Hometown Health

BROKER SUMMIT

BROKER RESOURCES FOR PLAN YEAR 2024

LADD/2306-2221448

August 17, 2023

Dear Broker Partners,
Welcome to the annual Hometown Health Broker Summit for plan year 2024. We celebrate a year of ongoing organizational improvement and exciting new business opportunities that we are thrilled to share with you during today's event.

The Sky is the Limit is a fitting theme, as Hometown Health offers remarkably affordable rates for your valued clients in 2024, which include new advantages to our portfolio that are going to take us to the next level. Our goal is to help you succeed by providing you with the options your clients need and want.

We are excited that you have joined us to hear about the ways we are delivering more each day.

You spoke, we listened. Now it's time to launch into 2024 with our sights set high!

Sincerely,

Bethany Sexton
Chief Executive Officer
Hometown Health

2024 Underwriting Guidelines

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Small Group Underwriting Guidelines

Effective Plan Years Beginning On or After January 1, 2024

These Small Group Underwriting Guidelines (Guidelines) apply to both Hometown Health Plan, Inc. and Hometown Health Providers Insurance Company, Inc. (collectively referred to as Hometown Health). These Guidelines apply to Small Employers who wish to purchase Hometown Health Small Group coverage. The Underwriting Department has final confirmation on approving employer groups, and recommend groups keep their current coverage until they have received notice of acceptance from Hometown Health.

Hometown Health's underwriting policies for Small Group healthcare coverage adhere to the laws and regulations set forth under the Affordable Care Act, Title 57 of Nevada Revised Statutes and other applicable laws and regulations. In the event there is a conflict between these Guidelines and Hometown Health's Evidence of Coverage (EOC), the EOC will prevail. In the event there is a conflict between documents provided by Hometown Health and federal or state regulation, the regulation will prevail. "Regulation" includes interpretive bulletins and sub-regulatory guidance issued by the Centers for Medicare and Medicaid Services (CMS) and the Nevada Division of Insurance (DOI).[1]

Contents

[1] Hometown Health will ensure all plan offerings, and operations comply with insurance law and do not conflict with Internal Revenue Service (IRS) and Department of Labor (DOL) requirements. However, it is the employer's sole responsibility to ensure compliance with IRS and DOL regulation when offering group coverage.

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

1. GROUP ELIGIBILITY

Generally, Hometown Health Small Group products are available to any Small Employer with at least one permanent W-2 employee located within the product's service area who works on average 30 or more hours per week or 130 hours per month.

i. Small Group/Employer – A Small Group or Small Employer is a Bona Fide Employer[2] who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.[3] If an employer that was in existence in the preceding calendar year was not an Applicable Large Employer in the preceding calendar year, the employer will be considered a small employer. The size of a new employer is based on the average number of employees reasonably expected in the current calendar year.

ii. In addition, the Full Time Equivalency (FTE) method provided in 26 USC § 4980H (e) is used to determine whether an employer is an Applicable Large Employer (ALE). By adding the total number of hours worked by part time employees each month and dividing by 120,[4] you can determine if the employer is an ALE. Refer to the example below for FTE calculation:

1. XYZ Company has 70 total employees, 42 are full-time EE's and 28 part-time EE's.
    a. 28 EE's work 15 hours per week
    b. Total monthly part-time hours
        i. 15 hrs/wk x 28 part-time EE's = 420
        ii. 420 part-time hrs/wk x 4 wks/mo = 1,680
    c. FTE for part-time EE's
        i. 1,680/120 = 14
    d. Total Full Time Equivalent and Full Time Employees 42+14 = 56

    For the example above, the group is considered an Applicable Large Group.

iii. Who should be included in the employee count:
1. All employees of a commonly controlled corporation, trade or business under the Internal Revenue Code section 414[5],

[2] A Bona Fide Employer is someone who has control over the company and employees as defined by NRS 692C.050.
[3] NRS689C.095 & 45CFR§144.103
[4] See definition of Full Time Equivalency (FTE) at; http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notes/EmployersGuide.pdf
[5] https://www.irs.gov/pub/irs-tege/epchd704.pdf

a. Hometown Health requires groups with 50% or more common ownership combine as one group when the group falls under the definition in IRS Title 26 code 414[6]. It is the group's responsibility to establish if they are a controlled group by submitting a Common Owner Certification. Documentation must be submitted and approved by underwriting prior to Employer Group's effective date.

2. Employees under a controlled group located outside the State of Nevada. If the affiliate is located outside the State of Nevada they may not be eligible for coverage but are still considered for employee count in regards to ALE.
3. Employees who are not requesting coverage, but who are employed by the same company in a different state. The Nevada Employees are a carve out from a large company with over 50 full time equivalent. For example, a company who has an office in California and Nevada, but are only requesting coverage for the Nevada employees. You must still count the California employees into the FTE count for ALE purposes.
4. Union Employees – Union may make offer of coverage on employer's behalf but they count toward Full Time Equivalents.

iv. Who shouldnot be included in the employee count:

1. Owners of a sole proprietorship;
2. Partners[7]; partners may count toward employee count when working on average 30 hours per week[8] or 130 hours per month;[9]
3. Shareholders owning more than 2% of an S corporation;
4. Owners of more than 5% of other businesses;
5. Family members or members of the household who qualify as dependents on the individual income tax return of a person listed above, including a spouse, domestic partner, child (or descendant of a child), sibling or step-sibling, and parent (or ancestor of a parent), step parent, niece or nephew, aunt or uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law;
6. Seasonal employees working 120 days or less in a year;
7. Independent contractors (form 1099 workers); and
8. COBRA and retired enrollees.

b. Sole Proprietors not Eligible – Sole Proprietors are not eligible for small group coverage. A Sole Proprietor is an employer with no employees other than the owner's spouse or dependents (as defined by the Internal Revenue Code). A business owner without one non-familial employee (any employee other than one's spouse or dependents) is considered a Sole Proprietor and is therefore not eligible for small group coverage. However, an owner with at least one non-familial employee is not a Sole Proprietor and is eligible for coverage even if all non-familial employees waive coverage.

[6] See definition of Employees of controlled group or organization at; 26IRC§414
[7] NRS689A.615(2)
[8] NRS689C.065
[9] 26CFR§54.4980H-1(a)(21)

c. Contract Plan Modifications (Break in Contract) – Employers may submit a request to change renewal date and plans outside of scheduled renewal date. This request will be reviewed by Underwriting.

d. Acquisitions – Current and proposal groups that have been acquired must submit the following documentation for review by Underwriting:
   i. Letter from group stating request, FIN and effective date
   ii. Group application if ownership changes
   iii. Enrollment and waiver forms (waivers at Underwriting's request)
      1. Current groups only if requesting waiver of the waiting period
   iv. Acquisition Agreement
   v. Proof of ownership such as purchase agreement, tax documentation or newly formed articles.
   vi. Wage and quarterly or two weeks of payroll
   vii. Business License

e. Mergers – Current and proposal groups that have merged must submit the following documentation for review by Underwriting:
   i. Letter from group stating request, FIN and effective date
   ii. Group application if ownership changes
   iii. Enrollment and waiver forms (waivers at Underwriting's request)
      1. Current groups only if requesting waiver of the waiting period
   iv. Proof of ownership such as tax documentation or newly formed articles.
   v. Wage and quarterly or two weeks of payroll
   vi. Business License

f. Startup Groups (Virgin Groups) – Groups with no current health coverage or are newly formed with less than six weeks of business must submit the following to be considered for coverage:
   i. Most recent wage and quarterly filed
   ii. Six weeks of payroll (If they have not filed a wage and quarterly)
      1. Payroll must include company name, dates of payroll period, employee name, wages paid, and withholdings
   iii. Group application
   iv. Enrollment and waiver forms (waivers at Underwriting's request)
   v. Business License
   vi. Groups with less than six weeks of payroll will be reviewed by Underwriting

g. Spinoff Groups – Groups that have formed off an existing company creating their own business. The employees are now employed by the spinoff entity. Refer to "Business Type" chart below to see what must be submitted for group to be considered for coverage.
   i. Most recent wage and quarterly filed
   ii. Two weeks of payroll (If they have not filed a wage and quarterly)
      1. Payroll must include company name, dates of payroll period, employee name, wages paid, and withholdings
   iii. Group application
   iv. Enrollment and waiver forms

v. Business License

Documentation Requirements for Each Business Type		
Business Type	In business more than 3 months	In business less than 3 months
C Corporation	Nevada Employer's Quarterly Contribution and Wage Report	Payroll records and Articles of Incorporation
S Corporation	Nevada Employer's Quarterly Contribution and Wage Report or K-1 for shareholder's income	Payroll records and Articles of Incorporation
Partnership	K-1 for partner's income or Schedule SE (self-employment tax) or Form 1065 Partnership Return and Nevada Employer's Quarterly Contribution and Wage Report for employees.	Partnership Agreement and SS-4 (application for tax id) and payroll records
Limited Liability Company (LLC)	May file as either a C Corporation or a Partnership (refer to above)	May file as either a C Corporation owner or a Partnership (refer to above)
Sole Proprietorship	Schedule SE and Schedule C filed with Form 1040 (tax return) and Nevada Employer's Quarterly Contribution and Wage Report for salaried employees.	Payroll records and SS-4 or appropriate tax ID verification. A sole proprietor can use a Social Security number instead of getting a new tax ID number
Farm	Form 1040 and Schedule F or K-1. Farms can also file Form 1041, 1065 or 1065B	Payroll records and SS-4 or Articles of Incorporation, Partnership Agreement, etc.
Nonprofit Organization	Form 940 or Form 990	Articles of Organization and IRS confirmation of nonprofit status
Startup Group (Virgin Groups)	N/A	Six weeks of payroll records, business license and Article of Incorporation A new business cannot be accepted until six weeks of payroll records are available or at Underwriting's discretion

h. Change in Tax ID or Business Name – To ensure compliance with IRS 1094 and 1095 reporting requirements, if the business owner obtains a new Tax identification number or the business name changes, Hometown Health will require a letter from the business indicating the new Tax Identification Number and business name and the effective date of the change.

i. Guaranteed Issue and Renewability – Except in certain circumstances, guaranteed issue requires health insurance companies to offer all products that are approved for sale in the group markets to any applicant, regardless of the applicant's health status or other factors, and to generally accept any employer that applies for any of those products.[10] Guaranteed Renewability requires health insurance companies offering health coverage in the group markets to renew or continue in force the coverage at the option of the plan sponsor.[11]

j. Exceptions to Guaranteed Issue and Renewability – These rules do not apply to grandfathered health plans and under certain circumstances. Additionally, Hometown Health may refuse to issue coverage or to renew coverage for any of the following reasons:
   i. Fraud – Misrepresentation of information regarding the employer or its employees;
   ii. Non-payment of premiums;
   iii. Inability to meet participation requirements (see Section 5 below);
   iv. Inability to meet employer contribution requirements (see Section 6 below);
   v. Termination of Product – Hometown Health no longer offers a coverage in a particular market;
   vi. Discontinuation of Product – Hometown Health discontinues offering a particular product in the group market;
   vii. Enrollee movement outside the service area – There is no longer any enrollee under the plan who lives, resides or works in the service area; [12]
   viii. Discontinuation of All Coverage – As allowed by state law; and
   ix. Incorrect Market – If the group size does not meet the definition of a Small Group or a bona fide employer-employee relationship does not exist.

k. Coverage Alongside other Carrier(s) - Hometown Health does not allow for coverage alongside other carriers, also referred to as "slice business".

2. PREMIUM QUOTE CALCULATION

a. Premium Calculation – Brokers may enter the group's census into Salesforce to receive an estimate of the cost of coverage for the group. The actual cost of coverage will be based on the actual enrollment of employees and dependents. The total premium for the group will be the sum of the rates for all employees/dependents based on the following:
   i. Rating Area of the group (see Paragraph 2.b below);

[10] ~~45CFR§147.104~~
[11] ~~45CFR§147.106~~
[12] Pursuant to ~~45CFR§147.104(a)~~ & ~~45CFR§147.104(c)(i)(1)~~ an employer must have at least one employee that lives, works or resides in the product's service area.

ii. Age of the members on the first day of new or renewing policy:
    1. Child age band – A single age band 0-14; individual age bands for ages 15-20;
    2. Adult age bands – For individuals age 21-63; and
    3. Older age band – A single age band for individuals age 64 and older;

    The premiums for no more than the three oldest covered children under the age of 21 and all covered adults 21 and over will be taken into account when determining the total employee family premium; and
iii. Effective Date – Rates are set for each calendar quarter as approved in advance by the DOI.

Hometown Health Small Group rates do not vary based on tobacco usage or any other health factor.

b. Geographic Service Area – For an employer group to be eligible for coverage they must have a physical address located in the product's geographic service area.
    i. If the employer's business address is in the product's geographic service area, the rates will be based on the Rating Area[13] where the business is located.

c. Number of Plans Selected by Employers – Hometown Health allows Small Employers to select up to two (2) plans for less than five enrolled employees and up to three (3) plans for five or more enrolled employees. There is no restriction of metal levels offered.

d. Management Carve Outs – State law requires carriers to offer the same coverage to all of the eligible employees of a small employer and their dependents. A carrier shall not offer coverage to only certain members of a small employer's group.[14] Furthermore, the ACA prohibits discrimination in favor of highly compensated individuals.[15] Therefore, Hometown Health will not facilitate management carve outs.

e. Composite Health Plan Rates Not Available – The ACA requires that the sum of the composite rate equal the sum of the age banded rate as of the effective date of the policy. This means that any quote prior to the effective date of coverage would only be a best guess until all enrollment is submitted, which could be as late as 31 days after the effective date of coverage for employees that have a qualifying life event. This could result in initial bills that are incorrect, delays to completing contracts and general dissatisfaction with the implementation process. Therefore, Hometown Health does not currently offer composite rates.

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[13] Rating Areas are defined by the DOI as follows:
Rating Area 1 is Clark and Nye Counties.
Rating Area 2 is Washoe County.
Rating Area 3 is Carson City and Douglas, Lyon and Storey Counties.
Rating Area 4 is all other Nevada counties.

[14] NRS689C.180

[15] Section 2718 of the Public Health Service Act as added by Section 10101 of the Patient Protection and Affordable Care Act (42USC§300gg-16). The IRS has requested comments regarding the law for formulation of regulation, (IRSNotice2010-63) but no regulation has been issued and enforcement has been delayed (IRSNotice2011-01). Enforcing regulations will determine tax penalties associated with plans that discriminate in favor of highly compensated individuals. However, based on the Affordable Care Act and NRS, civil actions could be taken by employees against employers that discriminate in favor of highly compensated individuals.

f. Supplemental benefits:
    i. Vision – A group's vision selection must be clearly noted with the confirmed plan selection. Modifications to the vision plan will not be allowed or retroactive for the contract period.

*** Required Group Application Documentation (Submit to Hometown Health)

1. Hometown Health requires a complete application and submission of all required documents as defined below no later than the 20th of each month prior to the group's effective date. Once Underwriting receives the completed documentation listed below they will notify the Sales department within 2-3 business days if the group is initially approved. If an incomplete submission requires Underwriting to request additional information, your group's effective date may be delayed. Completed Application for Group Insurance (preferably on-line)
2. Plan Selection and Signed Rate Agreement
3. Signed Group Subscription Agreement – Must be completed during the group's open enrollment period; otherwise, group is subject to termination.
4. Enrollment applications or enrollment file for electronic eligibility
5. Signed waivers verifying employee eligibility with paper application.
    1. Underwriting reserves the right to request waivers on electronic applications to verify eligibility and participation.
6. Binder Check for first month's premium based on the census or, if actual enrollment is available, based on the actual enrollment. If there is any discrepancy between the binder amount and the final enrollment, the balance will be billed or credited on the first premium bill. Hometown Health requires at least 75% of the premium paid for new and renewing groups.
7. Confirmation of physical business location by product
8. Most recent Nevada State Wage and Quarterly – For employees that live and work outside the State of Nevada a State specific Wage and Quarterly is required.
    i. Employees not listed on the wage and quarterly may submit four weeks of payroll receipts.
        1. Payroll must include company name, dates of payroll period, employee name, wages paid, and withholdings
9. Business License – The following are exempt from obtaining a State Business License in accordance with the NRS.[16]
    i. Nevada Nonprofit corporations formed under NRS Chapter 82 and Corporations Sole formed under NRS Chapter 84.
    ii. Statutory exemptions in which groups may declare an exemption online include:
        1. Governmental entity as defined by Chapter 76 of the Nevada Administrative Code[17]
        2. A nonprofit religious, charitable, fraternal or other organization that qualifies as a tax-exempt organization pursuant to 26 U.S.C. § 501(c).

[16] https://www.nvsilverflume.gov/questions?q=142
[17] https://www.leg.state.nv.us/nac/NAC-076.html

10. Hometown Health's Underwriting Department may request additional information upon enrollment, at renewal, or throughout the contract period in the following circumstances:
    i. Group's final enrollment changes from the initial submitted census by 20% or more;
    ii. Monthly Compliance Audits
    iii. Verification of National Network
    iv. Verification of business license exemption status
        1. Groups that are non-compliant with Underwriting's request will not be renewed or maybe be given a 60-day termination notice if documentation is not returned in accordance with the compliance letter.

3. RENEWALS

a. Timing – Notice of upcoming group renewals will be sent to Sales by the 9th of each month prior to the groups 60 day advance notice. Underwriting will conduct a review of the renewing group to determine if the group meets participation and contribution requirements and will notify Sales of any groups with potential failures to comply. Renewal packages will be mailed or sent electronically to the group and broker 60 days prior to the anticipated renewal date.

b. Default Plan – If the employer does not submit renewal documentation that indicates their plan selection by the 9th of the month prior to the effective date of the renewal, the employees and their dependents will be defaulted to the same plan upon renewal. If the same plan does not exist, the employees and their dependents with be defaulted to a similar plan, as determined by Hometown Health.

