Employees			
Employee	160	$389.95	$378.25	**Employee**	160	$378.25		
Employee + Spouse	32	$799.52	$775.53	**Employee + Spouse**	32	$775.53		
Employee + Children	35	$748.21	$725.76	**Employee + Children**	35	$725.76		
Employee + Family	60	$1,221.97	$1,185.30	**Employee + Family**	60	$1,185.30		
Monthly total	287	$187,482	$181,857	**Monthly total**	287	$181,857	-$5,626	$0
Annual total		$2,249,786	$2,182,279	**Annual total**		$2,182,279	-$67,508	$0
							-3.00%	0.00%

Monthly grand total		**$836,267**	**$811,174**	**Monthly grand total**		**$811,174**	-$25,094	$0
Annual grand total		**$10,035,207**	**$9,734,083**	**Annual grand total**		**$9,734,083**	-$301,124	$0
Renewal increase			**-3.00%**				-3.00%	0.00%

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: BlueSecure PPO 7 $25_$1500_80% 15/40/60/20% Essential Tiered Rx

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 member/ $4,500 family	$5,000 member / $15,000 family
Out-of-Pocket Limit	$6,000 member / $12,000 family	$12,000 member / $24,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Visit**	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	$0	50% coinsurance after deductible is met
Other Practitioner Visits: Retail Health Clinic	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse (www.livehealthonline.com)*	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$60copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	$60 Copay	50% coinsurance after deductible is met
Chemo/Radiation Therapy	$60 Copay	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$60 Copay	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	$60 Copay	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No Charge	50% coinsurance after deductible is met
X-Ray:		
Office	$60 copay	50% coinsurance after deductible is met
Freestanding Radiology Center	$60 copay	50% coinsurance after deductible is met

Outpatient Hospital	$60 Copay	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging: Office	$100 Copay	50% coinsurance after deductible is met
Freestanding Radiology Center	$100 Copay	50% coinsurance after deductible is met
Outpatient Hospital	$100 Copay	50% coinsurance after deductible is met
Emergency and Urgent Care **Urgent Care** *There may be other levels of cost share that are contingent on how services are provided.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$150 Copay, waived if admitted	Covered as In-Network
Emergency Room Doctor and Other Services *There may be other levels of cost share that are contingent on how services are provided.*		Covered as In-Network
Ambulance	$200 Copay for ground, air and water	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse **Doctor Office Visit**	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility Visit: Facility Fees	Deductible then $1500 per admit	50% coinsurance after deductible is met

Doctor Services	$40 copay	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	$500 Copay	50% coinsurance after deductible is met
Freestanding Surgical Center	$500 Copay	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible and copay is met	50% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible and copay is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	Deductible then $1,500 per Admit	50% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible and $1500 copay is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to30 visits per CYD. Limits are combined for all home health services.*	$60 Copay	50% coinsurance after deductible is met

Rehabilitation services: Office *Coverage for Physical,Occupational therapy Speech therapy is limited to 90 visits per CYD benefit period. Costs may vary by site of service.*	$60 Copay	50% coinsurance after deductible is met
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	Deductible then $1,500 per Admit	50% coinsurance after deductible is met
Cardiac rehabilitation Office *Coverage is limited to 60 visits per CYD per benefit period.*	$10 Copay	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an InNetwork Provider	Cost if you use a Non-Network Provider
Outpatient Hospital *Coverage is limited to 60 visits per CYD per benefit period.*	$10 Copay	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days per calendar year*	Deductible then $1500 per Admit	50% coinsurance after deductible is met
Hospice	$60 Copay	50% coinsurance after deductible is met
Durable Medical Equipment	Deductible then $60 Copay	50% coinsurance after deductible is met
Prosthetic Devices	Deductible then $60 Copay	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable

Pharmacy Out of Pocket	N/A	Combined with InNetwork medical	Combined with NonNetwork medical
Prescription Drug Coverage *This plan uses an Essential Drug List.* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Drugs not on the list are not covered.*			
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	N/A	$15 copay per prescription, deductible does not apply (retail) and $37.50 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*		$40 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Covered Prescription Drug Benefits	**Cost if you use a Preferred Network Provider**	**Cost if you use an InNetwork Provider**	**Cost if you use a Non-Network Provider**
	N/A		
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	N/A	$60 copay per prescription, deductible does not apply (retail) and $180 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy).*	N/A	20% coinsurance up to $500 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: BlueSecure PPO 7 $25_$1500_80% 15/45/75/30%
Essential Tiered Rx Your Network: PPO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (877) 811-3106

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY / TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 811-3106 .

Armenian (**հայերեն**). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 811-3106:

Chinese(**中文**)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 811-3106。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (877) 811-3106 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 811-3106.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 811-3106.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 8113106.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(877) 811-3106 にお電話ください。

Korean (**한국어**): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(877) 811-3106 로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (877) 811-3106.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (877) 8113106.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (877) 811-3106 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (877) 811-3106.