4. MEMBER ELIGIBILITY AND ENROLLMENT

a. Enrollment Periods – Hometown Health will comply with the open enrollment, special enrollment and limited enrollment provisions listed in the applicable EOC.

b. Eligible Employee – An Eligible Employee is generally an employee who:
    i. Works an average of at least 30 hours of service per week[18] or 130 hours of service per month;[19]
    ii. Is compensated for work by the employer and subject to withholding as it appears on a W-2 form;[20] and
    iii. Meets the employer defined waiting period[21]

[18] NRS689C.065
[19] 26CFR§54.4980H-1(a)(21)
[20] 26CFR§54.4980H-1(a)(15)
[21] 45CFR§147.116

The owner/employer and any partners are considered an Eligible Employee for the purposes of obtaining health insurance coverage in the Small Group market.[22] A retiree who is collecting a pension from the Public Employees' Retirement System, whose last employer is the small group and who is eligible to continue coverage with the small group pursuant to NRS 287.023 and pursuant to the group's health plan is considered an Eligible Employee for the purposes of obtaining health insurance coverage in the Small Group market.

Eligible Employees must meet the waiting period requirements as defined by the employer.[23]

- Service Area Eligibility – Some employees who live out of the service area or outside the state may not be eligible for coverage.[24]
  - HMO Out of Service Area Eligibility – Hometown Health will not offer Small Group HMO coverage to any employee that lives outside of Nevada.
  - EPO Out of Service Area Eligibility – Hometown Health will not offer Small Group EPO coverage to any employee that lives outside of Nevada.
  - PPO Out of State Eligibility – Hometown Health will not offer any new Small Group PPO coverage to any employee that lives and works outside the State of Nevada in the following circumstances:[25]
    - New Small Groups that have more than 10% of their employees who live outside the State of Nevada may not enroll their employees who live and work outside the State of Nevada in Hometown Health coverage.
      - At renewal Small Groups will be audited by Underwriting to ensure that the group has remained within the 10% threshold Hometown Health reserves the right to not renew groups that fall outside the national network guidelines.
- Dependent Eligibility – Dependents must meet the eligibility requirements for dependents[26] listed in the Enrollment and Eligibility section of the applicable EOC. Additionally, Employers may restrict dependent eligibility to one of the four following coverage options prior to open enrollment:[27]
  - Employees only
  - Employees and children;
  - Employees, spouses and children; or
  - Employees, spouses, domestic partners and children.

[22] NRS689C.065
[23] 45CFR§147.116
[24] 45CFR§147.104(c)(i)(1) & NRS689C.200
[25] This paragraph does not determine eligibility for the national network. To determine which employees are eligible to receive in-network benefits from Hometown Health's national network providers, see Paragraph 10.
[26] NRS698C.055
[27] Hometown Health recommends that, if an employer chooses to cover dependents, the employer should also pay for a portion of the dependent's coverage. If an employer does not wish to pay for a portion of the dependents' coverage, the employer should probably not cover dependents to allow the dependent to receive Advance Premium Tax Credits on the state exchange.

e. Required Enrollment Information – Hometown Health prefers receiving enrollment information via electronic file or through EpicCare Link with the required information listed below. If the employer does not have access to electronic submission methods, a paper application for each applicant may be submitted. The following information is required for each employee and dependent who chooses to enroll in Hometown Health coverage:
   i. Employee (Subscriber) Last Name
   ii. Employee (Subscriber) First Name
   iii. Employee (Subscriber) Date of Birth
   iv. Employee (Subscriber) Social Security Number
   v. Employee (Subscriber) Gender
   vi. Enrolling Dependent(s) First Name(s)
   vii. Enrolling Dependent(s) Last Name(s)
   viii. Enrolling Dependent(s) Date of Birth
   ix. Enrolling Dependent(s) Social Security Number
   x. Enrolling Dependent(s) Gender
   xi. Effective Date of Coverage
   xii. Employee (Subscriber) Date of Hire
   xiii. Employee (Subscriber) Complete Home Address
   xiv. Plan Selection
   xv. Signature of Employee (Subscriber) (on paper applications; employer should keep a copy of employee's selection and signature for their records)
   xvi. Signature of Employer

*** Required Eligibility and Enrollment Documentation (Employer Keep On File)

It is the employer's responsibility to collect the appropriate documentation to support qualifying life events. This documentation includes birth certificates, adoption certificates or guardianship papers, marriage licenses, certificates of domestic partnership, death certificates, certifications of loss of coverage from an employee's previous insurer and any other documentation that substantiates the qualifying live event. Hometown Health may request a copy of any or all of this documentation in accordance with established audit criteria.

*** Required Eligibility and Enrollment Documentation (Submit to Hometown Health)

The employer must provide the following documentation:

1. Large Families – To effectuate coverage, families with more than 3 dependents under the age of 21 will be required to furnish a birth certificate for all covered dependents under the age of 21. This documentation must be provided either at open enrollment or during a special enrollment.

5. Participation Requirements

Carriers must uniformly apply the requirements used to determine whether to provide group coverage. These requirements include, without limitation, requirements for minimum participation of eligible employees and minimum employer contributions. [28]

[28] ~~NRS689C.160~~

a. Inability to meet Participation Requirements – Groups that cannot meet the minimum participation requirements described in this section on initial enrollment may only enroll in coverage during the standard ACA open enrollment period between November 15 and December 15.[29] For those groups enrolling during the special enrollment period you will be required to meet small group participation guidelines at each renewal period.

b. Minimum Participation – Minimum participation requirements are as follows:
   i. Groups with two (2) eligible employees who do not have creditable coverage – Both employees must enroll in coverage;
   ii. Groups with three (3) eligible employees who do not have creditable coverage – Two (2) employees must enroll in coverage; and
   iii. Groups with four or more (4+) eligible employees who do not have creditable coverage – At least 50% of eligible employees must enroll in coverage.

   A carrier may not consider employees who have creditable coverage when determining whether participation is met.[30] Therefore, for the purposes of the minimum participation requirement calculation, employees with other creditable coverage will not be considered "eligible employees." Additionally, Hometown Health will provide coverage to a single person (a "group" of one) in the Small Group market as long as the employer is considered a Small Employer and all other Eligible Employees have other creditable coverage.

c. New Employees Counted – Employees who have submitted an Enrollment Application and who are within the waiting period of their effective date will be considered when determining participation compliance.

6. EMPLOYER CONTRIBUTION REQUIREMENTS

a. Inability to meet Contribution Requirements – Groups that cannot meet the minimum contribution requirements described in this section on initial enrollment may only enroll in coverage during the standard ACA open enrollment period between November 15 and December 15.[31]

b. Minimum Contribution – An employer must contribute a minimum of 50% of the cost of coverage for employee only coverage for each enrolled employee.

   i. Multiple Plans – If an employer offers multiple plan options, the minimum 50% contribution will be based on the lowest premium plan available to each employee.

c. No Contribution Requirement for Dependents – Employers are not required to pay for any portion of dependent coverage, though it is recommended (see Paragraph 4.d above and the accompanying footnote).

d. Additional Contribution Allowed – An employer may choose to pay for any portion of the cost of coverage above the minimums described in this section.

[29] 45CFR§147.104(b)(1)(i)(B)
[30] NRS689C.170(2). See NRS689C.053 for the types of coverage considered Creditable Coverage.
[31] 45CFR§147.104(b)(1)(i)(B)

i. When an employer group is contributing 100% of the employee premium, no eligible employee can waive coverage except for those that have creditable coverage. For the purposes of this requirement, coverage under another health plan that is sponsored by the employer is not considered creditable coverage.

e. Full Premium Due – Regardless of the amount of contribution the employer elects to pay, full premium must be paid by the due date on the applicable invoice, regardless of whether the employer has collected the appropriate amount of premium from the employer's employees.

7. Waiting Periods

A small employer may not have a waiting period with coverage that begins later than 60 days on or following the date of benefit eligible employment. A small employer may elect to include a reasonable and bona fide orientation period, not to exceed 30 days, prior to the start of the waiting period.[32]

8. New Group Deductible Credit

For new groups, Hometown Health will provide credit for medical or combined deductibles met under prior group health coverage. Proof of the deductible amount must be submitted in a format defined by Hometown Health within 90 days of the group's effective date of coverage.

Hometown Health will not provide credit for any new employee who applies for coverage after the initial group deductible credit has been completed.

Hometown Health will not reprocess claims that were processed prior to the date the deductible credit list was received.

9. Grandfathered Plans

Grandfathered small group health plans may be rated based on health status and are exempt from certain requirements of the Affordable Care Act and the Public Health Service Act.[33]

10. National Network

National Network – Hometown Health's national network is the network of providers who are included in the network leased by Hometown Health.

a. HMO National Network Eligibility – Hometown Health does not offer its national network to any HMO member.

b. EPO National Network Eligibility – Hometown Health does not offer its national network to any EPO member.

[32] 45CFR§147.116
[33] 45CFR§147.140

c. PPO National Network Eligibility – Hometown Health has a comprehensive network within the State of Nevada. The national network will only be available to employees in the following circumstances:
   i. The subscriber lives and works outside the state of Nevada. Please see Paragraph 4.c.iiiabove for additional restrictions regarding this eligibility.
   ii. The subscriber's covered dependent is attending a college which requires the dependent's physical attendance at the college outside of Nevada; or
   iii. The subscriber's covered dependent under the age of 19 who lives outside of Nevada with the dependent's primary guardian.

A spouse will not have access to the national network unless the subscriber lives and works outside of Nevada as described in (i) above. A dependent will not have access to the national network unless one of the conditions described in (i) through (iii) above apply.

To gain access to the national network, the employer or broker must provide Hometown Health the applicable eligibility provision above which applies to the member.

The national network shall be available to a member effective on the first of the month that Hometown Health receives a valid, approved request to provide access to the national network for that member.

Small & Large Group Resources

Hometown Health

GROUP APPLICATION – INFORMATION DOCUMENT

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

1 Full Legal Name of Contract Holder *(Include punctuation and abbreviations)*

Last Name _____ First Name _____ Middle Initial _____

1a. Federal Tax ID Number _____ **1b.** IRS Section 125 ☐ ***YES*** ☐ ***NO***

2 Address

Physical Address _____

City _____ State _____ Zip _____

Mailing Address *(If different – Street or PO Box)* _____

City _____ State _____ Zip _____

2a. Telephone _____ **2b.** Fax _____ **2c.** Email _____

3 Name / Title of Owner, General Manager or CEO

Name _____ Title _____

3a. Telephone _____ **3b.** Fax _____ **3c.** Email _____

4 Company Billing Name and Address *(If Different from Legal Name Noted Above)*

Company Billing Name _____

Physical Address _____

City _____ State _____ Zip _____

Mailing Address *(If different – Street or PO Box)* _____

City _____ State _____ Zip _____

4a. Telephone _____ **4b.** Fax _____

5 Business Industry or Nature of Business _____

6 NAICS Code *(If available)* _____ **6a.** Member of Builders Association ☐ ***YES*** ☐ ***NO***

7 Company Type

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

8 Year Business Established _____

8a. Number of Employees *(FT & PT)* _____

8b. Number of Employees Eligible To Enroll _____

8c. Number of Employees Waiving Enrollment _____

8d. Please check appropriate box below to indicate your organization's size.*

- ☐ Less than 20 full- or part-time employees**
- ☐ 20 to 99 full- or part-time employees**
- ☐ 100 or more full- or part-time employees**

**Mandatory Insurer Reporting Law-Section 111 of Public Law 110-173*

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

9 Does Your Company Offer Other Insurance Options, Not Associated With Hometown Health?

☐ ***YES*** ☐ ***NO*** *(e.g. Dental and/or Vision)*

9a. If Yes, please list below

Coverage Type _____

Carrier Name _____

Coverage Type _____

Carrier Name _____

AREA FOR HOMETOWN HEALTH USE ONLY

Effective Date _____

Parent Code _____

10 Employer Contribution to Employee and Dependent Premium

Enter the Percentage or Dollar Amount;
Minimum is 50% of Employee Premium

Hourly	**Salaried**	**Other** *(Please specify)* _____
EE ____	EE ____	EE ____
DEP ____	DEP ____	DEP ____

Hometown Health

GROUP INFORMATION

A COMPANY INFORMATION

1a. Company Name _____

B COMPANY BENEFIT ADMINISTRATOR(S)

1b. Corporate Contact

Last Name _____ First Name _____ Middle Initial _____

Title _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

☐ Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter

2b. Local Contact *(If Same as Corporate Contact, Leave Blank)*

Last Name _____ First Name _____ Middle Initial _____

Title _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

☐ Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter

3b. Premium Billing Contact *(If Different than Contacts Listed Above)*

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

4b. Other Company Contacts *(If Applicable)*

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

Hometown Health

GROUP ELIGIBILITY AND PAYMENT PROVISIONS

Please return with renewal/new packet.

A Company Name _____ Group Size _____

Check categories in each Provisions Section: **B – Eligibility Status** and **C – Commencement of Coverage**

B ELIGIBILITY STATUS *(Check All Categories Applicable)*

Salaried	Hourly	Other *(Please List)*
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____

1b. Eligible Employees:

☐ Active Employees ☐ Retirees
☐ Permanent Full Time Employees* ☐ Leave of Absence
☐ Other *(Attach Explanation)*

**Eligible employee means a permanent employee who has a regular working week of 30 or more hours.../NRS689C.065*

2b. Dependent Policy

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

C COMMENCEMENT OF COVERAGE *(Check All Categories Applicable)*

ELIGIBLE EMPLOYMENT BEGINS ON

☐ Date of Hire *(Default)*

OR

☐ Following a reasonable and bona fide employment-based orientation period of _____ days (not to exceed 30 days).
By selecting this box you attest that the orientation period you require is both reasonable and bona fide.
Eligible employment also begins when a part time employee begins to work full time.

Salaried	Hourly	Other *(Please List)*
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____

1c. Newly Eligible Employees Effective For Coverage

☐ 1st of Month on or following date of eligible employment
Termination of Coverage = Last day of month which employee ceases to be eligible

☐ 1st of Month OR following _____ day(s) of eligible employment (60 days max)
Termination of Coverage = Last day of month which employee ceases to be eligible

☐ 1st of Month on or following 1 month of eligible employment
Termination of Coverage = Last day of month which employee ceases to be eligible

☐ Additional Information *(Attach Explanation)*
Termination of Coverage = _____

LARGE EMPLOYERS ONLY HAVE THE FOLLOWING ADDITIONAL OPTIONS

☐ Date of eligible employment
Termination of Coverage = Midnight, the date of termination

☐ _____ ☐ days OR ☐ months from date of eligible employment (90 days max)
Termination of Coverage = Midnight, the date of termination

☐ Other *(Attach Explanation)*
Termination of Coverage = Last day of month which employee ceases to be eligible

2c. Newly Eligible Dependents – Births and Loss of Coverage Will Always be Date of Event

☐ 1st of Month following Date of Eligibility/Event ☐ Date of Eligibility/Event ☐ Other *(If other, explain below)*

Hometown Health

C COMMENCEMENT OF COVERAGE *(Continued)*

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

3c. Part Time to Full Time Policy

Only applies to large groups

☐ Does Not Apply

Minimum Number of _____ ☐ Days OR ☐ Months

WORKING P/T BEFORE GOING F/T, THEN COVERAGE EFFECTIVE

☐ Date of Full Time Status

☐ 1st of Month following Full Time Status

☐ Other (*Attach Explanation*)

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

4c. Rehire Employee Policy

☐ Does Not Apply

If Rehired within _____ ☐ Days OR ☐ Months of Termination then is Coverage Effective

Maximum period for rehire policy is 12 months

☐ Date of Rehire (Only applies to large groups)

☐ 1st of Month following Rehire

☐ Other (*Attach Explanation*)

D PAYMENT PROVISIONS

Full Monthly Premium	
IF COMMENCEMENT OF COVERAGE FALLS ON	The 1st through the 15th of the month - **FULL PREMIUM DUE** The 16th through the end the month - **NO PREMIUM DUE**
IF TERMINATION OF COVERAGE FALLS ON	The 1st through the 14th of the month - **NO PREMIUM DUE** The 15th through the end the month - **FULL PREMIUM DUE**

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

Print Name _____ Date _____

Print Title of Company Representative _____

Signature of Company Representative _____

Primary Contact _____ Email Address _____

Secondary Contact _____ Email Address _____

Notes _____

AREA FOR HOMETOWN HEALTH USE ONLY

Renewal Effective Date _____

Date _____ SSR _____ Section Changed _____ Effective Date _____

Hometown Health

PRODUCER STATEMENT

THIS SECTION MUST BE COMPLETED BY PRODUCER/AGENCY.

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

PRODUCER OF RECORD

Company / Agency _____

Producer Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

IRS Tax ID Number _____

SECOND PRODUCER OF RECORD *(If Applicable)*

Company / Agency _____

Producer Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

IRS Tax ID Number _____

COMMISSIONS

☐ Standard ☐ Net of Commissions ☐ None ☐ Split* Split Arrangement* _____

☐ Other _____

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

MUST INCLUDE IRS TAX ID NUMBERS FOR ALL PRODUCERS OF SPLIT ARRANGEMENTS.