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (877) 811-3106.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Custom Health Savings Account (HSA-Compatible) PPO Plan 22E $2800/100% Essential Rx

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,800 member / $5,600 family	$5,600 member / $11,200 family
Out-of-Pocket Limit	$2,800 member / $5,600 family	$7,000 member / $14,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prenatal and Post-natal Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Medical Chats - *within our mobile app*	0% coinsurance after deductible is met	Not Applicable
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse (www.livehealthonline.com)*	0% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Services in an Office:</u>		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility Visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 30 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Physical, Occupational, and Speech therapy combined is limited to 90 visits each per benefit period. Costs may vary by site of service.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 60 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 60 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *This plan uses an Essential Drug List.* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Drugs not on the list are not covered.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (877) 811-3106

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 811-3106 .

Armenian (**հայերեն**). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 811-3106:

Chinese(**中文**)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 811-3106。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (877) 811-3106 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 811-3106.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 811-3106.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 811-3106.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(877) 811-3106 にお電話ください。

Korean (**한국어**): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(877) 811-3106로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (877) 811-3106.

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Services included and buy-up options

Carson City

Effective July 1, 2021 through June 30, 2022

Quote highlights

Funding type: Fully Insured

Included in Premiums
Fully Insured Foundational Program
Smart Shopper

Buy-Up Options	PCPM	Confirm Purchase Here
FI Get Strong Engagement Package	*$2.93*	
FI Get Control Engagement Package	*$2.14*	
FI Be Active Engagement Package	*$5.63*	
FI Take Charge Engagement Package	*$4.54*	

Account Administration Buy-Up Options (charged separately)	Fee Billed Per Participant Per Month	Confirm Purchase Here
Act Wise Commuter	*$3.40*	
Act Wise FSA	*$3.40*	
Act Wise HRA with FSA, Dependent FSA, Commuter	*$3.40*	
FSA or Dependent FSA or Commuter add on to Member Pay HRA	*$0.75*	
FSA or Dependent FSA or Commuter add on to Provider Pay HRA	*$0.80*	
Limited Purpose FSA or Dependent FSA or Commuter Add on to Act Wise HSA	*$1.15*	

Notes

Rates are described as Per Contract Per Month (PCPM) and will be added to premiums if buy up offering is selected.

Additional details for buy up options available upon request.

HRA and HSA plan designs include Act Wise Account Administration.

Act Wise FSA pricing is also applicable to Limited Purpose FSAs and Dependent Care FSAs.

Applicable taxes or assessments are not reflected in the buy-up option pricing.

Authorized Signature: _____

By typing my name I intend for it to serve as my signature, and that I am authorized to sign on behalf of this group.

Title: _____

Date: _____

0163844-05

March 26, 2021

LP Insurance Services
Kevin Monaghan
300 E. 2nd Street Suite 1300
Reno, NV 89501

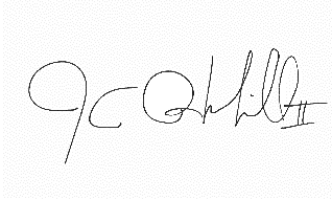
RE: Carson City Wellness Fund

Kevin:

This letter confirms that Anthem will provide an annual wellness credit in the amount of $5,000 for Carson City to use at their discretion.

Let me know if you have any questions of concerns. We look forward to working with you and Carson City.

Sincerely,



James Cohill
Director of Large Group
Anthem Blue Cross & Blue Shield of Nevada
james.cohill@anthem.com
(702) 772-9863 Mobile

Client Implementation Questionnaire
(New Business)

Anthem BlueCross BlueShield

Important information – To help avoid delays or inaccuracies in the implementation of your plan and the creation of plan materials, it is important that you provide us with complete and current information as requested below.

Section 1: Group information

Indicate group name as it should appear on billing statement (33 characters):

C a r s o n C i t y

If other than Legal name is to appear on EOCs or separate EOCs for other divisions are needed, list names below.