New Producer? ☐ Yes ☐ No

Producer must be appointed by Hometown Health

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

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

Print Name _____ Date _____

Print Title of Company Producer _____

Signature of Company Producer _____

Hometown Health

EMPLOYERS STATEMENT

Company Name _____

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

Print Name _____ Date _____
Print Title of Company Representative _____

Signature of Company Representative _____

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Hometown Health

ATTESTATION FORM

For Sole Proprietor or Business where the Owner is the Sole Employee

PARTNERSHIPS WITH NO EMPLOYEES

BUSINESS ORGANIZATION INFORMATION

Name of Organization _____

State Business License Number _____

Primary Business Activity _____

Address _____

City _____ State _____ Zip _____

CONTACT INFORMATION FOR BUSINESS ORGANIZATION

Last Name _____ First Name _____ Middle Initial _____

Title _____

Telephone _____ Fax _____

CHECK ONE BELOW

☐ **Sole Proprietor or Business where the Owner is the Sole Employee**

I hereby attest that: (i) I am the owner and operator of the above described business organization; (ii) I work a minimum of thirty (30) hours per week for this business organization; (iii) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization.

☐ **Partnership**

I hereby attest that: (i) I am one of the owners of the above described business organization and have the authority to enter into an agreement to purchase health insurance coverage on behalf of all of the partners of this business organization; (ii) the above business organization does not offer health insurance coverage to any of the partners through another company; (iii) the above business organization does not have any "W-2" employees; (iv) only the partners that work a minimum of thirty (30) hours per week for this business (and their eligible dependents) will seek health coverage through the organization.

☐ **None of the Above**

If the above does not describe you, check here; no signature is needed.

I agree to provide upon request appropriate tax forms to Hometown Health to validate the eligibility status. Before application will be approved, the applicant must execute this Attestation Form and provide the tax information and related documents indicated on the attached checklist. Hometown Health reserves the right to modify these documentation and eligibility requirements in the future. I agree to promptly advise Hometown Health in the event that any of the statements made in this Attestation are no longer accurate. The undersigned certifies that, to the best of his or her knowledge and belief, and under penalty of perjury, the information listed above is true and complete.

Signature of Applicant _____ Date _____

Hometown Health

COMMON OWNERSHIP CERTIFICATION

PLEASE COMPLETE, SIGN AND SUBMIT THE COMMON OWNERSHIP CERTIFICATION.

This form must be filled out and returned even if you do not have multiple companies.

Please list all employer groups that qualify under 26 USC Section 414(b) (c) (m) or (o) of the Internal Revenue Code.

COMPANY INFORMATION

Name of Employer Group _____

Business Owner _____

Primary Business Location _____

Name of Business Entity	Employer Federal Tax ID Number (FEIN)	Percentage of Ownership	Number of Full-Time Equivalent (FTE) Employees
1			
2			
3			
4			
5			
6			

- **A FULL-TIME EMPLOYEE** is an employee who is employed on average, per month, at least 30 hours of service per week, or at least 130 hours of service in a calendar month.
- **A FULL-TIME EQUIVALENT EMPLOYEE** is a combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.
- **AN AGGREGATED GROUP** is commonly owned or otherwise related or affiliated employers, which must combine their employees to determine their workforce size.

I certify that the group named above is a single employer under section 414 of the Internal Revenue Code of 1986 (26 U.S.C. Section 414 (b), (c), (m), or (o)), and under any applicable state law. I further certify that there are no other affiliated entities other than the ones listed above who are eligible to file a combined state tax return. I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I understand that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Signature _____ Date _____

Relationship to company *(Please Check One of the Following)*

☐ Owner ☐ HR Rep ☐ Accountant for Employer ☐ Attorney representing employer

HOMETOWN HEALTH USE ONLY

G# _____

M# _____

L _____

F, M _____

Hometown Health

ENROLLMENT / CHANGE FORM

HUMAN RESOURCES ONLY

Employer _____ Group Number _____

Effective Date _____ Employee's Weekly Hours _____ Employee's Date of Hire _____

Employer Signature _____

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____

City _____ State _____ Zip _____ County _____

Physical Address _____

City _____ State _____ Zip _____ County _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation _____ Home Phone _____ Work Phone _____

PLAN ELECTED

*Street Address only, no P.O. Boxes

☐ HMO	☐ EPO	☐ PPO	☐ PPO w/HSA*
Plan Elected	**Plan Elected**	**Plan Elected**	**Plan Elected**

OTHER MEDICAL COVERAGE

Do you or any of your Dependents listed on the next page have Medical/Health Insurance (Including Medicare/Medicaid)?

☐ ***YES*** ☐ ***NO***

If yes, please provide copy of insurance card (front & back).

CONTRACT TERMINATION ONLY

Completion of this section will terminate coverage for subscriber and all dependents.

☐ Left Company
☐ Deceased
☐ Moved
☐ Ineligible
☐ Dissatisfied
☐ Other *(If other, explain below)*

REASON FOR CHANGE

☐ New Hire
☐ Name
☐ Annual Election
☐ Rehire
☐ COBRA (18-29-36)
☐ Other *(If other, explain below)*
☐ PT/FT
☐ Reinstatement
☐ Waive Coverage
☐ Retiree
☐ Transfer
☐ Address

Plan Change From _____ To _____

ADD/DELETE DEPENDENT

☐ Marriage**
☐ Birth/Adoption**
☐ Loss of Dependent Status**
☐ Loss of Insurance**
☐ Divorce**
☐ Other**
☐ Court Ordered/ Legal Guardianship**
☐ Deceased**

***Attach legal documentation as proof of event.*

MEMBER INFORMATION – COMPLETE WITH NEW OR CHANGE INFORMATION

EMPLOYEE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

SPOUSE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

***Attach legal documentation as proof of action (Add, Change or Delete).*

† It is member's responsibility to verify physician availability in their area.

ACKNOWLEDGMENT OF TERMS

Employee Signature ______ Date ______

See Next Page

Hometown Health

ACKNOWLEDGMENT OF TERMS

I understand and agree that, with the exception of emergency procedures, all services must be performed by a Hometown Health participating provider, or authorized in advance by Hometown Health, to be considered for payment at the in-network rate. Additional requirements may apply. See the appropriate plan documents for details.

I understand that I am responsible for paying any required deductibles, copayments, and coinsurance directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to Plan Types

HMO Health Maintenance Organization
EPO Exclusive Provider Organization
PPO Preferred Provider Organization
TPA Third Party Administrator for self-funded plan
HSA Health Savings Account

STATEMENT OF ACCOUNTABILITY

To be completed only when the applicant cannot complete the application
NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English
☐ Applicant does not write English ☐ Other *(Explain)* _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant ☐ Or by _____

I also translated and fully explained the "Application Understandings, Conditions and Agreement," and "Payment Method."

Translator Signature *(Required)* _____ Date *(Required)* _____

I confirm that the application was translated on my behalf.

Applicant Signature *(Required)* _____ Date *(Required)* _____
Language interpreted *(e.g. Spanish)* _____

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Hometown Health

WAIVER OF HEALTH COVERAGE BENEFITS

All the sections on this form must be completed and signatures are required from employee and employer.

SEE INSTRUCTIONS ON PAGE 2

EMPLOYER INFORMATION

Name of Employer _____

Address _____

City _____ State _____ Zip _____

Telephone _____

APPLICANT / EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Date of Hire _____ Job Title _____

OTHER COVERAGE INFORMATION

Do you have other health benefit coverage?

☐ ***YES*** – If Yes, please complete below

☐ ***NO*** – I do not have other health insurance coverage

Coverage Information

Name of primary person on policy _____

Name of Employer or the Party providing health care coverage _____

Name(s) of dependent(s) covered on policy _____

Name of health plan provider / insurer _____

PLEASE ATTACH A PHOTOCOPY OF YOUR HEALTH PLAN PROVIDER ID CARD.

VALIDATION OF WAIVER OF BENEFITS

*I understand that I have been offered group health insurance by my employer, with Hometown Health. I have elected **NOT** to enroll myself, and/or my dependent(s). I understand that if I and/or my dependent(s) decide, at some time in the future, that I (we) desire this coverage, I must wait for my employer's "open enrollment' period, or special enrollment period due to qualifying event. (i.e.: Divorce, marriage, birth of child, death, loss of medical insurance, etc).*

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Comments _____

Hometown Health

INSTRUCTIONS

ALL THE SECTIONS ON THIS FORM MUST BE COMPLETED
and signatures are required from employee and employer.

EMPLOYER INFORMATION

1. Enter company data in the appropriate Employer information areas.

APPLICANT / EMPLOYEE INFORMATION

1. Enter your personal data in the appropriate Applicant / Employee information areas.

OTHER COVERAGE INFORMATION

1. Please indicate if you do or do not have other health benefit coverage.
2. Please indicate the name of both the Employer, the primary member holding this insurance coverage and the insurance carrier providing you and/or your dependents with the coverage.
3. Attach a photocopy of the Plan Provider ID card.

VALIDATION OF WAIVER OF BENEFITS

1. **EMPLOYEE**
   Read the statement carefully, then sign and date the Waiver of Coverage Form. Please return the form to your employer.
2. **EMPLOYER**
   Please sign form before returning to Hometown Health.

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FILED ONLINE - DO NOT MAIL

Nevada Unemployment Insurance - Quarterly Contribution Report Worksheet

This is a record of your information to complete your Unemployment Insurance Contribution Report.
Do not file the worksheet.

03/31/2021
Period Ending

[redacted]
Company Legal Name

[redacted]
FEIN

[redacted]
Company Legal Address

[redacted]
Unemployment No.

Address Line 2

Not Applicable
Company ID

RENO
City

NV
State

89509
Zip Code

3
Number of Employees

UNEMPLOYMENT INSURANCE

Total Wages		$ 123,393.47
Excess Wages Wage Base $ 33400.00		$ 39,732.90
Taxable Wages		$ 83,660.57
UI Contributions	Rate 1.1500	$ 962.10
CEP Amount Due thIs Quarter	Rate .0500	$ 41.83
Prior Credit (if applicable)		$
Charge for Late Filing of this Report		$
Additional Charge for Late Filing (after 10 Days)		$
Interest on Past Due UI Contributions		$
Total Payment Due		$ 1,003.93

Number of employees receiving pay for pay period which includes 12th day of the month

1st Month	2nd Month	3rd Month
3	3	3

Nevada Unemployment Insurance - Wage Report Worksheet

This is a record of your information to complete your Employer Report of Wages Paid.
Do not file the worksheet.

[redacted]
Company Legal Name

[redacted]
FEIN

Not Applicable
Company ID

[redacted]
Unemployment No.

03/31/2021
Period Ending

Employee SSN	Employee Name	Total Tips Reported	Total Gross Wages Plus Tips
[redacted]		0.00	16,860.57
		0.00	51,252.00
		0.00	55,280.90
		Total Gross Wages + Tips this Page	123,393.47

Hometown Health Right of Access Form

Instructions: Please complete the following information exactly as it appears on your Member Identification Card (ID). Complete the form in its entirety and include as much information as possible. If necessary, call the Member Services Department Number found on your ID card for assistance.

Note: This form does not need to be completed to share information with the legal guardian of an emancipated minor.

Member Full Name:					
Member ID Number:		Primary Telephone Number:			
Date of Birth:		Secondary Telephone Number:			
Member Address:					
City:		State:		Zip Code:	

I authorize Hometown Health/Senior Care Plus, and its affiliates and agents, to disclose information about my health care and/or payment for my health care with the individual listed below:

Name:	Relationship:

I do ***NOT*** authorize the release of the following types of sensitive information (check boxes that apply):

☐ Drug, Alcohol & Substance Abuse Records ☐ Communicable Disease Records, including without limitation, HIV/AIDS Records ☐ Genetic Testing Records	☐ Psychiatric & Mental Health/Behavioral Health Records ☐ Other:_____ _____

_____ _____

MEMBER SIGNATURE **DATE**

Designated Legal Representative/Guardian

If this form is signed by a legal representative/guardian on behalf of an individual, please include the following: a copy of a Health Care Power of Attorney, a court order or other documentation establishing Custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf.

Legal Representative (print full name): _____

Representative's Relationship to member: _____

_____ _____

LEGAL REPRESENTATIVE SIGNATURE **DATE**

Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

APPLICATION WILL NOT BE CONSIDERED COMPLETE WITHOUT
THE REQUIRED DOCUMENTATION LISTED BELOW.

Please be aware that rates are subject to change based on final information and census.

Business Name _____ Effective Date _____

ALL APPLICANTS

- ☐ **Completed application and plan selections**
- ☐ **Current Nevada State Business License or Notice of Exemption letter from Nevada Secretary of State**
- ☐ **Completed Common Ownership Attestation**
- ☐ **Completed Business Attestation** *(Partnerships Only)*
- ☐ **Enrollment application, electronic enrollment application, or enrollment file for electronic eligibility**
- ☐ **Estimated 1st month premium binder check**
  - Any discrepancy between the binder amount and the final enrollment will be billed or credited on the first premium bill.

BUSINESSES WITH "W-2" EMPLOYEES

- ☐ **Most recent filed State Wage & Quarterly**
  - Businesses in operation less than three months must submit Articles of Incorporation along with two weeks of payroll in lieu of the State Wage & Quarterly.
- ☐ **Two weeks of payroll receipts for employees that do not appear on the group's State Wage & Quarterly**
  - Business Verification Form maybe submitted in lieu of payroll at Underwriting's approval
- ☐ **Waiver of Health Coverage Benefits for all Eligible Employees who are waiving coverage or who are eligible for and/or participating in COBRA. "Eligible Employee" means a permanent employee who has a regular working week of 30 or more hours**

BUSINESSES WITH OWNERS THAT DO NOT APPEAR ON THE STATE WAGE & QUARTERLY

PROVIDE AT LEAST ONE ITEM FROM THE LIST BELOW

- ☐ **Partnership Business Type** – US Return of Partnership Income Form 1065 *(Schedule K-1)*
- ☐ **S Corporation Business Type** – US Return of Shareholder Income Form 1120S *(Schedule K-1)*
- ☐ **Limited Liability Company (LLC) with Partners** – Form 1065 *(Schedule K-1)*

BUSINESSES APPLYING FOR BUILDERS ASSOCIATION OF NORTHERN NEVADA

BUILDERS/SUBCONTRACTORS

- ☐ **Current contractor license**
- ☐ **Builders Association Eligibility Attestation**

Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

DOCUMENTATION REQUIREMENTS FOR EACH BUSINESS TYPE.

Business Type	In business more than 3 months	In business less than 3 months
C CORPORATION	Nevada Employer's Quarterly Contribution and Wage Report	Payroll records and Articles of Incorporation
S CORPORATION	Nevada Employer's Quarterly Contribution and Wage Report or K-1 for shareholder's income	Payroll records and Articles of Incorporation
PARTNERSHIP	K-1 for partner's income or Schedule SE (self-employment tax) or Form 1065 Partnership Return and Nevada Employer's Quarterly Contribution and Wage Report for employees.	Partnership Agreement and SS-4 (application for tax id) and payroll records
LIMITED LIABILITY COMPANY (LLC)	May file as either a C Corporation or a Partnership (refer to above)	May file as either a C Corporation owner or a Partnership (refer to above)

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The Builders AHP Resources

Save up to 40% on your Health Insurance Premiums

Contact your Health Insurance Agent or Broker today

With ever-increasing cost in all areas of the construction industry today, and the critical need for employee retention, let The Builders Association Health Plan and Hometown Health save you money and provide you and your employees with quality and flexible health insurance plans from Hometown Health and other employee benefits at up to 40% savings to your company.

Builders Association Members save up to 40% on premiums with the new low-cost tier rated plans for qualifying groups.

- Guaranteed Issue age-banded rates save up to 20%
- Dental, Vision and Life Insurance plans available through Unum
- ACA Compliant – Plans meet minimum essential coverage guidelines

THE BUILDERS ASSOCIATION BENEFIT TRUST

Hometown Health

Hometownhealth.com

THE BUILDERS ASSOCIATION

Thebuilders.com

The Builders Association Benefit Trust and Hometown Health offer
The Builders Association Health Plan exclusively for Eligible Member Companies*

Enrolling Your Clients in The Builders Association Health Plan

The documentation and steps to enroll in the association health plans offered by the Builders Association of Northern Nevada can be found online:

- Age Banded – https://brokers.hometownhealth.com/thebuilders/age-banded/
- Composite – https://brokers.hometownhealth.com/thebuilders/composite-plans/

Step 1 – Pick Your Plans

Step 2 – Determine Your Eligibility

Step 3 – Become a Builders Association Member

Step 4 – Apply for Health Coverage

Step 5 – Enroll Your Employees

Step 6 – Complete iSolved COBRA Service Agreement

Step 7 – Distribute Documents to Your Employees

If an employer calls Asset Solutions Group, our first question is always, "Who is your broker?" If you, the broker, have questions, you can always contact your Hometown Health Sales representative or Asset Solutions Group.

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Association Health Plan Participation Requirements

Effective Plan Years Beginning On or After October 1, 2023

These Association Health Plan Participation Requirements (Requirements) apply to both Hometown Health Plan, Inc. and Hometown Health Providers Insurance Company, Inc. (collectively referred to as Hometown Health). These Requirements apply to employers who wish to purchase Hometown Health Association Health Plan coverage.

Hometown Health's participation requirements for Association Health Plan coverage adhere to the laws and regulations set forth under the Affordable Care Act, 29 CFR Part 2510, Title 57 of Nevada Revised Statutes and other applicable laws and regulations. In the event there is a conflict between these Requirements and Hometown Health's Evidence of Coverage (EOC), the EOC will prevail. In the event there is a conflict between documents provided by Hometown Health and federal or state regulation, the regulation will prevail. "Regulation" includes interpretive bulletins and sub-regulatory guidance issued by the Centers for Medicare and Medicaid Services (CMS), the Department of Labor (DOL) and the Nevada Division of Insurance (DOI).[1]

Contents

[1] Hometown Health will ensure all plan offerings, and operations comply with insurance law and do not conflict with Internal Revenue Service (IRS) and Department of Labor (DOL) requirements. However, it is the employer's sole responsibility to ensure compliance with IRS and DOL regulation when offering group coverage.

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

1. GROUP ELIGIBILITY

a. Generally, Hometown Health Association Health Plan products are available to any employer that is an approved membership type of the applicable association. For instance, if an association has a full membership and an associate membership, but only full members are eligible for coverage, employers that are associate members would not be eligible. Enrollment will not be effectuated until Hometown Health receives proof of the group's membership in the association.

b. Sole Proprietors not Eligible – Sole Proprietors are not eligible for association health plan coverage. A Sole Proprietor is an employer with no employees other than the owner's spouse or dependents (as defined by the Internal Revenue Code). A business owner without one non-familial employee (any employee other than one's spouse or dependents) is considered a Sole Proprietor and is therefore not eligible for association health plan coverage. However, an owner with at least one non-familial employee is not a Sole Proprietor and is eligible for coverage even if all non-familial employees waive under small group coverage.

c. Contract Plan Modifications (No Break in Contract) – Employers may submit plan changes at renewal. A group may only add or remove a plan during their anniversary month.

d. Change in Tax ID or Business Name – To ensure compliance with IRS 1094 and 1095 reporting requirements, if the business owner obtains a new Tax identification number or the business name changes, Hometown Health will require a letter from the business indicating the new Tax Identification Number and business name and the effective date of the change.

e. Guaranteed Issue and Renewability – Hometown Health will issue the health plans and rates offered to the applicable association to each small employer that is a member of the association and who is eligible for the health plan, based on underwriting criteria agreed to by Hometown Health and the association. Large employers may not be eligible, unless otherwise agreed to by Hometown Health and the association.

f. Geographic Service Area – For an employer group to be eligible for coverage they must have a physical address located in the product's geographic service area.
    i. If the employer's business address is in the product's geographic service area, the rates will be based on the Rating Area[2] where the business is located.

g. Exceptions to Guaranteed Issue and Renewability – These rules do not apply under certain circumstances. Additionally, Hometown Health may refuse to issue coverage or to renew coverage for any of the following reasons:

[2] Rating Areas are defined by the DOI as follows:
Rating Area 1 is Clark and Nye Counties.
Rating Area 2 is Washoe County.
Rating Area 3 is Carson City, Douglas, Lyon and Storey Counties and, if applicable, eastern California.
Rating Area 4 is all other Nevada counties.

i. Fraud – Misrepresentation of information regarding the employer or its employees;
ii. Non-payment of premiums;
iii. Non-payment of association dues;
iv. Inability to meet association eligibility requirements;
v. Inability to meet participation requirements (see Section 5 below);
vi. Inability to meet employer contribution requirements (see Section 6 below);
vii. Sole proprietor – Sole proprietors are not eligible for association health plan coverage; employers in which a bona fide employer-employee relationship does not exist are not eligible for coverage;
viii. Termination of Product – Hometown Health no longer offers a coverage in a particular market;
ix. Discontinuation of Product – Hometown Health discontinues offering a particular product in the group market;
x. Enrollee movement outside the service area – There is no longer any enrollee under the plan who lives, resides or works in the service area;
xi. Discontinuation of All Coverage – As allowed by state law; and
xii. Incorrect Market – If the group size does not meet the definition of a Small Group (unless Hometown Health and the association agree to cover large groups). Groups that are already enrolled in association coverage and who grow larger than 50 full time employees may remain on the association health plan as long as they meet all other underwriting criteria.

2. PREMIUM QUOTE CALCULATION

a. Number of Plans Selected by Employers – Hometown Health allows employers to select one (1) plan if only one (1) employee enrolls, up to two (2) plans for less than five (5) enrolled employees and up to three (3) plans for five or more (5+) enrolled employees. There is no restriction of metal levels offered. Employer groups that are covered under a plan with composite rates may select up to two (2) plans.

b. Supplemental benefits. The following supplemental benefits may be purchased (if available) for an additional cost:
   i. Dental – A group's dental selection must be clearly noted with the confirmed plan selection. Modifications to the dental plan will not be allowed for the contract period.
   ii. Vision – A group's vision selection must be clearly noted with the confirmed plan selection. Modifications to the vision plan will not be allowed for the contract period.

****** Required Group Application Documentation (Submit to Hometown Health)***

c. Hometown Health requires a complete application and submission of all required documents as defined below no later than the 20th of each month prior to the group's effective date. Once Underwriting receives the completed documentation listed below they will notify the Sales department within 2-3 business days if the group is initially approved. If an incomplete submission requires Underwriting to request additional information your group's effective date may be delayed.

1. Completed Application for Group Insurance (preferably on-line)
2. Plan Selection and Signed Rate Agreement
3. Completed Business Attestation Form
4. Completed Common Ownership Attestation Form
5. Signed Adoption Agreement & Eligiblity Attestation – Must be completed during the group's open enrollment period; otherwise, group is subject to termination.
6. Enrollment applications or enrollment file for electronic eligibility.
7. Waiver of Health Coverage for all Eligible Employees who are waiving coverage or who are eligible for and/or participation in COBRA. Underwriting reserves the right to request waivers on electronic applications to verify eligibility and participation.
6. Binder Check issued in company or owner name for first month's premium based on the census or, if actual enrollment is available, based on the actual enrollment. If there is any discrepancy between the binder amount and the final enrollment, the balance will be billed or credited on the first premium bill. Hometown Health requires at least 75% of the premium paid for new and renewing groups.
7. Most recent filed State Wage & Quarterly stating employee's status.
    i. Business Verification Form and two weeks of payroll receipts may be submitted for employees not listed on the Wage & Quarterly. Payroll must include company name, dates of payroll period, employee name, wages paid, and withholdings
8. Confirmation of physical business location for the selected product.
9. Hometown Health reserves the right to request an additional State Wage & Quarterly to verify the employer census in the following circumstances:
    a. Upon group renewal (60 day compliance letter released to group and broker with request). Group may not be renewed if documentation is not returned by Group's date of renewal.
    b. Verification of National Network
10. Business License Number
11. Contractor License (if applicable)
12. Businesses with owners that do not appear on the State Wage & Quarterly must provide of the following:
    i. Form 1040 Schedule C
    ii. US Return of Partnership Income Form 1065 (Schedule K-1)
    iii. US Return of Shareholder Income Form 1120S (Schedule K-1)
13. The groups enrollment in the applicable association must be complete and verifiable with the applicable association. Additionally, any other documentation required of the association, such as eligibility attestations or other documents, must be submitted to Hometown Health for verification.

3. RENEWALS

a. Timing – Hometown Health will conduct a review of the renewing group to determine if the group meets participation and contribution requirements and will notify sales of any groups with potential failures to comply. Renewal packages will be mailed or sent electronically to the group and broker 60 days prior to the anticipated renewal date.

b. Default Plan – If the employer does not submit renewal documentation that indicates their plan selection by the 9th of the month prior to the effective date of the renewal, the employees and their dependents will be defaulted to the mapped plan upon renewal. If the same plan does not exist, the employees and their dependents with be defaulted to a similar plan, as determined by Hometown Health.

4. MEMBER ELIGIBILITY AND ENROLLMENT

a. Enrollment Periods – Hometown Health will comply with the open enrollment, special enrollment and limited enrollment provisions listed in the applicable EOC.

b. Eligible Employee – An Eligible Employee is generally an employee who:
   i. Works an average of at least 30 hours of service per week or 130 hours of service per month;[3]
   ii. Is compensated for work by the employer and subject to withholding as it appears on a W-2 form;[4] and
   iii. Meets the employer defined waiting period[5]

   The owner/employer and any partners are considered an Eligible Employee for the purposes of obtaining association health plan coverage. Hometown Health coverage shall be made available to all eligible employees. A retiree who is collecting a pension from the Public Employees' Retirement System, whose last employer is the small group and who is eligible to continue coverage with the small group pursuant to NRS 287.023 and pursuant to the group's health plan is considered an Eligible Employee for the purposes of obtaining association health plan coverage.

c. Service Area Eligibility – Some employees who live out of the service area or outside the state may not be eligible for coverage.[6]
   i. HMO Out of Service Area Eligibility – Hometown Health will not offer association health plan HMO coverage to any employee that lives outside of Nevada.
   ii. EPO Out of Service Area Eligibility – Hometown Health will not offer association health plan EPO coverage to any employee that lives outside of Nevada.
   iii. PPO Out of State Eligibility – Hometown Health will not offer any new association health plan PPO coverage to any employee that lives and works outside the PPO Network Service Area[7] in the following circumstances:[8]
      1. New Small Groups that have more than 20% of their employees who live outside the State of Nevada may not enroll their employees who live and work outside the State of Nevada in Hometown Health coverage.

[3] 26 CFR § 54.4980H-1(a)(21)
[4] 26 CFR § 54.4980H-1(a)(15)
[5] 45 CFR § 147.116
[6] 45 CFR § 147.104(c)(i)(1) & NRS 689C.200
[7] The PPO Network Service Area is generally defined as the State of Nevada as well as those areas of eastern California that are east of the Sierra and near Lake Tahoe.
[8] This paragraph does not determine eligibility for the national network. To determine which employees are eligible to receive in-network benefits from Hometown Health's national network providers, see Paragraph 9.

A. At renewal Small Groups will be audited by Underwriting to ensure that the group has remained within the 15% threshold Hometown Health reserves the right to not renew groups that fall outside the national network guidelines.

d. Dependent Eligibility – Dependents must meet the eligibility requirements for dependents listed in the Enrollment and Eligibility section of the applicable EOC. Additionally, Employers may restrict dependent eligibility to one of the four following coverage options prior to open enrollment:[9]
   i. Employees only
   ii. Employees and children;
   iii. Employees, spouses and children; or
   iv. Employees, spouses, domestic partners and children.

e. COBRA and FMLA – Employers shall be required to comply with COBRA, state mini-COBRA and FMLA notice requirements and collection of premium as applicable. Hometown Health will continue coverage under COBRA and FMLA as required by law as long as the employer provides proper notice to Hometown Health.

f. Required Enrollment Information – Hometown Health prefers receiving enrollment information via electronic file or through EpicCare Link with the required information listed below. If the employer does not have access to electronic submission methods, a paper application for each applicant may be submitted. Enrollment information must be provided within thirty (30) days of the effective date of change. The following information is required for each employee and dependent who chooses to enroll in Hometown Health coverage:
   i. Employee (Subscriber) Last Name
   ii. Employee (Subscriber) First Name
   iii. Employee (Subscriber) Date of Birth
   iv. Employee (Subscriber) Social Security Number
   v. Employee (Subscriber) Gender
   vi. Enrolling Dependent(s) First Name(s)
   vii. Enrolling Dependent(s) Last Name(s)
   viii. Enrolling Dependent(s) Date of Birth
   ix. Enrolling Dependent(s) Social Security Number
   x. Enrolling Dependent(s) Gender
   xi. Effective Date of Coverage
   xii. Employee (Subscriber) Date of Hire
   xiii. Employee (Subscriber) Complete Home Address
   xiv. Plan Selection
   xv. Signature of Employee (Subscriber) (on paper applications; employer should keep a copy of employee's selection and signature for their records)
   xvi. Signature of Employer

[9] Hometown Health recommends that, if an employer chooses to cover dependents, the employer should also pay for a portion of the dependent's coverage. If an employer does not wish to pay for a portion of the dependents' coverage, the employer should probably not cover dependents to allow the dependent to receive Advance Premium Tax Credits on the state exchange.

g. Termination – Employers shall immediately advise Hometown Health when a Member is no longer employed or otherwise does not meet membership requirements. No person will be kept on an employer's payroll or otherwise be represented as a Member for the sole purpose of obtaining or maintaining coverage. Hometown Health shall be held harmless for all costs and fees incurred or associated with such an ineligible individual, including, without limitation, attorney fees and liability incurred in the defense of any claim or suit brought at any time by a person ineligible for coverage.

****** Required Eligibility and Enrollment Documentation (Employer Keep On File)***

It is the employer's responsibility to collect the appropriate documentation to support qualifying life events. This documentation includes birth certificates, adoption certificates or guardianship papers, marriage licenses, certificates of domestic partnership, death certificates, certifications of loss of coverage from an employee's previous insurer and any other documentation that substantiates the qualifying live event. Hometown Health or the applicable association may request a copy of any or all of this documentation in accordance with established audit criteria. Additionally, Hometown Health or the applicable association may request other documentation for the purpose of enrolling Members, processing terminations, affecting changes due to a Member becoming eligible for Medicare, affecting changes due to a Member becoming disabled or being eligible for short-term or long-term disability, determining the amount payable by the Member Employer Groups under the Contract, or for any other purpose reasonably related to the administration of the Contract. Hometown Health, the applicable association or their representative may perform a payroll audit upon five (5) business day's prior written notice.

****** Required Eligibility and Enrollment Documentation (Submit to Hometown Health)***

The employer must provide the following documentation:

1. Large Families – To effectuate coverage, families on age banded plans with more than 3 dependents under the age of 21 will be required to furnish a birth certificate for all covered dependents under the age of 21, families on composite rated plans with more than one dependent will be required to furnish a birth certificate for all covered dependents This documentation must be provided either at open enrollment or during a special enrollment.

5. PARTICIPATION REQUIREMENTS

a. Inability to meet Participation Requirements – Groups that cannot meet the minimum participation requirements described in this section on initial enrollment may not enroll in association health plan coverage.

b. Minimum Participation – Minimum participation requirements are as follows:
   i. Groups with two (2) eligible employees who do not have creditable coverage – Both employees must enroll in coverage;
   ii. Groups with three (3) eligible employees who do not have creditable coverage – Two (2) employees must enroll in coverage; and
   iii. Groups with four or more (4+) eligible employees who do not have creditable coverage – At least 50% of eligible employees must enroll in coverage.

   For the purposes of the minimum participation requirement calculation, employees with other creditable coverage will not be considered "eligible employees." Additionally,

Hometown Health will provide coverage to a single person (a "group" of one) as long as the employer is considered an employer, is not a sole proprietor and all other Eligible Employees have other creditable coverage.

c. New Employees Counted – Employees who have submitted an Enrollment Application and who are within the waiting period of their effective date will be considered when determining participation compliance.

6. EMPLOYER CONTRIBUTION REQUIREMENTS

a. Minimum Contribution – An employer must contribute a minimum of 50% of the cost of coverage for employee only coverage for each enrolled employee.

   i. Multiple Plans – If an employer offers multiple plan options, the minimum 50% contribution will be based on the lowest premium plan available to each employee.

b. No Contribution Requirement for Dependents – Employers are not required to pay for any portion of dependent coverage, though it is recommended (see Paragraph 4.d above and the accompanying footnote).

c. Additional Contribution Allowed – An employer may choose to pay for any portion of the cost of coverage above the minimums described in this section.

d. Full Premium Due – Regardless of the amount of contribution the employer elects to pay, full premium must be paid by the due date on the applicable invoice, regardless of whether the employer has collected the appropriate amount of premium from the employer's employees.

7. WAITING PERIODS

An employer may not have a waiting period with coverage that begins later than 60 days on or following the date of benefit eligible employment. An employer may elect to include a reasonable and bona fide orientation period, not to exceed 30 days, prior to the start of the waiting period.[10]

8. NEW GROUP DEDUCTIBLE CREDIT

For new groups, Hometown Health will provide credit for medical or combined deductibles met under prior group health coverage. Proof of the deductible amount must be submitted in a format defined by Hometown Health within 90 days of the group's effective date of coverage.

Hometown Health will not provide credit for any new employee who applies for coverage after the initial group deductible credit has been completed.

Hometown Health will not reprocess claims that were processed prior to the date the deductible credit list was received.

[10] 45 CFR § 147.116

9. NATIONAL NETWORK

National Network – Hometown Health's national network is the network of providers who are included in the network leased by Hometown Health.

a. HMO National Network Eligibility – Hometown Health does not offer its national network to any HMO member.

b. EPO National Network Eligiblity – Hometown Health does not offer its national network to any EPO member.

c. PPO National Network Eligibility – Hometown Health has a comprehensive network within the PPO Network Service Area as defined in section 4.c.ii and the accompanying footnote. The national network will only be available to employees in the following circumstances:
   i. The subscriber lives and works outside the PPO Network Service Area. Please see Paragraph 4.c.ii above for additional restrictions regarding this eligibility.
   ii. The subscriber's covered dependent is attending a college which requires the dependent's physical attendance at the college outside the PPO Network Service Area; or
   iii. The subscriber's covered dependent under the age of 19 who lives outside the PPO Network Service Area with the dependent's primary guardian.

   A spouse will not have access to the national network unless the subscriber lives and works outside the PPO Network Service Area as described in (i) above. A dependent will not have access to the national network unless one of the conditions described in (i) through (iii) above apply.

   To gain access to the national network, the employer or broker must provide Hometown Health the applicable eligibility provision above which applies to the member.

   The national network shall be available to a member effective on the first of the month following Hometown Health's receipt of a valid, approved request to provide access to the national network for that member.

THE BUILDERS ASSOCIATION OF NORTHERN NEVADA
BENEFIT TRUST FUND
Composite Rate Underwriting Guidelines
Effective July 1, 2023

NEW GROUP QUOTE CHECKLIST – A group may only apply once in a 12-month period. To receive a fully underwritten quote the following must be provided.