Group mailing address, if different than physical street address:

Street address	City	State	ZIP code
201 N Carson St, Ste 4	Carson City	NV	89701

Main phone no.	Main fax no.
775-238-7088	

Section 2: Decision maker

This individual will interface with Anthem Blue Cross and Blue Shield (Anthem) for major decisions regarding my account:

Name	Title
Melanie Bruketta	Human Resources Director

Street address	City	State	ZIP code
201 N Carson St, Ste. 4	Carson City	NV	89701

Phone no.	Fax no.	Email address
775-283-7088		mbruketta@carson.org

Section 3: Group administrator

This individual will interface with Anthem on all nonbilling related issues/service issues:

Name	Title
same as above	

Street address	City	State	ZIP code

Phone no.	Fax no.	Email address

Section 4: Designated HIPAA representative

This individual is authorized to receive and securely handle protected health information – not specific to individual HIPAA authorizations for claims:

Name	Title
same as above	

Street address	City	State	ZIP code

Phone no.	Fax no.	Email address

Section 5: Billing contact

This individual will interface with Anthem on all billing related issues – if same as above, indicate same:

Name	Title
Jacque Cassinelli	HR Generalist

Street address	City	State	ZIP code
201 N Carson St. Ste 4	Carson City	NV	89701

Phone no.	Fax no.	Email address
775-283-7043	775-887-2067	jcassinelli@carson.org

Reset Form Save and Print

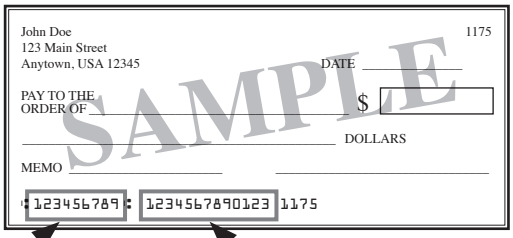
Section 6: Payment information

6A. Payment Information — **Select both** initial and recurring payment options

Initial payment	Recurring payments	Complete sections 6B & 6C	Select one of the following options for **initial and recurring** monthly payments	Client initiates payment	Anthem initiates payment
☐		✓	**Electronic Debit Payment.** Electronic debit for the Binder Payment is processed after the initial (first) bill has been dropped.		✓
☐	☐		**Automated Clearing House (ACH) or Wire Transfer.** Client sets-up ACH/Wire with their own bank and provides Anthem with transaction information.	✓	
☐	☐		**EmployerAccess.** Self-service option to manually schedule ongoing payments through EmployerAccess, our online Employer Portal. Consult with your Sales representative for details.	✓	
	☐	✓	**Automatic Recurring Payment via EmployerAccess.** Premiums are contractually due on the 1st day of each billing period (e.g., due 7/1 for Jul 1–Aug 1 period). However, you may authorize Anthem to automatically withdraw the invoiced "Total Amount Due" on a specific day each month (1st through 15th). **Select day: _____ Monthly Payment Withdrawal Day.**		✓
	☐		**Employer EasyPay.** Self-service option to submit a single premium payment through Anthem's Online EasyPay Application.	✓	
	☐		**Self bill — Non-Pooled Cases Only.** Manually upload your self bill worksheet and schedule your monthly payments via EmployerAccess.	✓	
☐	☐		**Other.** Please consult with your Sales representative. (i.e., physical check).	✓	

6B. Financial institution information for initial and/or future recurring payment

Financial institution name			
Financial institution street address	City	State	ZIP code
Transit routing number	Account number	Account type ☐ Checking ☐ Savings	



6C. Authorization information — Signature required

This transaction will appear on your next bank statement as an Electronic Funds Transfer (EFT).
I hereby authorize Anthem Blue Cross and Blue Shield and/or HMO Colorado dba HMO Nevada and/or Anthem Life Insurance Company to debit our account for **payment by electronic transfer** for initial and/or recurring payments due under this and any future product in which your group enrolls. If this item is returned unpaid, I may be charged an additional fee for each payment returned for insufficient funds.

☐ I agree	Authorized signature. Please type name. **X**	Title	Date (MM/DD/YYYY)

Section 7: Billing information

How would you like your bill to appear?
☐ One invoice sorted by employees' last name (Anthem Standard) ☐ Multiple invoices sorted by employees' last name ☐ Other

Please provide "other" details
☐ **Dept codes –** Dept codes can be added to an invoice for payroll reasons. Dept codes are a six-digit alpha numeric code entered at the member level representing whatever the employer wants (i.e. salary versus hourly or Admin, Labor, Exec, etc.) The invoices can be sorted based on this code.
☐ **Employee codes –** Employee codes can be added to the invoice for payroll reasons. Employee codes are another member level designation that can be used by the employer for the sorting of invoices (i.e. employee numbers in a HRIS system).
☐ **Group no. order –** Rather than sorting by the employees' last name first, invoices can also be sorted by group number (product first).
☐ **Other –** Add comments: _____

Standard process is for Anthem to process enrollment based on the following washout code.

Activity	Wash-out code 16
Enrollment	Enrolled on the first - 15th premium charged from the first of current month. Enrolled 16th - 31st premium charged beginning the first of the next month.
Contract changes	Dates of events: first - 15th, premium charged from the first of current month. Dates of events 16th - 31st, premium charged from the first of next month.
Terminations	Benefits terminated: first - 15th, premium credited from the first of current month. Benefits terminated 16th - 31st, premium credited from the first of next month.

Section 8: Terminations

Terminations will be effective on:
☑ The first of the month following the date of the event (Anthem standard)
For Colorado fully-insured accounts – Term notifications must be provided the month in which the employee terminates coverage.
☐ Actual date of the event
For Colorado fully-insured accounts – Term notifications must be provided to Anthem on date of event.

Section 9: Dependents

☑ (Anthem standard) The term "child" includes unmarried children of any age medically certified as disabled and children under 26 years old regardless of student status, marital status, financial dependency, eligibility for group sponsored insurance, eligibility as an employee under the same plan, or service in the armed forces. Children can be covered under one, but not both, parents when both parents work for the same employer and are covered under the same Anthem plan.

If the group refers to the term "child" in any other manner, please list the definition here and speak to your Sales Representative about getting this definition approved.
Definition of term "child": _____

Section 10: Additional information

Third-Party Administration (TPA) for invoicing purposes

Will a TPA perform any functions for your group? ☐ Yes ☑ No
If yes, please provide the name of the TPA: _____
If yes, what portion of your business do you use the TPA for? ☐ Active employees ☐ COBRA ☐ Both
Should the bills be sent directly to the TPA? ☐ Yes ☐ No
If bills should be sent directly to the TPA, what portion of the bills should go to the TPA? ☐ Active employees ☐ COBRA ☐ Both
If any portion of the bill needs to be sent directly to the TPA, please provide the following TPA contact information.

Contact name at the TPA office	Contact email	Contact phone no.	
Contact street address (where bill will be mailed)	City	State	ZIP code

Approved leave of absence

Anthem standard is employee remains eligible during an approved leave of absence up to three months. If employer group has a different policy, please list it here.
Different policy: _____

Rehire policy

Health Care Reform requires rehires to be eligible on the date of rehire if rehired within 13 weeks or 91 calendar days. If the group wishes to extend the time in which rehires can be rehired on the date of rehire, please provide the amount of time in which rehires can be rehired: _____

Section 11: Enrollment information

Where would you like **initial** identification cards mailed?
☑ Employee's residence (as indicated on the Member Enrollment Application), recommended
☐ Group (as indicated on the Employer Application)
☐ Broker (as indicated on the Employer Application)

Where would you like **maintenance** identification cards (i.e., new hires) mailed?
☑ Employee's residence (as indicated on the Member Enrollment Application), recommended
☐ Group (as indicated on the Employer Application)
☐ Broker (as indicated on the Employer Application)

Standard process is to send HMO cards (and Blue Priority PPO cards) to every member under a contract (due to the PCP assignments). Standard PPO ID cards will get sent only to the employee and/or spouse. The children are expected to use the parents' cards.
Do you want ID cards to go to all the members under a PPO contract? ☐ Yes ☐ No

Do you have 20 or more associates residing outside of the following states: CA, CO, NV WI, MO, IN, KY OH, GA, VA NY, NH, CT and/or ME? ☐ Yes ☐ No

Please choose one of the following options for how **initial** enrollment will be loaded into Anthem's system:
☑ **Census Tool –** Enhanced Excel file with built in macros used for medical, dental (including Prime and Complete), vision, life and disability enrollments (Anthem will supply a customized Excel document.)
☐ **834 File or Anthem Proprietary File Format** (4-6 weeks set-up time required) – File comes in through the EDI gateway and is then processed through the electronic eligibility work flow. (834 is a standard file format in the industry.)
☐ **EmployerAccess:** (choose one option) Anthem must receive the group level paperwork before member level entry can be completed. Anthem may take up to 5 weeks to get the company structure and benefits loaded before the client can load member data in EmployerAccess.
  ☐ Online member enrollment (member performs their own enrollments online)
  ☐ Online enrollment Census Tool (group administrator loads membership with Excel tool)
  ☐ Group administrator performs online enrollments (additions, changes and terminations)
☐ **Paper applications** (not recommended) – The group will send in paper applications for processing.
If 834/Anthem Proprietary File Format was selected as the initial enrollment option, please list the vendor associated with the file and the vendor's email address.

Vendor	Vendor email

When will member enrollment be submitted to Anthem (if using Census or Paper Applications)? ____/____/____ (MM/DD/YYYY)
When will member enrollment be completed (if using File or EmployerAccess)? ____/____/____ (MM/DD/YYYY)

Please choose one of the following options for how **ongoing** enrollment will be loaded into Anthem's system:
☐ **Census Tool –** Enhanced Excel file with built in macros used for medical, dental (including Prime and Complete), vision, life and disability enrollments (Anthem will supply a customized Excel document.)
☐ **834 File or Anthem Proprietary File Format** (4-6 weeks set-up time required) – File comes in through the EDI gateway and is then processed through the electronic eligibility work flow. (834 is a standard file format in the Industry.)
☑ **EmployerAccess –** An easy to access online tool that allows the group/broker to quickly make enrollment additions, changes and terminations.
If 834/Anthem Proprietary File Format was selected as the ongoing enrollment option, please list the vendor associated with the file and the vendor's email address.