1. **Underwriting Risk**
    a. Group name, address and NAICS code (*required for all applicants*)
    b. Census, in Excel format including each employee and their dependents with the following information: first name, last name, date of birth, zip code, gender, current plan enrolled in, current tier, number of dependents enrolled, anticipated enrollment status (enrolling; waiving; termed). The census should include *all* employees, including those employees on medical leave, employees in their waiting period and employees who are waiving coverage (*required for all applicants*); and
    c. Monthly claims experience, subscriber and member count, and premium for the past 24 months, large claims over $25,000 for the past 24 months and current and renewal rates from the current carrier (*required for groups with 100+ eligible employees*); and

    Waivers are always required for those employees who do not want coverage at initial application and renewal.

2. **Verification of Business**
    a. Current State of Nevada Business License
    b. Current Contractor License – When the group has common ownership or multiple subgroups the majority of employees must be contractors or subcontractors.

NEW GROUP APPLICATION CHECKLIST – Upon underwriting acceptance, the following must be provided to verify group enrollment and eligibility

1. **Enrollment** - Enrollment / Change Forms or Waiver Forms
2. **Builders BTF Adoption Agreement & Eligibility Attestation**
    a. Employer must sign first page; must fill out all four pages
    b. no more than 2 plans elected
3. **Common Ownership Attestation** (not required if previously provided to Hometown Health for enrollment in another product)
4. **Verification of Employee Status** (not required if previously provided to Hometown Health for enrollment in another product except as may be required by Underwriting as discussed in paragraph 4.a of the Renewing Group Checklist below)
    a. Wage & Quarterly tax statement – most recent
    b. Two pay periods for new employees to include employee name, wages state and other deductions, hours worked in pay period
5. **Other**

a. Current Builder Association of Northern Nevada membership verified
b. Estimated premium "binder check" based on actual enrollment. 75% of premium must be paid for new and renewing groups.

BROKER REQUIREMENTS

Must be appointed by Hometown Health.

NEW GROUP SUBMISSIONS

For a group to obtain final rates, all documentation must be received and completed before the process can begin. The Underwriting Department must receive all completed documentation by the 20th of the month prior to the effective date. If Underwriting requires additional information, a later effective date may be assigned.

All groups are required to provide all the documentation noted on the New Group Application Checklist. If the group is a new company, it is required that the group is in business long enough to provide the required documentation (i.e. wage & quarterly or tax forms).

RENEWING GROUP CHECKLIST – At renewal, the following must be provided:

1. **Enrollment** –
    a. Enrollment / Change Forms for:
        1. Any employee changing plans at open enrollment
        2. Any employee newly enrolling in a plan (must also provide a medical assessment form)
    b. Waiver Forms for any employee waiving coverage who was previously enrolled in coverage
2. **Builders BTF Group Adoption Agreement & Eligibility Attestation**
    a. Employer must sign first page; must fill out first page
    b. No more than 2 plans elected
    c. Any item on pages 2-4 that is changing should be filled out
3. **Other**
    a. If the group has fewer than 7 subscribers enrolled, Underwriting may request a current Wage & Quarterly tax statement to confirm eligibility
    b. Current Builder Association of Northern Nevada membership verified

RENEWAL GROUPS

Upon renewal, all groups will be underwritten for continued coverage under Builders BTF composite rates. If a group is no longer eligible for the composite rates based on medical and pharmacy claims or other factors presented at time of renewal, other plan options will be presented.

If a group no longer qualifies for Builders BTF composite rates, they will need to wait at least 12 consecutive months to submit for underwriting again.

EMPLOYEES IN WAITING PERIOD

In determining the group's eligibility, the medical conditions of all employees and dependents will be evaluated. Employees in their waiting period must be included in the census for underwriting.

GROUP PARTICIPATION REQUIREMENTS

Enrollment will not be effectuated until Hometown Health receives a completed Builders BTF Eligibility Attestation and proof of the group's membership in the Builders Association of Northern Nevada.

An eligible employee is defined as a permanent employee who has a regular working week of 30 or more hours. Before coverage begins for a given employee, the employees must meet the employer's waiting period. All enrolled employees must have a bona fide employee relationship with the Employer Group: FICA/Federal/State taxes must be deducted by the employer, and employees must have workers compensation coverage (unless eligible to waive coverage).

All groups must have 50% of all eligible employees enroll into the group health plan or must show proof of credible coverage. To be considered credible coverage, all waivers must include a copy of member's insurance card or provide the Name and Phone number of the Insurance Carrier along with policy number. Groups must enroll at least 5 subscribers for the group to qualify for Builders BTF composite rates.

EMPLOYER CONTRIBUTION

An employer must contribute a minimum of 50% toward the employee only monthly premium.

MISREPRESENTATION OR FRAUD

If a group or individual within a group is found to have misrepresented themselves, the group's application may be declined, the group's coverage may be terminated, or the group may not be renewed.

Medical Assessment Form

Any information disclosed cannot be used to deny medical coverage to any individual within an approved group
(valid for 60 days)

FILL OUT FORM IN INK
***ALL* QUESTIONS MUST BE ANSWERED**
RETURN TO YOUR HR DEPARTMENT

A. EMPLOYEE INFORMATION

Business Name _____

Employee's Name _____ Job Title _____

Home Address of Employee _____ Full-time Hire Date _____
City State Zip

LIST ALL FAMILY MEMBERS TO BE INSURED – *If additional space is needed, attach, date and sign a separate sheet.*

	Name First MI Last	Sex M/F	Date of Birth MM/DD/YYYY	Height	Weight	Tobacco, nicotine or E-cigarette use	If last name different explain relationship*
Employee						☐Yes ☐No	☐ Married ☐ Single
Spouse						☐Yes ☐No	
Child						☐Yes ☐No	
Child						☐Yes ☐No	
Child						☐Yes ☐No	
Child						☐Yes ☐No	

** If last name is different from employee, legal documentation must be provided.*

B. THE FOLLOWING QUESTIONS MUST BE ANSWERED ACCURATELY AND COMPLETELY

* Please provide details in section C

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any healthcare professionals during the last 5 years for any illness, injury or health condition listed below? Check all that apply and explain fully in section C.

1. ☐ **Cancer / tumor / cyst** – ☐Brain ☐Breast ☐Esophagus ☐Stomach ☐Colon ☐Leukemia ☐Lymphoma ☐ Multiple myeloma ☐Kidney ☐Liver ☐Lung ☐Melanoma ☐Pancreas ☐Prostate ☐ Testicular ☐ Cervical ☐ Uterine ☐ Throat ☐ Thyroid ☐Other cancer (type/location _____) ☐Non-malignant tumor (type/location _____)
   Diagnosis date _____ Cancer stage (0-4; if known) ___ Cancer category (if known) ☐ In situ ☐ localized ☐ regional ☐ distant
   Treatment: ☐Surgery date _____ ☐Chemo timeframe _____ – _____ ☐Radiation timeframe _____ – _____
   ☐ Remission ☐Yes ☐No If yes, provide date of remission _____
2. ☐ **Heart / vascular –** ☐ Aneurysm (location _____) ☐Blocked arteries (e.g. carotid, heart, abdomen, legs) ☐Heart attack ☐Heart valve disorder ☐Congestive heart failure ☐Cardiomyopathy ☐Irregular or abnormal heart rhythm ☐Stroke ☐Vasculitis (type _____) ☐Bypass / angioplasty / stent (location _____) ☐Pacemaker or cardiac defibrillator ☐ Other*
3. ☐ **Blood / clotting disorder –** ☐Hemophilia (specify type below) ☐Anemia (specify type below; e.g. sickle cell, hemolytic, aplastic) ☐Blood clots ☐ Other*
4. ☐ **Reproductive / gynecological –** ☐Current pregnancy: specify if it's a spouse, dependent child or other expectant parent even if not listed on the application (due date _____, if multiples # ____, any complications _____) ☐ Intending to adopt ☐Infertility ☐ Other*
5. ☐ **Gastrointestinal / endocrine –** ☐Diabetes ☐Crohn's / ulcerative colitis ☐Autoimmune hepatitis ☐Cirrhosis ☐Pancreatitis ☐Hepatitis B (specify acute or chronic) ☐Hepatitis C (if cured, when did treatment end? _____) ☐Growth disorder ☐Adrenal, pituitary, thyroid gland disorder (specify type below) ☐Other disorders of the gallbladder, stomach, pancreas, liver, colon*
6. ☐ **Brain / neurological –** ☐Amyotrophic lateral sclerosis ☐Cerebral palsy ☐Neuropathy / polyneuropathy ☐Multiple sclerosis ☐Myasthenia gravis ☐Muscular dystrophy ☐Brain and/or spinal cord disorder or injury ☐Paralysis, quadriplegia, paraplegia ☐Other*
7. ☐ **Immune / dermatology –** ☐HIV or Aids ☐Immunodeficiency disorder ☐Connective tissue disorder (specify type below; e.g. lupus, scleroderma) ☐Heredity angioedema ☐Skin disorder (specify type below; e.g. psoriasis, eczema, ulcers, infections) ☐Other*
8. ☐ **Lung / respiratory –** ☐Cystic fibrosis ☐COPD, chronic bronchitis, emphysema ☐Pulmonary hypertension ☐Pulmonary fibrosis ☐Asthma ☐Sarcoidosis ☐Other*
9. ☐ **Urinary / kidney –** ☐Kidney disease / disorder (specify type below) ☐Kidney failure ☐Dialysis: date started _____ ☐Possible dialysis within the next 18 months ☐Bladder disorder ☐Prostate disorder ☐Other (specify details below)

10. ☐ **Musculoskeletal –** ☐Rheumatoid arthritis ☐Psoriatic arthritis ☐Disorder of the back / neck / spine ☐Chronic pain disorder ☐Disorder of the joints (specify location; e.g., hips, knees, shoulders) ☐Osteomyelitis ☐Amputation ☐ Other*

11. ☐ **Mental health / Substance abuse –** ☐Alcohol and/or drug abuse (specify type below) ☐Eating disorder ☐Anxiety / depression ☐Bipolar disorder ☐Schizophrenia ☐Suicide attempt ☐Oppositional defiant / conduct disorder ☐Autism ☐ABA therapy ☐ Other*

12. ☐ **Transplant –** ☐Organ or bone marrow / stem cell transplant already performed (date _____) ☐Future transplant planned / scheduled (date _____) ☐Transplant discussed / recommended / possible within the next 18 months ☐Transplant complications ☐Other*

13. ☐ **Birth / inherited conditions –** ☐Premature birth (gestational age:____ # weeks) ☐Congenital birth defect ☐Genetic / metabolic disorder ☐Any syndrome* ☐Other*

14. ☐ **Eyes / ears / nose / throat –** ☐Acoustic neuroma ☐Cataracts ☐Cleft lip / palate ☐Deviated septum ☐Glaucoma ☐Retinopathy ☐Chronic ear infections ☐Chronic sinusitis ☐Other*

15. ☐ **Incapacitated –** ☐Disabled ☐Handicapped ☐Congenital disorder ☐Other*

16. ☐ **Medications –**

- ☐ Have you or any of your dependents ever received IV infusion medications that are typically administered by a doctor or nurse in a doctor's office, hospital, other health care facility, or at home?
- ☐ Have you or any of your dependents taken specialty medications? Specialty medications are high-cost oral or injectable medications used to treat complex or rare chronic conditions such as cancer, rheumatoid arthritis, hemophilia, HIV, psoriasis, inflammatory bowel disease, and hepatitis C. These can also be defined as drugs that cost greater than $700 per month supply.

17. ☐ **Other* –** ☐Hospitalizations in the past 5 years ☐Other conditions not addressed elsewhere in the application ☐Future surgeries or hospitalizations discussed, planned, recommended or scheduled in the next 18 months

C. *PROVIDE COMPLETE DETAILS BELOW FOR ALL HEALTH CONDITIONS SELECTED ABOVE AND THOSE NOT LISTED

If additional space is needed, attach, *date and sign* a separate sheet. Write N/A if not applicable.

Ques. No.	Enrollee Name	Medical Condition	Treatment / Medication (include surgery, hospitalization, DME, supplies, and all medicines)	Dates Treated From MM/YY To MM/YY	Is treatment ongoing? If **yes**, provide details of any current or future treatment

Please provide COMPLETE names and addresses of all attending doctors/hospitals/clinics and the condition for which treatment was received

Name of Doctor (including Family Practitioner)/Hospital/Clinic	Address	Phone Number	Medical Condition / Enrollee Name

D. APPLICANT'S STATEMENT – READ CAREFULLY:

I certify that all information provided in this application is full, complete and true to the best of my knowledge, information and belief. If I become aware of any new information that would change any answer on this form after I have completed this enrollment form but before the effective date of coverage, I agree to provide that information to BANN's Administrator as soon as possible. I understand that any material misstatement or failure to provide requested information may be used as a basis of termination of my coverage. When applicable, I authorize my employer to deduct premiums from my earnings. I understand that no coverage will be effective until this application has been approved by the insurer. I understand that this information is not valid after 60 days from completion.

Employee Signature: _____ Date: _____

Application and Adoption Agreement for Association Health Plan Employer Group Enrollment

Groups that are new to this Association must complete this entire application.
Groups that are renewing must complete pages 1 and 2 and any section that has changed from the previous year's application.

BANN BTF 2022 Age Banded

This APPLICATION AND ADOPTION AGREEMENT FOR ASSOCIATION HEALTH PLAN EMPLOYER GROUP ENROLLMENT ("Agreement") in the association health plan program provided by Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc. (collectively referred to as "Hometown Health") and Builders Association of Northern Nevada Benefit Trust Fund ("Association") is hereby submitted by the following Employer Group:

1. FULL LEGAL NAME OF EMPLOYER GROUP

_____

2. LOCATION ADDRESS

_____
Street City State Zip Code

3. REQUESTED EFFECTIVE DATE (first of a month) ASSOCIATION GROUP ID

_____ _____

All days begin and end at 12:00 midnight. All initial and renewal terms will be 12 months

I certify that:

1. Employer Group is a bona-fide business establishment that meets and will continue to meet all Association Health Plan Participation Requirements.
2. Employer Group desires to enroll in and agrees to the terms of the Policy and this Agreement, the Association's Group Subscription Agreement, the applicable Evidence of Coverage and Schedule of Benefits and the Association Health Plan Participation Requirements.
3. Employer Group understands and agrees to distribute all plan documents consistent with Association's Guidelines for Distribution, abide by the eligibility rules applicable to employee and dependent enrollment, COBRA continuation of coverage notice requirements, regardless of the number employees employed by Employer Group, and payment rules as provided in the approved Plan, this Agreement and the Policy and that this Agreement can only be revised at renewal in writing.
4. Employer Group will fully defend, indemnify and hold harmless Association and its Trustees, employees, consultants and administrators against any and all loss, damage, liability, claim, demand or suit resulting from injury or harm to any person or property arising out of or in any way connected with the participation of the Participating Employer under this Adoption Agreement. This is intended to include, but is not limited to, employment-related claims, statutory violations, breach of contract claims and claims for damages resulting from personal injury or injury to property.
5. Employer Group understands and agrees to abide by the following prepayment requirement: Monthly prepayment fees are due and payable, in full, by the first day of the calendar month for which services are provided. Premium is delinquent if not received by the 15th of the month. Coverage will terminate on the last day of the month retroactive to the month for which payment is not received. Any other payment arrangements require our prior approval.
6. Employer Group herewith tenders $_____and, in consideration of approval of the Agreement, promises to pay any balance necessary to constitute the full initial payment herein identified. It is understood that Association and/or Hometown Health have the right to accept or reject this Application. Coverage will not commence until the Agreement has been accepted.
7. To the best of my knowledge and belief, the information provided in this Application is true and is the basis for issuance of coverage.

_____
Print name and title of **Employer Group** representative

_____ _____
Signature of **Employer Group** representative Date

_____
Producer Title, Name & Agency

_____ _____
Producer Signature Date

For Hometown Health use only:
Approved effective date: _____
Parent code: _____

THE BUILDERS ASSOCIATION

Application and Adoption Agreement for Association Health Plan Employer Group Enrollment

Hometown Health

5. TAX INFORMATION:
4a. Federal Tax ID #: _____ 4b. IRS Section 125: ☐ YES ☐ NO

4c. Year Business Established _____

6. MAILING ADDRESS (if different from the location listed in item 2 above):

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

7. NAME & TITLE OF OWNER, GENERAL MANAGER OR CEO:

_____
Name Title

Telephone: _____ Fax: _____ Email: _____

8. COMPANY BILLING NAME AND ADDRESS (If different from legal name in item 1 above):

_____
Name

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

9. BUSINESS INDUSTRY OR NATURE OF BUSINESS:

_____ _____
Description NAICS Code

10. COMPANY TYPE: ☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S–Corp.
☐ Political Subdivision ☐ Union ☐ Sole Proprietor ☐ Other: _____

11. COMPANY SIZE:
10a. #Employees (FT & PT): _____ 10b. #Employees Eligible To Enroll: _____ 10c. #Employees Waiving Enrollment: _____
10d. Please check appropriate box below to indicate your organization's size:
☐ Less than 20 full- or part-time employees*
☐ 20 to 99 full- or part-time employees*
☐ 100 or more full- or part-time employees*
* If organization represents multiple employer groups, please count employees in other groups also.

12. EMPLOYEES BY COUNTY
Enter the number of employees eligible to enroll that live in the following areas (total should equal 10b above):
1 – Clark & Nye: _____ 2 – Washoe: _____ 3 – Carson, Douglas, Storey, and Lyon: _____
4 – All other Nevada: _____ 5 – All other out of state: _____

13. OTHER COVERAGE:
Does your company offer other insurance options (i.e. dental/vision) not associated with Hometown Health? ☐ YES ☐ NO
13a. If Yes:
Coverage Type: _____ Carrier Name: _____
Coverage Type: _____ Carrier Name: _____

14. EMPLOYER CONTRIBUTION:
Enter the percentage (%) or dollar ($) amount (minimum is 50% of total funding requirement):

Hourly Employees	Salaried Employees	Other (Please specify):
Employees: _____	Employees: _____	Employees: _____
Dependents: _____	Dependents: _____	Dependents: _____

15. CORPORATE CONTACT:

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

16. LOCAL CONTACT (If same as corporate contact, leave blank):

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

17. PREMIUM BILLING CONTACT (If same as corporate or local contact, leave blank):

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

18. OTHER CONTACT (If applicable):

Name _____ Title _____

Telephone: _____ Fax: _____ Email: _____

19. EMPLOYEE ELIGIBILITY:
All employees who meet the waiting period requirement and who work at least 30 hours per week are eligible. Additionally, those employees who are on Family Medical Leave Act (FMLA) leave are eligible.

20. DEPENDENT ELIGIBILITY:
- ☐ Employee Only
- ☐ Employees and dependent children
- ☐ Employees, spouse and dependent children
- ☐ Employees, spouses, domestic partners and dependent children

21. WAITING PERIOD

Eligible employment begins on:

☐ On the date of hire (default).

☐ Following a reasonable and bona fide employment-based orientation period of ____ days (not to exceed 30 days).

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

Salaried	Hourly	Other (Please list)	Once eligible employment begins as described above, employee *coverage* begins:
☐	☐	☐ :	☐ 1st of the month on or following date of eligible employment
☐	☐	☐ :	☐ 1st of the month on or following ____ day(s) of eligible employment (60 days max)
☐	☐	☐ :	☐ 1st of the month on or following 1 month of eligible employment

22. REHIRE POLICY:

This section only applies to employees that were covered under the employee health plan on the date of termination of the immediately previous employment period.

☐ Does not apply (default – rehire policy will default to newly eligible employee provisions)

☐ If rehired within ____ days (365 days max) then coverage effective on the 1st of the month following rehire.

☐ If rehired within ____ months (12 months max) then coverage effective on the 1st of the month following rehire.

23. COVERAGE BEGIN AND END:

Employee coverage always begins on the first of the month. Dependent coverage always begins on the first of the month, except in the case of birth, adoption or placement for adoption, in which case coverage begins on the date of the event and in the case of loss of other coverage in which case coverage begins on the day after loss of coverage. Coverage always ends on the last day of the month in which the employee ceases to be eligible, except in the case of death.

24. PAYMENT PROVISIONS:

If coverage begins on: The 1st through the 15th of the month – FULL PREMIUM and HEALTH PLAN FUNDING DUE
The 16th through the end of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE

If coverage ends on: The 1st through the 15th of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE
The 16th through the end of the month – FULL PREMIUM and HEALTH PLAN FUNDING DUE

25. PRODUCER OF RECORD (New producers contract Sales & Marketing at (775) 982-3100):

Company/Agency

Producer Name

26. SECOND PRODUCER OF RECORD (if applicable; new producers contract Sales & Marketing at (775) 982-310):

Company/Agency

Producer Name

☐ Split commission. Second producer of record will receive _____% (1-99%) of the commissions applicable to this employer group.

THE BUILDERS ASSOCIATION OF NORTHERN NEVADA
BENEFIT TRUST FUND

Annual Eligibility Attestation
By Participating Employer

I, _____ hereby attest on this ____ day of _____,
(full name of attester) (date) (month)

20___ that my organization, _____ ("Organization"),
(year) (name of member employer group)

meets one or more of the following Builders Association of Northern Nevada Benefit Trust Fund ("BANN") eligibility requirements:

-- check all that apply --

- ☐ Active Contractors License
- ☐ Developer
- ☐ Direct Jobsite Service/Facilitation
- ☐ Critical Component (e.g. Engineering, Architect, Planner, etc.) whose primary revenue stream is the building industry
- ☐ Supplier Direct to Builder or Industry Member whose primary revenue stream is the building industry
- ☐ Specialized scope of work/services offered in building/construction whose primary revenue stream is the building industry

Furthermore, this attestation authorizes BANN, or its authorized representative, to audit applicable records to confirm that Organization meets the eligibility requirements selected above, no more than one time annually. Such audit shall not cause undue burden on Organization. Organization may require BANN, or its authorized representative, as applicable, to sign reasonable confidentiality agreements.

The undersigned representative of Organization has reviewed the above information, agrees to its accuracy and is not an insurance agent or broker.

Signature: _____

Title: _____

Builders Association of Northern Nevada
Benefit Trust Fund
Guidelines for SPD Distribution

As a participating employer in the BANN Benefit Trust Fund, ***it is the employer's responsibility to ensure the Summary Plan Description (SPD), Evidence of Coverage, and Schedule of Benefits are distributed to all participants***. The DOL can impose significant penalties against employers that fail to distribute SPDs in accordance with the applicable regulations. The SPD must be distributed in a manner reasonably calculated to ensure actual receipt, which means it may be hand delivered or sent by first, second or third class mail.

Prior to distribution, the employer should fill out the information on page 1 of the SPD, check the applicable waiting period at the bottom of page 1 and check the applicable dependent coverage on page 7. The SPD is not complete without inclusion of the Evidence of Coverage and Schedule of Benefits for your applicable BANN BTF plan. If you offer other benefits, you should contact your HR or benefits expert to ensure you comply with the requirement of 29 CFR Part 2520.

Due dates for distribution:

- *New Participants* – The employer should distribute the SPD to a new participant when they become a plan participant, but no later than 90 days after the employee becomes a plan participant.
- *New or Renewal Plan* – The employer should distribute the initial SPD for a new or renewal plan to all participants as soon as possible, but no later than 120 days after the effective date or renewal date.
- *Request from Participant or Beneficiary* – SPDs must also be distributed to a participant or beneficiary who requests the SPD within 30 days of the request.

Acceptable methods of distribution:

- In-hand delivery to employees at their worksites.
- Special insert in an employee periodical if:
    - the distribution list is comprehensive, up to date, and accurate, and
    - the front page prominently states the SPD is inserted. (Note: If some participants and beneficiaries are not on the mailing list for the periodical, this method may be combined with another distribution method.)
- First-class mail.
- Second- or third-class mail if return and forwarding postage are guaranteed and address corrections are requested. (Note: If SPDs are distributed by second- or third-class mail and an SPD is later returned with a corrected address, the plan administrator must distribute the SPD again by first-class mail or personal delivery to the participant at his or her worksite.)

Recordkeeping:

We recommend employers keeps a record of the method of distribution of the SPD, Evidence of Coverage and Schedule of Benefits in each employee's file.

Hometown Health

ATTESTATION FORM

For Sole Proprietor or Business where the Owner is the Sole Employee

PARTNERSHIPS WITH NO EMPLOYEES

BUSINESS ORGANIZATION INFORMATION

Name of Organization _____

State Business License Number _____

Primary Business Activity _____

Address _____

City _____ State _____ Zip _____

CONTACT INFORMATION FOR BUSINESS ORGANIZATION

Last Name _____ First Name _____ Middle Initial _____

Title _____

Telephone _____ Fax _____

CHECK ONE BELOW

☐ **Sole Proprietor or Business where the Owner is the Sole Employee**

I hereby attest that: (i) I am the owner and operator of the above described business organization; (ii) I work a minimum of thirty (30) hours per week for this business organization; (iii) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization.

☐ **Partnership**

I hereby attest that: (i) I am one of the owners of the above described business organization and have the authority to enter into an agreement to purchase health insurance coverage on behalf of all of the partners of this business organization; (ii) the above business organization does not offer health insurance coverage to any of the partners through another company; (iii) the above business organization does not have any "W-2" employees; (iv) only the partners that work a minimum of thirty (30) hours per week for this business (and their eligible dependents) will seek health coverage through the organization.

☐ **None of the Above**

If the above does not describe you, check here; no signature is needed.

I agree to provide upon request appropriate tax forms to Hometown Health to validate the eligibility status. Before application will be approved, the applicant must execute this Attestation Form and provide the tax information and related documents indicated on the attached checklist. Hometown Health reserves the right to modify these documentation and eligibility requirements in the future. I agree to promptly advise Hometown Health in the event that any of the statements made in this Attestation are no longer accurate. The undersigned certifies that, to the best of his or her knowledge and belief, and under penalty of perjury, the information listed above is true and complete.

Signature of Applicant _____ Date _____

Hometown Health

COMMON OWNERSHIP CERTIFICATION

PLEASE COMPLETE, SIGN AND SUBMIT THE COMMON OWNERSHIP CERTIFICATION.

This form must be filled out and returned even if you do not have multiple companies.

Please list all employer groups that qualify under 26 USC Section 414(b) (c) (m) or (o) of the Internal Revenue Code.

COMPANY INFORMATION

Name of Employer Group _____

Business Owner _____

Primary Business Location _____

Name of Business Entity	Employer Federal Tax ID Number (FEIN)	Percentage of Ownership	Number of Full-Time Equivalent (FTE) Employees
1			
2			
3			
4			
5			
6			

- **A FULL-TIME EMPLOYEE** is an employee who is employed on average, per month, at least 30 hours of service per week, or at least 130 hours of service in a calendar month.
- **A FULL-TIME EQUIVALENT EMPLOYEE** is a combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.
- **AN AGGREGATED GROUP** is commonly owned or otherwise related or affiliated employers, which must combine their employees to determine their workforce size.

I certify that the group named above is a single employer under section 414 of the Internal Revenue Code of 1986 (26 U.S.C. Section 414 (b), (c), (m), or (o)), and under any applicable state law. I further certify that there are no other affiliated entities other than the ones listed above who are eligible to file a combined state tax return. I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I understand that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Signature _____ Date _____

Relationship to company *(Please Check One of the Following)*

☐ Owner ☐ HR Rep ☐ Accountant for Employer ☐ Attorney representing employer

HOMETOWN HEALTH USE ONLY

G# _____

M# _____

L _____

F, M _____

Hometown Health

ENROLLMENT / CHANGE FORM

HUMAN RESOURCES ONLY

Employer _____ Group Number _____

Effective Date _____ Employee's Weekly Hours _____ Employee's Date of Hire _____

Employer Signature _____

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____

City _____ State _____ Zip _____ County _____

Physical Address _____

City _____ State _____ Zip _____ County _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation _____ Home Phone _____ Work Phone _____

PLAN ELECTED

*Street Address only, no P.O. Boxes

☐ HMO	☐ EPO	☐ PPO	☐ PPO w/HSA*
Plan Elected	**Plan Elected**	**Plan Elected**	**Plan Elected**

OTHER MEDICAL COVERAGE

Do you or any of your Dependents listed on the next page have Medical/Health Insurance (Including Medicare/Medicaid)?

☐ ***YES*** ☐ ***NO***

If yes, please provide copy of insurance card (front & back).

CONTRACT TERMINATION ONLY

Completion of this section will terminate coverage for subscriber and all dependents.

☐ Left Company
☐ Deceased
☐ Moved
☐ Ineligible
☐ Dissatisfied
☐ Other *(If other, explain below)*

REASON FOR CHANGE

☐ New Hire
☐ Name
☐ Annual Election
☐ Rehire
☐ COBRA (18-29-36)
☐ Other *(If other, explain below)*
☐ PT/FT
☐ Reinstatement
☐ Waive Coverage
☐ Retiree
☐ Transfer
☐ Address

Plan Change From _____ To _____

ADD/DELETE DEPENDENT

☐ Marriage**
☐ Birth/Adoption**
☐ Loss of Dependent Status**
☐ Loss of Insurance**
☐ Divorce**
☐ Other**
☐ Court Ordered/ Legal Guardianship**
☐ Deceased**

***Attach legal documentation as proof of event.*

MEMBER INFORMATION – COMPLETE WITH NEW OR CHANGE INFORMATION

EMPLOYEE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

SPOUSE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

***Attach legal documentation as proof of action (Add, Change or Delete).*

† It is member's responsibility to verify physician availability in their area.

ACKNOWLEDGMENT OF TERMS

Employee Signature ______ Date ______

See Next Page

Hometown Health

ACKNOWLEDGMENT OF TERMS

I understand and agree that, with the exception of emergency procedures, all services must be performed by a Hometown Health participating provider, or authorized in advance by Hometown Health, to be considered for payment at the in-network rate. Additional requirements may apply. See the appropriate plan documents for details.

I understand that I am responsible for paying any required deductibles, copayments, and coinsurance directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to Plan Types

HMO Health Maintenance Organization
PPO Preferred Provider Organization
TPA Third Party Administrator for self-funded plan
HSA Health Savings Account

STATEMENT OF ACCOUNTABILITY

To be completed only when the applicant cannot complete the application
NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English
☐ Applicant does not write English ☐ Other *(Explain)* _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant ☐ Or by _____

I also translated and fully explained the "Application Understandings, Conditions and Agreement," and "Payment Method."

Translator Signature *(Required)* _____ Date *(Required)* _____

I confirm that the application was translated on my behalf.

Applicant Signature *(Required)* _____ Date *(Required)* _____
Language interpreted *(e.g. Spanish)* _____

10315 Professional Cir. • Reno, NV 89521 • 775-982-3232 • hometownhealth.com

Hometown Health

WAIVER OF HEALTH COVERAGE BENEFITS

All the sections on this form must be completed and signatures are required from employee and employer.

SEE INSTRUCTIONS ON PAGE 2

EMPLOYER INFORMATION

Name of Employer _____

Address _____

City _____ State _____ Zip _____

Telephone _____

APPLICANT / EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Date of Hire _____ Job Title _____

OTHER COVERAGE INFORMATION

Do you have other health benefit coverage?

☐ ***YES*** – If Yes, please complete below

☐ ***NO*** – I do not have other health insurance coverage

Coverage Information

Name of primary person on policy _____

Name of Employer or the Party providing health care coverage _____

Name(s) of dependent(s) covered on policy _____

Name of health plan provider / insurer _____

PLEASE ATTACH A PHOTOCOPY OF YOUR HEALTH PLAN PROVIDER ID CARD.

VALIDATION OF WAIVER OF BENEFITS

*I understand that I have been offered group health insurance by my employer, with Hometown Health. I have elected **NOT** to enroll myself, and/or my dependent(s). I understand that if I and/or my dependent(s) decide, at some time in the future, that I (we) desire this coverage, I must wait for my employer's "open enrollment' period, or special enrollment period due to qualifying event. (i.e.: Divorce, marriage, birth of child, death, loss of medical insurance, etc).*

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Comments _____

Hometown Health

INSTRUCTIONS

ALL THE SECTIONS ON THIS FORM MUST BE COMPLETED
and signatures are required from employee and employer.

EMPLOYER INFORMATION

1. Enter company data in the appropriate Employer information areas.

APPLICANT / EMPLOYEE INFORMATION

1. Enter your personal data in the appropriate Applicant / Employee information areas.

OTHER COVERAGE INFORMATION

1. Please indicate if you do or do not have other health benefit coverage.
2. Please indicate the name of both the Employer, the primary member holding this insurance coverage and the insurance carrier providing you and/or your dependents with the coverage.
3. Attach a photocopy of the Plan Provider ID card.

VALIDATION OF WAIVER OF BENEFITS

1. **EMPLOYEE**
   Read the statement carefully, then sign and date the Waiver of Coverage Form. Please return the form to your employer.
2. **EMPLOYER**
   Please sign form before returning to Hometown Health.

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Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

APPLICATION WILL NOT BE CONSIDERED COMPLETE WITHOUT
THE REQUIRED DOCUMENTATION LISTED BELOW.

Please be aware that rates are subject to change based on final information and census.

Business Name _____ Effective Date _____

ALL APPLICANTS

- ☐ **Completed application and plan selections**
- ☐ **Current Nevada State Business License or Notice of Exemption letter from Nevada Secretary of State**
- ☐ **Completed Common Ownership Attestation**
- ☐ **Completed Business Attestation** *(Partnerships Only)*
- ☐ **Enrollment application, electronic enrollment application, or enrollment file for electronic eligibility**
- ☐ **Estimated 1st month premium binder check**
  - Any discrepancy between the binder amount and the final enrollment will be billed or credited on the first premium bill.

BUSINESSES WITH "W-2" EMPLOYEES

- ☐ **Most recent filed State Wage & Quarterly**
  - Businesses in operation less than three months must submit Articles of Incorporation along with two weeks of payroll in lieu of the State Wage & Quarterly.
- ☐ **Two weeks of payroll receipts for employees that do not appear on the group's State Wage & Quarterly**
  - Business Verification Form maybe submitted in lieu of payroll at Underwriting's approval
- ☐ **Waiver of Health Coverage Benefits for all Eligible Employees who are waiving coverage or who are eligible for and/or participating in COBRA. "Eligible Employee" means a permanent employee who has a regular working week of 30 or more hours**

BUSINESSES WITH OWNERS THAT DO NOT APPEAR ON THE STATE WAGE & QUARTERLY

PROVIDE AT LEAST ONE ITEM FROM THE LIST BELOW

- ☐ **Partnership Business Type** – US Return of Partnership Income Form 1065 *(Schedule K-1)*
- ☐ **S Corporation Business Type** – US Return of Shareholder Income Form 1120S *(Schedule K-1)*
- ☐ **Limited Liability Company (LLC) with Partners** – Form 1065 *(Schedule K-1)*

BUSINESSES APPLYING FOR BUILDERS ASSOCIATION OF NORTHERN NEVADA

BUILDERS/SUBCONTRACTORS

- ☐ **Current contractor license**
- ☐ **Builders Association Eligibility Attestation**

Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

DOCUMENTATION REQUIREMENTS FOR EACH BUSINESS TYPE.