Vendor	Vendor email

Anthem is focused on delivering consumer-grade experiences across all digital channels in an effort to make it easier to do business with. Anthem wants consumers to get instant and time-sensitive information by having them include their email addresses in any of the above enrollment methods you choose to adopt. If you should need help identifying where the member email addresses need to be input on the electronic files, please reach out to your Anthem Sales Executive or Anthem Account Manager to help set-up a meeting with our 834 File Analysts. Providing member-level email addresses is not mandatory, but it does assist Anthem to facilitate communications more efficiently. Please check here to indicate you have read and understand the above information. ☐

Evidence of Coverage (EOC) production and delivery – mark all that apply

English EOCs are available on anthem.com once members register and log in after they are enrolled. Electronic version of EOC will be sent out to:
☑ Group administrator ☐ Decision maker ☐ Other

Contact name	Email

Coordination of Benefits

Standard Coordination of Benefits policy for Anthem in CO/NV is to pay and pursue (meaning Anthem will pay claims if members are eligible and if any possible other coverage situations arise, Anthem will then pursue the possibility of payment by other parties). Please advise your employees of this policy as Anthem may request additional information after a claim has already been processed.

Consumer Driven Health Plans only

Are you using an Anthem associated banking arrangement with your HSA or HRA plan? ☐ Yes ☑ No If yes, please choose which bank you will be using?
☐ UMB Bank ☐ PNC Bank ☐ BenefitWallet ☐ HealthEquity ☐ HSA Bank

What pro-ration method will you be using to fund members' accounts under your HRA/HIA Plus plan?
☐ N/A ☐ Monthly (Standard) ☐ Quarterly ☐ Annually

Will members be carrying over balances from an existing HRA? ☐ Yes ☐ No ☑ N/A

Section 12: Pharmacy

If ESI pharmacy was purchased through Anthem, select the formulary purchased.

☑ Essential ☐ National ☐ Both

If 'Both' is chosen, please indicate which plans have which formulary: _____

Section 13: Dental PPO

Dental Prime/Complete sold? ☐ Yes ☐ No

Dental Essential/Consumer Choice sold? ☐ Yes ☐ No

Do you want to apply amounts used and/or import annual maximum carry-over amounts from your prior carrier? Please note that this information would be based on information found in your dental proposal. ☐ Yes ☐ No

If yes, please indicate which benefits will be credited from the prior carrier. (Please provide prior carrier Excel file.):

Deductible and annual maximum: ☐ Yes ☐ No

Orthodontic lifetime maximum: ☐ Yes ☐ No

Annual maximum carry-in: ☐ Yes ☐ No

Section 14: Life and disability coverage

Life and/or disability sold? ☐ Yes ☐ No If no, skip to next section.

Check all plans that have been purchased		Billing type	Age band changes and benefit reductions occur:	Spouse rates are based on:
☐	Life and AD&D	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	
☐	Life – No AD&D	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	
☐	Dependent Life	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	
☐	Optional Voluntary Life	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	☐ Employee date of birth ☐ Spouse date of birth
☐	Optional Voluntary AD&D	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	☐ Employee date of birth ☐ Spouse date of birth
☐	Optional Voluntary Dependent Life	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	☐ Employee date of birth ☐ Spouse date of birth
☐	Optional Dependent AD&D	☐ List-bill ☐ Self-bill	☐ First of the month following date of birth ☐ Group anniversary	☐ Employee date of birth ☐ Spouse date of birth

Check all plans that have been purchased		Billing type	Pre- or post-tax deductions	W2/FICA services
☐	Short Term Disability*	☐ List-bill ☐ Self-bill	☐ Pre-tax ☐ Post-tax ☐ N/A	W2 prep included. To opt out, please complete and return W2/FICA Opt Out form
☐	Long Term Disability	☐ List-bill ☐ Self-bill	☐ Pre-tax ☐ Post-tax ☐ N/A	W2 & FICA prep included. To opt out, please complete and return W2/FICA Opt Out form
☐	Voluntary Short Term Disability*	☐ List-bill ☐ Self-bill	☐ Pre-tax ☐ Post-tax ☐ N/A	W2 prep included. To opt out, please complete and return W2/FICA Opt Out form
☐	Voluntary Long Term Disability	☐ List-bill ☐ Self-bill	☐ Pre-tax ☐ Post-tax ☐ N/A	W2 & FICA prep included. To opt out, please complete and return W2/FICA Opt Out form
☐	ASO Short Term Disability*	☐ List-bill ☐ Self-bill	☐ Pre-tax ☐ Post-tax ☐ N/A	

* STD plans: do you have employees working in NY, NJ, RI, CA, HI or Puerto Rico with non-Anthem administered state short-term disability plan? ☐ Yes ☐ No

If "Yes," number of eligible employees working in: NY: _____ NJ: _____ RI: _____ CA: _____ HI: _____ Puerto Rico: _____

* Statutory STD plan: Complete if Anthem will administer a Statutory Disability Plan (quote required):

Is Anthem replacing a state mandated STD plan? ☐ Yes ☐ No If no, please disregard the rest of this section.

Federal employers ID no.: _____ Workers' compensation bureau no.: _____

Unemployment insurance Employer no.: _____ Employee contribution ☐ Weekly ☐ Monthly

Underwriting consideration for approval required for employees not actively-at-work on the coverage effective date? If yes, complete and return the *Actively-at-Work Statement.*

☐ Yes ☐ No

Mandatory documents required for life and disability implementation, required for life and disability implementation	
☐ Included	Enrollment/Eligibility.
Replacing coverage?	☐ Yes ☐ No If yes, complete next two questions.
☐ Included	Prior Carrier Certificates/EOC – For all LTD products.
☐ Included	Last Prior Carrier bill with benefit amounts or grandfathered listing if Self-Billed – For all optional life and disability products.

Section 15: Comments or special instructions

Please indicate all requested nonstandard benefits, provisions, class arrangements and any other special instructions.

Section 16: Certification and indemnification

The Employer certifies and acknowledges that no attempt will be made to re-identify the individuals that are the subjects of the data provided as a result of a request for De-identified[1] or Summary Health Information.[2] In addition, the Employer further certifies that it will require any downstream vendors or other parties that may receive De-identified and/or Summary Health Information at the request of the Employer to certify that they will also make no attempt to re-identify the individuals that are subject to the data provided. Any attempt by a Recipient to re-identify the data could constitute the use, disclosure, or maintenance of protected health information under HIPAA which would require Recipient to meet all requirements for safeguarding protected health information and/or personal information set out in federal and/or state law. Recipient will indemnify and hold harmless Anthem Blue Cross and Blue Shield (Anthem) and any Anthem affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any nonpermitted or prohibited use or disclosure of re-identified protected health information by Recipient or any subcontractor, agent, person or entity under Recipient's control.

Section 17: Client authorization

Date form submitted to Anthem (MM/DD/YYYY):		First proposed enrollment meeting date (MM/DD/YYYY):	
☐ I agree	Authorized signature. Please type name. **X**	Title	Date (MM/DD/YYYY)

1 De-identified Data has all 18 identifiers removed as required by HIPAA (§164.514) and that cannot be used alone or in combination with other information to re-identify individual(s) who are subjects of that data.
2 Summary Health Information summarizes claim data for an employer group to meet the requirements of De-identified Data that is aggregated to a five-digit ZIP code.

Employer Application
Nevada PPO

Anthem

Section 1: Applicant

Reason for application: ☑ New ☐ Change		Effective date: 07012021 (MM/DD/YYYY)		
Medical case no.	Dental case no.	Vision case no.	Life case no.	EAP case no.
Group legal name (including DBA) Carson City				
Nature of business City Government		SIC code	Federal tax ID no. 886000189	
Street address 201 N Carson St, Suite 4	City Carson City	State NV	ZIP code (5+4) 89701	
Group implementation contact name Melanie Bruketta	Group implementation contact phone no. 775-283-7088	Group implementation contact email address mbruketta@carson.org		
Form of organization: Government Unit/Agency		Number of years in business:		
Is the Group subject to ERISA? ☐ Yes ☑ No	Does the employer have a cafeteria plan under IRS section 125? ☑ Yes ☐ No			
If your HSA plan includes cash incentives paid directly to the HSA account, I acknowledge that I offer benefits through a Section 125 Cafeteria plan. Initials: _____				
Employees of the following subsidiaries or affiliates are to be included – Please attach a separate sheet for additional locations. Company name: _____ Address: _____ Company name: _____ Address: _____				

Section 2: Coverage – Select all plans that will be offered and attach your quote/proposal to the application.

Coverage		Specific plan	Employer contribution (Enter %) Employee	Dependent
Medical	PPO Plan	Custom Plan - See attached quote	99	50-75
	Health Savings Account (HSA) PPO Plan	Custom Plan - see attached quote	99	50-75
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
Dental	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
Vision	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
Life and Disability	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
EAP	Select plan from dropdown or type plan here			N/A
Health and Wellness	Select from dropdown or type option here			

Section 2: Coverage – Continued

Coverage		Specific plan	Employer contribution (Enter %) Employee	Dependent
CDHP accounts	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			
	Select plan from dropdown or type plan here			

Does the Group have different enrollee classes (management vs. hourly, administration employees vs. field employees, etc.)? ☑ Yes ☐ No
If so, please provide us the different class break-outs on a separate sheet of paper.