Business Type	In business more than 3 months	In business less than 3 months
C CORPORATION	Nevada Employer's Quarterly Contribution and Wage Report	Payroll records and Articles of Incorporation
S CORPORATION	Nevada Employer's Quarterly Contribution and Wage Report or K-1 for shareholder's income	Payroll records and Articles of Incorporation
PARTNERSHIP	K-1 for partner's income or Schedule SE (self-employment tax) or Form 1065 Partnership Return and Nevada Employer's Quarterly Contribution and Wage Report for employees.	Partnership Agreement and SS-4 (application for tax id) and payroll records
LIMITED LIABILITY COMPANY (LLC)	May file as either a C Corporation or a Partnership (refer to above)	May file as either a C Corporation owner or a Partnership (refer to above)

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Order Form and Add-On Services Agreement

Employer hereby subscribes for the Services indicated below and agrees to pay the fee set forth below, on the payment terms set forth in this Order Form and the Terms and Conditions. If any terms and conditions contained in this Order Form conflict with terms and conditions of any previously executed agreements, the terms set forth in this order form shall supersede those conflicting terms. The Initial Term of the Agreement begins with the First Billing Date and continues for the Initial Term specified below. If neither party gives notice of non-renewal at least 60 days before the end of the Initial Term or any succeeding Renewal Term, the Agreement automatically renews for an additional one-year term ("Renewal Term"). Billing begins on the First Billing Date, regardless of whether or when Employer begins using the Services.

Section 1. Employer Information

Employer Legal Name (hereinafter "Employer")			
Account Number		# of FEINs	**1**
FEIN Number			
Initial Term	**One (1)**		
Bill To	**Hometown Health HHP**		
Total Employees			
Implementation Contact			
Date		Email Address	
Name			
Phone Number		Fax number	
Mailing Address			

Agency Details

Agency Name		Agency Contact	
Phone		Fax	
Address			
Email		Other	
We authorize designee for:	☐ Online Access	☐ COBRA Notice Contact	
	☐ PHI Contact	☐ Receive Reports	

Section 2. Summary of Service and Fees

RECURRING FEES

Item	Quantity	Unit Type	Rate	Monthly Minimum	Annual Minimum
COBRA Notices Admin : Core Service		PIEPM	*		*
		Select			
		Select			
		Select			
		Select			
Promotion					

**COBRA, POP, ERISA and ACA bill on an annual basis*

ONE-TIME FEES

Item	Total

Section 3. The Agreement, Terms and Condtions, Order Forms adn other Documents

The Agreement between the Employer and isolved (together the "Parties," and each individually a "Party") means the Terms and Conditions contained at https://www.isolvedhcm.com/legal/agreements/terms-and-conditions or any other previously agreed to Terms and Conditions, together with the Additional Terms and Conditions below and any associated Addenda, Service Summary and any applicable Service Terms, Statements of Work or other written documents made between Employer and isolved, whether by execution of such document by both Parties incorporated by reference.

isolved Benefit Services Terms and Conditions

Additionall Benefit Services Terms and Conditions

Signatures

isolved HCM Services, LLC

By:

Date of Signature:

Title:

Name:

Employer:

By:

Date of Signature:

Title:

Name:

Address

11215 N. Community House Rd, Suite 800

Charlotte, NC 28277

Phone: (980)272-1921

Email:

Address

City

State & Zip Code

Phone:

Email:

COBRA

Employer Legal Name:

Notices – The information provided below will be used to generate the COBRA notices for your company.

1. Provide the name of your group health plan:

If you do not provide it, we will list it as "(Legal Name) Group Health Plan"

2. Are there locations or insured employees who reside in California? ** ☐ Yes ☐ No ***If no, move to question 3*

If not answered or both are answered, isolved Benefit Services will include

a. Is the group health plan fully insured or self insured? ☐ Fully insured ☐ Self-insured

b. Is the group health plan written in the state of California? ☐ Yes ☐ No

c. Are 51% or more of your employees and the principal place of business located in California? ☐ Yes ☐ No

3. Does your company sponsor any group health plan insurance or HMO contract(s) written in the state of Illinois? ☐ Yes ☐ No

4. Does your company sponsor any group health plans written in any of the following states?

☐ Arizona	☐ Delaware	☐ Minnesota	☐ Pennsylvania	☐ Virginia
☐ Colorado	☐ Georgia	☐ New Jersey	☐ Texas	☐ Washington D.C.
☐ Connecticut	☐ Maryland	☐ New York	☐ Utah	

5. Who is your Plan Administrator?

If you do not provide it, we will use the employer as the Plan Administrator

COBRA Activity

1. How will you be reporting New Enrollees/General Notices and Qualifying Events? (please select one of the following)

☐ File Feed (EDT/EDI) – please note, file feed builds can take up to 8-12 weeks

☐ Direct Entry via COBRA Online Portal ☐ isolved integration

2. Is there anyone on your group health plan currently receiving coverage under COBRA? ☐ Yes ☐ No

3. Is there anyone who has recently been mailed a COBRA event notice and is still within their 60-day COBRA election period? ☐ Yes ☐ No

4. OBRA of 1989 amended COBRA to allow an employer to choose an optional extension of COBRA time frames. This provision allows employers to calculate the COBRA coverage from the loss of coverage date instead of the qualifying event date. Normally, COBRA coverage is calculated from the event date, often causing COBRA coverage to begin while still covered as an active plan participant or for the COBRA coverage to end in the middle of a month. With your carrier's approval, COBRA coverage can be calculated from the loss of coverage date. COBRA coverage would then expire at the end of the final month of COBRA. **NOTE: Always check with your carrier prior to using this rule and obtain their approval in writing.**
Choose either OBRA of 1989 Rule for coverage period end or Month End Expires Rule for coverage period end:

☐ OBRA of 1989 Rule (COBRA ends 18/29/36 months from loss of coverage);

☐ Month End Expires (COBRA ends last day of 18/29/36 months of COBRA coverage);

☐ Neither (COBRA ends 18/29/36 months from event date). If none selected, this option will be applied.

COBRA Activity Continued

5. isolved Benefit Services delays the aging of participant records for nonpayment by a variable time period called the mail transit period. This period allows payments which are postmarked within the grace period to reach us before coverage is terminated. This mail transit period is typically between seven and ten calendar days. For shortened mail transit periods, if a valid payment postmarked within the grace period is received after a Removal due to nonpayment has been sent to you, a Reinstatement will be sent requesting that you reinstate the COBRA coverage. Shortened mail transit periods may result in an increase in Reinstatements.

*Do you wish to shorten the mail transit period for any of your plans? ☐ Yes – Number of Days ☐ No

** If unanswered, isolved Benefit Services will use the standard eight (8) days

(Please note: isolved Benefit Services highly recommends that at least three (3) mail transit days be allowed. If you wish to shorten the mail transit period for any of your plans, a Mail Transit Period Change Form will be provided for your signature.)

Additional Information

The General Notice of COBRA Rights is a required COBRA notice. Notification to participants already covered on the

plan is done by a blanket mailing as part of the implementation of the account.

isolved Benefit Services Blanket Mailing Service: A Memorandum of Agreement will be needed for this service and will be provided by the Account Manager setting up your account. This would be at an additional charge of $3. 45 per notice with a $50 minimum.

Do you wish to use our blanket mailing services ☐ Yes ☐ No

isolved Benefit Services offers three options for reporting COBRA elections, terminations and plan changes to carriers. Please choose one option.

- ☐ isolved Benefit Services sending the report to the employer or third-party contact: The employer or third party will be responsible for communicating reinstatement/removal and plan changes to the carrier. If a reporting option is not selected, the account will be setup with this option.
- ☐ isolved Benefit Services faxes or emails report to the carrier: An authorization form will be required for this option. Carrier direct reporting will be implemented upon receipt of the signed form. Employer will receive copies of the report and should audit the reports and carrier records on a regular basis to confirm all changes were made.
- ☐ COBRA Eligibility Management Service: isolved Benefit Services will communicate COBRA elections, terminations and plan changes directly to the carriers utilizing the carrier's web portals. Additional fees may apply for this service. The employer will receive reports for auditing purposes, but isolved Benefit Services will handle the work. Please note: If you choose this option, you must complete the attached Application for isolved Benefit Services COBRA Eligibility Management and return it along with the COBRA Setup Forms.

For COBRA Eligibility Management Service (CEMS) we expect to receive access to all carriers within 45 days from our initial contact. After 45 days, if the project is not showing progress, the isolved Benefit Services Team will close the project. Closed projects will not receive follow up reminders from the isolved Benefit Services Team. We will begin billing upon receipt of the first carrier's credentials.

Coverage Information – Indicate the types of health plans offered by your company:

☐ Medical	☐ Dental	☐ Vision	☐ Wellness Program
☐ Health FSA	☐ Health Reimbursement Arrangement (HRA)	☐ Employee Assistance Plan (EAP)	☐ Other

Please complete the coverage information form to include each of these plans.

Coverage and Plan Information

Instructions

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

Special Note Regarding Health Reimbursement Arrangement (HRA) Premiums:

HRA plans are subject to COBRA and require a COBRA premium. You must offer COBRA even if the HRA has a spend-down provision that allows participants to spend down their unused account balance after termination of employment.

Per COBRA law, the COBRA premium is 102 percent of the total cost of coverage to the plan. Because an HRA is a self-funded group health plan, there are special rules for calculating the total cost of coverage to the plan. These rules are in 26 USC §4980B(f)(4), a copy of which is available from isolved Benefit Services. In summary, two options are available:

- **Reasonable Actuarial Estimate:** A reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries that is determined on an actuarial basis.
- **Past Cost:** The cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period, adjusted for inflation. This option is not available for new HRAs or HRAs experiencing a significant design change in the current plan year.

Because an HRA has less than a 100 percent utilization rate each year, it is not permissible to simply use the annual contribution as the basis for calculating the HRA COBRA premium. Determining the applicable HRA COBRA premium may require assistance from an accountant, reinsurance carrier or other professional service. Your broker may be able to assist as well. Isolved Benefit Services clients can access an HRA Premium Calculation Tool located on our website behind your Client Login. Just enter your username and password and look for **HRA COBRA Premium Calculation Tool.**

Account Name:

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

isolved Benefit Services will calculate the 2% administration fee and send you a confirmation. Do not include the 2% fees in your rates below.

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Important: After your account is established, you will receive a Plans and Rates report listing premiums. Please review the report carefully to ensure accuracy of rates.

Completed by (please print): Date:

Account Name:

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

isolved Benefit Services will calculate the 2% administration fee and send you a confirmation. Do not include the 2% fees in your rates below.

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Important: After your account is established, you will receive a Plans and Rates report listing premiums. Please review the report carefully to ensure accuracy of rates.

Completed by (please print): Date:

Account Name:

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

isolved Benefit Services will calculate the 2% administration fee and send you a confirmation. Do not include the 2% fees in your rates below.

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Important: After your account is established, you will receive a Plans and Rates report listing premiums. Please review the report carefully to ensure accuracy of rates.

Completed by (please print): Date:

Client* Electronic Funding Authorization

Contact Information

Company Legal Name	
DBA Name (if applicable)	
FEIN	
Contact Person Name	
Phone:	Email:

For new bank accounts a voided company check and the bank verification letter must be supplied with this form.

Default Bank Account Information

Bank Name
Bank Address
Bank Routing Number
Bank Account Number

Service Fees

Client authorizes isolved to debit Client bank account at the beginning of each month for the agreed upon monthly rate as well as any other additional services agreed upon and rendered that are associated with the Documentation.

Use Default Bank Account | Use Bank Account Below | ☑ Not Applicable

Primary Contact		Title	
Phone	Email		
Bank Name	Bank Phone Number		
Bank Transit Routing Number: ABA#			
Bank Account Number			
Bank Address	City	State	Zip

*"Client" has the same meaning in this Client Electronic Funding Authorization ("Authorization") as "Employer" in the Documentation.

**Client agrees that for any services or fees added or any other changes to Client's services after the Effective Date (as defined in the Documentation), isolved will use the Default Bank Account identified in this Authorization for withdrawals or debits associated therewith, unless Client amends this Authorization.

Payroll ACH Processing

If the services provided hereunder include Direct Deposit Services, Client authorizes isolved to debit Client Accounts in the amount of the payments to be made on behalf of Client in accordance with the Documentation, including any Fees. The funds transfer from Client to isolved will occur on the first Business Day prior to the date that payroll deposits are to be made to the Payee Accounts (the "**Check Date**"). Client will arrange with isolved to transmit its payroll data including payroll amounts, payroll dates, employee bank account information, and any other information provided to isolved in connection with the Services (collectively, the "**Payroll Data**"). isolved will timely attempt to process but shall not be liable for stop payments and direct deposit debits requested by Client. isolved will retain the interest earned on Client funds held in an isolved account while payment of such funds to others is pending.

Client and Employee Authorizations. Client shall obtain and maintain, at its sole cost and expense, any and all licenses, permits and other authorizations necessary to perform its business and duties hereunder in a lawful manner including the debiting and crediting to the designated bank accounts of Client's employees (the "**Payee Accounts**") and the debiting of payments from the Client's authorized accounts (the "**Client Accounts**"). Prior to the first credit or debit to the account of any employee or other individual (a "**Payee**"), Client will obtain an Employee Direct Deposit and Debit Authorization in the form required or approved by isolved ("**AEDDA**") from such Payee. The AEDDA will include (i) authorization from such Payee to the initiation of credits and debits from any such Payee's account and (ii) an agreement from such Payee to repay and authorization to withhold from future checks that may be payable to such Payee, any funds deposited in error to such Payee Account that may not be available to reverse due to insufficient funds in such Payee's Account, closure of such Payee Account or other reason. Client will retain a copy of each AEDDA during the period such AEDDA is in effect and for two years thereafter and will furnish such copy to isolved upon request. Client represents and warrants to isolved and for the benefit of the bank originating (the "**Originating Bank**") debit/credit instructions on isolved's behalf, if applicable, that: (a) each credit and debit (reversing or correcting a prior payroll credit) to the account of a Payee is timely and has been authorized pursuant to an AEDDA signed by such Payee and held by Client; (b) at the time any debit/credit is made to the account of any such Payee, Client has no knowledge of the revocation or termination of such AEDDA; c) each debit to the account of a Payee is for a sum which is due and owing to Client, and that Client has the Payee's authorization to make the debit; (d) the amount indicated by Client as being owed to each Payee is in fact due and owing to such Payee; and (e) Client's electronic credit payments comply with United States laws and all other applicable laws.

The payment for Payroll ACH services rendered will be direct debited from Employer's bank account listed above or you can complete the information below if you would prefer a different account be used for your payroll and tax filing obligations

Use Default Bank Account	Use Bank Account Below	☑ Not Applicable

Primary Contact	Title
Phone	Email
Bank Name	Bank Phone Number
Bank Transit Routing Number: ABA#	
Bank Account Number	
Bank Address	City / State / Zip

Benefit Services

ACH transactions for COBRA Remittance
On a monthly bases, isolved will generate and make available Premium Remittance Reports as well as any Voucher Premium Invoice Reports: as applicable, through the secure COBRA/Direct Billing portal (i.e. The Download Center). These reports will be available to the designated contact(s) of Client on the first day of each month and will identify the remittance amount that will be sent by direct deposit. isolved will remit payment of premiums received within five (5)business days of delivery of the Premium Remittance Report.

☐ Use Default Bank Account ☐ Use Bank Account Below ☐ Not Applicable

Primary Contact Title

Phone Email

Bank Name Bank Phone Number

Bank Transit Routing Number: ABA#

Bank Account Number

Bank Address City State Zip

ACH transactions for COBRA fees
Client authorizes isolved to debit Client bank account for fees in accordance with the Documentation.

☐ Use Default Bank Account ☐ Use Bank Account Below ☐ Not Applicable

Primary Contact Title

Phone Email

Bank Name Bank Phone Number

Bank Transit Routing Number: ABA#

Bank Account Number

Bank Address City State Zip

ACH transactions for Add-On Service fees
Client authorizes isolved to debit Client bank account for fees in accordance with the Documentation.

☐ Use Default Bank Account ☐ Use Bank Account Below ☐ Not Applicable

Primary Contact Title

Phone Email

Bank Name Bank Phone Number

Bank Transit Routing Number: ABA#

Bank Account Number

Bank Address City State Zip

Benefit Services Continued

ACH transactions for Fringe Benefit fees
Client authorizes isolved to debit Client bank account for fees in accordance to the Documentation.

Use Default Bank Account	Use Bank Account Below	☑ Not Applicable

Primary Contact	Title		
Phone	Email		
Bank Name	Bank Phone Number		
Bank Transit Routing Number: ABA#			
Bank Account Number			
Bank Address	City	State	Zip

This Authorization is executed pursuant to and shall be incorporated into as an integral part thereof, the Documentation between isolved and Client for the provision by isolved of certain administrative services related to certain Client benefit plans ("Benefit Plan(s)") and other services to Client, as such may be amended from time to time. Client hereby authorizes isolved to initiate debit entries and/or credits from time to time to the most recently provided Client bank account (or default bank account, whichever is provided last in time) o n record with isolved for transactions associated with the Documentation, including but not limited to recurring service fee payments and/or reimbursements. Client must notify isolved of any change to the then current Client bank account on record with isolved by written notification to isolved as required by isolved no less than thirty (30) calendar days in advance of the desired effective date of the change. Client understands the National Automated Clearinghouse Association Rules ("NACHA Rules") and laws of the United States will apply and Client agrees to comply at all times with same. Client represents and warrants to isolved that Client's electronic credit payments comply with NACHA Rules and all applicable laws and isolved reserves the right to and Client agrees to allow isolved from time to time to audit Cient's compliance with applicable laws . Client represents and warrants that it shall produce evidence of this Authorization and authorization of Payee Accounts upon request from isolved, the relevant bank any interested regulator(s).