Will the different classes have different Group contribution amounts? ☑ Yes ☐ No
If so, please provide the contribution amounts for each class on a separate sheet of paper.

Will the different classes have different plan designs or benefit amounts? ☐ Yes ☑ No
If so, please provide the plan designs or benefit amounts for each class on a separate sheet of paper.

Does the Group self-fund any portion of the deductible, copayments, or cost-shares? ☐ Yes ☑ No If yes, how much?

Who should Anthem bill the active (non-COBRA) invoices to? ☑ Group ☐ TPA

If the Group wants Anthem to send the invoice directly to the TPA, please ensure the TPA section of the Group Implementation Questionnaire is completed.

Who should Anthem bill the COBRA invoices to? ☐ Group ☐ TPA

If the Group wants Anthem to send the invoice directly to the TPA, please ensure the TPA section of the Group Implementation Questionnaire is completed.

For Consumer Driven Health Products (HSA, HRA, HIA Plus):
☐ Group wants to establish a Health Savings Account (HSA) with Anthem facilitating with a banking services provider.
☑ Group will establish the Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

Section 3: Contribution and minimum enrollment percentage requirements

Anthem Blue Cross and Blue Shield recommends that the employer contribution be at least 50% of the employee rate for the least expensive benefit plan offered for all active employees who are enrolled in the group health plan. The rates for the benefits provided assume that at least 50% of the eligible employees and 75% of Net Eligible employees will participate in the plan.

Section 4: Prior coverage

Is there other coverage being replaced? ☑ Yes ☐ No If yes, please indicate the carrier and coverage information being replaced.

Name of prior **Medical** carrier	Type of coverage being replaced (i.e. HMO, PPO)	Prior carrier's annual deductible (if applicable)
Hometown Health	PPO and HDHP/HSA	$1500 deductible on PPO $2800 deductible on HDHP

Name of prior **Dental** carrier	Type of coverage being replaced (i.e. HMO, PPO)	Start date/end date

Section 5: Eligibility and enrollment

Eligible participants are:
- ☑ Active full-time employees working | 3 0 | hours per week
- ☐ Active part-time employees working | | hours per week
- ☑ Retirees (Retirees must be covered under group plan prior to retirement, and retiree coverage is subject to Underwriting approval.)
- ☐ Full-time or part-time students going to school with at least | | credit hours
- ☐ Other – Please list other here:

Total number of eligible employees or subscriber participants enrolling in the Anthem plans:	
Total number of employees or subscriber participants eligible for employer-sponsored health plan:	
Total number of eligible employees or subscriber participants covered under other non-Anthem health plan:	
Total number of employees or subscriber participants (regardless of status who are covered, not covered or covered elsewhere):	

Section 6: Waiting period

All products sold or medical only

If a waiting period with an asterisk is selected, Anthem will adjust the coverage effective date to ensure the waiting period between enrollees' eligibility date and the effective date of their coverage does not exceed 90 days from date of hire.

Waiting period for: Medical products ONLY

Eligibility/coverage begin date: 1st of the month following 60 days from date of hire*

Notes:

Specialty products only

Waiting period for: Select waiting period from drop down

Eligibility/coverage begin date: Select eligibility/coverage begin date from drop down

Notes:

Would you like to waive the waiting period for initial enrollment? ☐ Yes ☑ No
(i.e., all active full-time employees who have or have not met their probationary period can enroll.)

Section 7: Eligible dependents

Do you want to offer domestic partner coverage? ☑ Yes ☐ No

Dependent Children – Dependent children are covered until the end of the month in which they become age 26. Unmarried dependent children age 26 or older may be covered as specified by the Certificate. If the Group wishes to cover dependent children beyond age 26, please provide the guidelines which the Group imposes.

Enter guidelines below, if applicable:

Section 8: Electronic services

By signing below, I, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of non-payment and cancellation and other notices, via email or other electronic means. I agree that I will provide and update Anthem with a current email address. I understand that at any time I can request a free copy of these materials by mail, by contacting Anthem at 1-800-922-4770. I also agree that by providing Anthem with an employee or participant's e-mail address, the employer thereby represents that: (1) the employer has the employee's consent to receive plan documents (including explanation of benefits and claim denials) electronically; (2) the employee has reasonable access to the electronic communication at work; and (3) the employer obtained the employee consent using Anthem's application form or in a manner that clearly and conspicuously described the types of communications which can be made electronically, any hardware or software required to access those communications, the ability and process to change email addresses or withdraw consent and request a paper copy or otherwise in a manner that complies with applicable state and federal law regarding electronic delivery of plan materials and adverse benefit determinations.

We, the Group, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem or HMO Nevada to access the Group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem or HMO Nevada to make changes to the Group's information on behalf of the Group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the Group's designated agent/producer/broker/general agent changes.

☐ Check this box ONLY if the Group elects to opt-out of authorizing the agent/producer/broker/general agent to access and change the Group's information on behalf of the Group.

Section 9: Broker information

Brokerage name			Brokerage tax ID no.
LP Insurance Services			273054238
Brokerage street address	**City**	**State**	**ZIP code**
300 E 2nd St, Ste 1300	Reno	NV	89501
Brokerage phone no.	**Broker status:**		
775-996-6000	☐ New ☑ Existing		

Broker commission Broker commission per contract per month: _____ PCPM or Medical commission percentage: 0 %

Dental: _____% Vision: _____% Life: _____% Disability: _____% EAP: _____% Is the above commission standard? ☐ Yes ☐ No

Commissions to be paid to: ☐ Broker ☐ Brokerage ☐ General Agent ☐ General Agency

Anthem Broker Number of the agent or agency receiving commissions: _____

Broker Certification – I hereby certify:

1. I have reviewed the attached employee and employer applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem or HMO Nevada to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem or HMO Nevada reviews and approves the application and the employer receives a written notice from Anthem or HMO Nevada.
5. I am the appointed broker and am receiving commissions for the submission of this client. I have disclosed to the applicant all compensation I will or may be eligible to receive as a result of the applicant's business. Absent the written signed consent of Anthem, no portion of my commission payments from Anthem shall be paid to a broker/producer not appointed/approved by Anthem.

Authorized **Broker of Record** signature	Printed name	Date (MM/DD/YYYY)
X	Kevin Monaghan	
Broker tax ID no.	**Broker email address**	
273054238	kevin.monaghan@lpins.net	
Authorized **General Agent** signature	Printed name	Date (MM/DD/YYYY)
X		
General agent tax ID no.	General agent email address	

Section 10: General agreement — Read carefully

Upon acceptance of the application, the Group will inform all persons who are eligible for coverage that they may apply for Anthem Blue Cross and Blue Shield (Anthem) or HMO Nevada coverage under the Agreement/Policy.

Application is hereby made to Anthem or HMO Nevada, or the appropriate affiliated company, for a Group Benefit Agreement/Group Policy providing health service benefits. If this application is accepted, an Agreement/Policy will be issued which will set forth the terms, benefits and conditions of the relationship between the Group and Anthem or HMO Nevada. This application will become part of that Agreement/Policy.

It is understood that no agent or representative except the President, a Vice President, or the Secretary has power on behalf of Anthem or HMO Nevada to bind Anthem or HMO Nevada to accept risk, issue an Agreement/ Policy, or commit to particular provisions of an Agreement/ Policy. The quote/proposal along with this application will become part of the Agreement/Policy. No coverage will come into effect unless and until this application is accepted. If accepted, the terms of the relationship will be defined entirely within an Agreement/ Policy.

The Group agrees that by signing this document, they are representing themselves as a large employer group as defined by applicable law and that it understands that by electing to apply for the above products it may be ineligible to later select small group plan options.

To be eligible for coverage under Anthem Life Insurance Company (Anthem Life) products, an employee must be actively at work on a full-time basis on the effective date of his or her coverage. The Group employees that are not presently actively at work and/or are not expected to be actively at work on the requested Group effective date should be provided on the Actively at Work Statement. Anthem Life may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated on the Request to Waive Actively at Work Provision Form, they will not be covered under Anthem Life products until they return to active work.

If life and/or disability products were elected in Section 2, the undersigned employer and/or authorized representative hereby requests that it be approved for insurance coverage through Anthem Life. Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To provide notice of applicable conversion rights to eligible employees and eligible dependents.
3. Regarding life and/or disability insurance, statements of medical history will be required of employees, and dependents, when applying for insurance within or outside the time frames or amount of coverage limits established by Anthem Life.

ARBITRATION AGREEMENT (Not applicable to life and disability coverage)

IF THE GROUP IS NOT SUBJECT TO ERISA, ANY DISPUTE BETWEEN A PERSON COVERED UNDER THE AGREEMENT/POLICY AND ANTHEM BLUE CROSS AND BLUE SHIELD (ANTHEM), INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS NEVADA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE PERSON COVERED AND ANTHEM ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. IF THE GROUP IS SUBJECT TO ERISA, DISPUTES INVOLVING AN ADVERSE BENEFIT DETERMINATION FOR A HEALTH CLAIM ARE NOT SUBJECT TO BINDING ARBITRATION, BUT, MUST FOLLOW THE ERISA CLAIMS APPEAL PROCESS.

Employer/Group signature

I understand and agree to all of the above.

Authorized Group signature	Printed name of officer, partner or proprietor	Title	Date (MM/DD/YYYY)
X			

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