The person executing this Authorization on Client's behalf is a duly authorized representative of Client, with full power and authority to bind Client as set forth herein. isolved may at any time and for any reason terminate this Authorization after providing Client reasonable notice. This Authorization shall remain in full force and effect until termination of the Documentation or written notice of the termination of this Authorization in such time and manner as to allow isolved and any third parties involved in the debit entries and/or credits a reasonable opportunity to act upon such notice.

Employer
Signature
Print Name
Title
Date

Claims Funding Arrangement Options for Fringe Benefit Services

Claims Based (Client funding provided as Participants incur claims):

Reimbursements initiated off isolved's bank account (checks, direct deposits, debit cards)

Client hereby authorizes isolved to print, sign and release checks or process ACH transactions and, if necessary, void and reissue checks or reverse ACH transactions for any errors from the designated account and depository (bank or financial institution) named below. I (we) further agree that in the event an ACH transaction fails for reasons not attributable to isolved Benefit Services, reimbursements related to the failed ACH will be held until another ACH transaction can be reprocessed, and the above-named Company shall be subject to and pay a $75 ACH processing failure fee.

Reimbursements initiated off clients designated account (checks and direct deposits)

Client hereby authorizes isolved to initiate ACH debits against Client's designated account("Account") at the depository financial institution named below. isolved is hereby authorized to initiate ACH debits from the Account, daily or as applicable if less frequent than daily, for the amount equal to the total check and direct deposit issued amounts submitted and paid for the previous business day by isolved. Client must provide a voided check with a MICR line added attached to the Check Signature Authorization form provided.

Bank Name: Routing Number: Account Number:

Please check this box if you wish to have debit cards issued for participant use:

Client hereby authorizes The Bancorp Bank (Bancorp) to initiate ACH debits against Client's designated account("Account") at the depository financial institution named below. Bancorp is hereby authorized to initiate ACH debits from the Account equal to the total participant debit card transaction settlement amounts, daily or as applicable (if less often than daily), for the debit card transactions submitted and paid for the previous business day by Bancorp. Additional banking forms for Bancorp Bank will need completed if this is selected.

Disbursement options:

Direct Deposits and Checks will be created on the isolved benefit services custodial account based on the disbursement frequency below.

Weekly on Monday Tuesday Wednesday Thursday Friday

Daily Other

Contribution Based (Client funding provided based on scheduled employee deductions* only available for FSA and HSA plans):

Ongoing Funding: Client hereby authorizes isolved to initiate an ACH debit against Client's designated account

("Account") for each pay period contribution amount on or before each applicable pay date in which contributions are deducted. In the event an ACH transfer fails for reasons not attributable to isolved, the above-named Client shall be subject to and pay a $75 ACH transfer failure fee. I (we) acknowledge that frequent ACH transfer failures may result in this option no longer being available, at isolved's sole discretion. If at any time, funds are not available for claims reimbursement due to this method of funding, isolved may notify Client of the deficiency and Client will be required to provide additional funds. Reimbursements may be suspended until funds are available for claims reimbursement.

Reconciliation: At the completion of each plan year, any remaining funding shall be reconciled and returned to Client (less amounts owed to isolved) as soon as administratively feasible, but in general, no later than sixty (60) days after the completion of any run-out period and any ancillary manual claims settlement.

Signature: Print Name: Date:

Broker Onboarding & Commissions

Onboarding Resources

Contents

Hometown Health Broker Onboarding

Looking To Get Appointed with Us?

Contact our team at brokeronboarding@hometownhealth.com

What We Need to Get Started:

- Agency - A Licensed Agency who is paid commission for associated Writing Agents
  - ☐ Line of Business you are interested in selling (MA, Commercial or Both)
  - ☐ NPN (National Producer Number)
  - ☐ Email

- Independent Agent/Broker - A Licensed Agent who is paid directly and does not work for an agency.
  - ☐ Line of Business you are interested in selling (MA, Commercial or Both)
  - ☐ NPN (National Producer Number)
  - ☐ Email

- Writing Agent/Broker - A Licensed Agent who works for an agency and is paid by their agency
  - ☐ Line of Business you are interested in selling (MA, Commercial or Both)
  - ☐ NPN (National Producer Number)
  - ☐ Email
  - ☐ Agency's information if not yet appointed (NPN, Email & Line of Business selling)

Be Prepared to Upload the Following Documents:

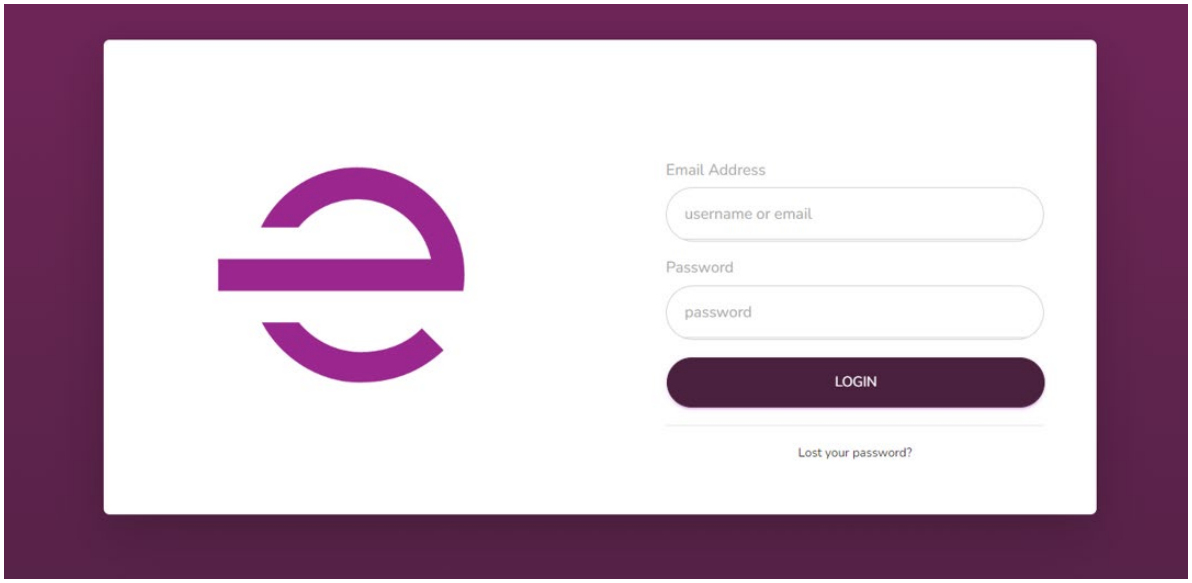
- ☐ Banking information (if paid directly)
- ☐ America's Health Insurance Plan (if selling MA)
- ☐ Error and Omissions Certificate
- ☐ License
- ☐ W9

Once the above information is provided, you will receive an email from Evolve to start the onboarding process. Evolve NXT is our broker portal – the following pages in this section provide step-by-step instructions on "how to access statements, book of business and onboarding agents."

NOTE: If you are selling Medicare, there will be a broker test during onboarding in the portal.
To review the study guide, please visit:
brokers.hometownhealth.com/become-a-broker/

EVOLVENXT

To begin the onboarding process email brokeronboarding@hometownhealth.com: send the agent/agency NPN, Email, and Product considering to sell (MA, Commercial or both).



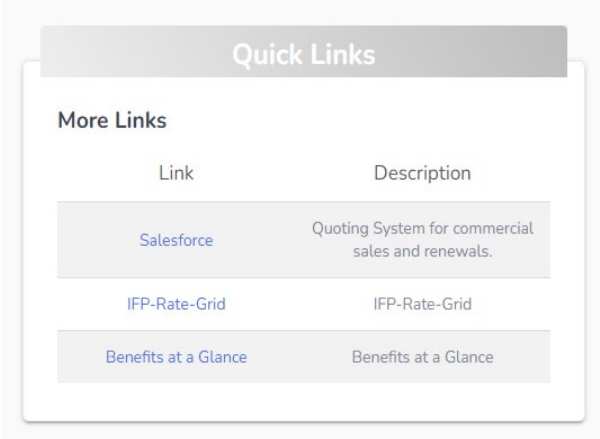
EVOLVE PORTAL GUIDE

EVOLVE PORTAL
URL: https://hth.evolvenxt.com/login.htm

AGENT/AGENCY DASHBOARD

Quick Links

Helpful URL links to access quickly

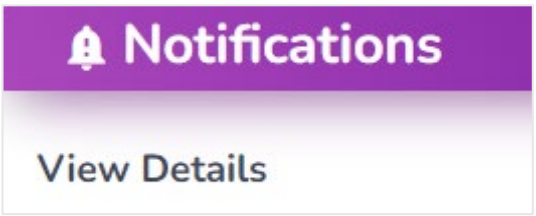


Commissions

Graphical View of commissions earned

Notifications

Click View Details to see messages



My Downline's Credentials (Agency Only)

Graphical View of commission

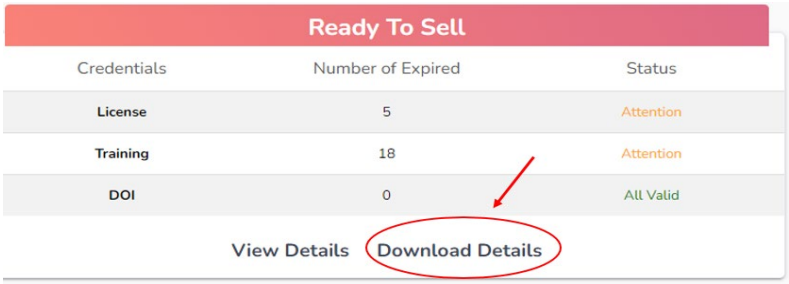
Book of Business

Graphical View of MA and Commercial

Ready to Sell (Agency Only)

Displays what License, Training and DOI are valid or need attention

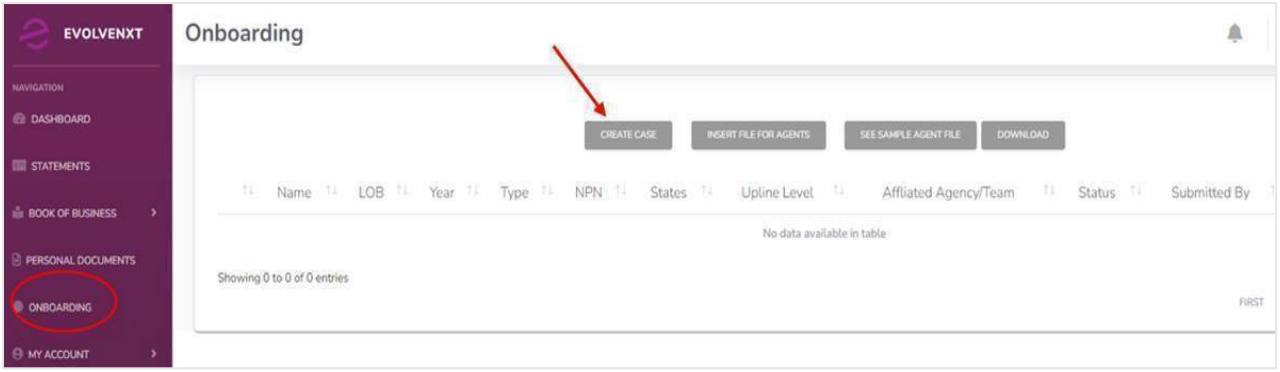
- Select Download Details > Excel report will generate > select the tabs to view



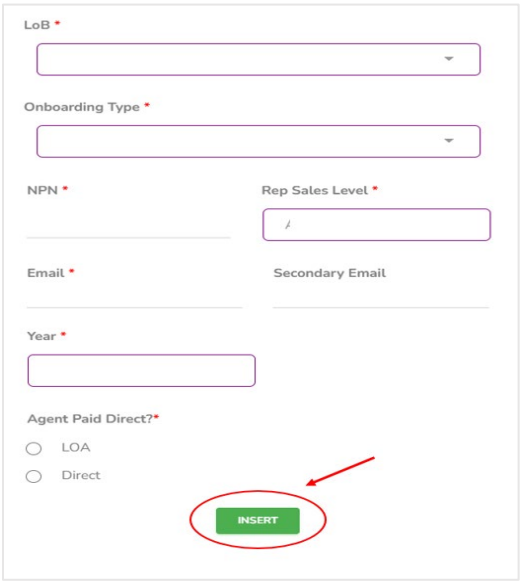
ONBOARDING

AGENCY CREATING NEW ONBOARDING CASE

- Select ONBOARDING tab > CREATE CASE



- Complete fields accordingly (if LOB is Medicare select Medicare & Commercial)
- Sales Level: Agent 01, General Agency 10 or Master Agency 20
- Select LOA-commissions paid to Agency or Direct-commissions paid to agent



AN EMAIL NOTIFICATION IS SENT OUT TO THE AGENT/AGENCY WHEN A CASE IS CREATED.

- If you have an existing Evolve profile login with other carriers use current credentials

From: donotreply@evolvenxt.com <donotreply@evolvenxt.com>
Sent: Wednesday, April 6, 2022 12:21 PM
To: Test Testing <TestTesting@hometownhealth.com>
Subject: Evolve Agent Contracting Registration

Dear Test Testing,

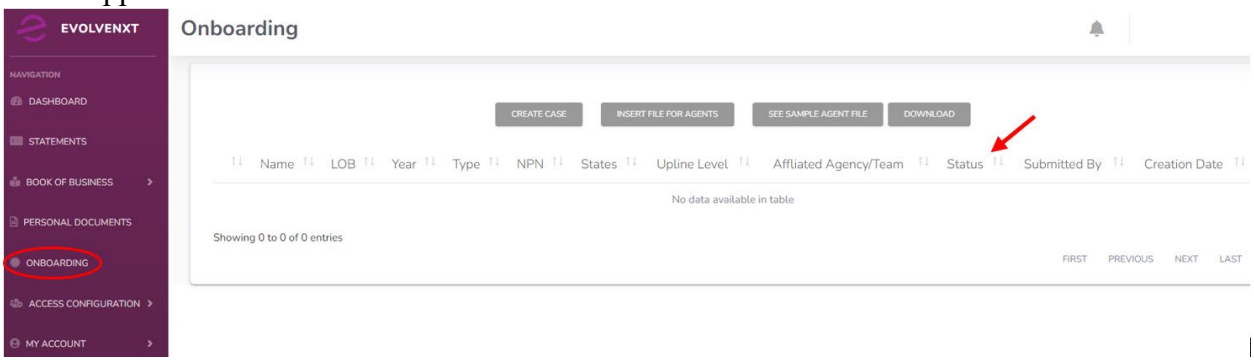
Please use the link below in order to complete your contract and 2022 certification for Hometown Medicare Advantage and Commercial Group Plans.

URL: https://hth.evolvenxt.com/login.htm
Login email address: Test.Testing@hometownhealth.com
Password: C7A3897AD273

If you are unable to access the link above or have any questions regarding the process, please contact your upline agency, or Broker Onboarding at brokeronboarding@hometownhealth.com or call Hometown Health Broker Services at 775-982-3100.
Thank you!

ONBOARDING CASE STATUS

- Under ONBOARDING view Status
- If Approved a welcome RTS email notification will be sent



- If Denied or Incomplete an email notification will be sent to the agent
  Email Example:

From: donotreply@evolvenxt.com <donotreply@evolvenxt.com>
Sent: Wednesday, April 27, 2022 3:40 PM
To: Test Testing <TestTesting@hometownhealth.com>
Subject: Hometown Health 2022 Contract and Certification Incomplete - Action Required

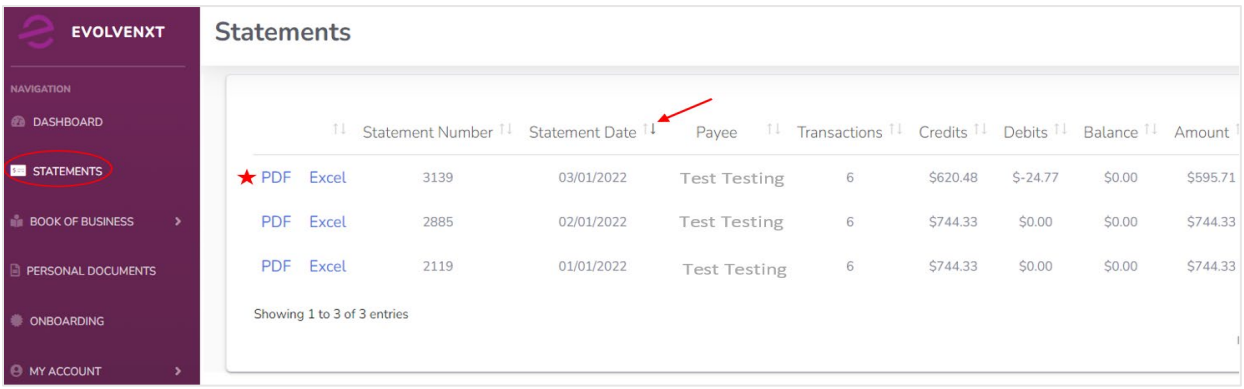
Dear Test Testing,

We are unable to complete your contract and 2022 certification at this time. Please see comment below in order to correct the information.
If you would like commissions to be paid directly to you, please enter banking information. Otherwise, please disregard and resubmit. Thank you!
You will need to login to the portal in order to correct the information above.
URL: https://hth.evolvenxt.com/login.htm

If you are unable to access the link above or have any questions regarding the process, please contact your upline agency, or Broker Onboarding at brokeronboarding@hometownhealth.com or call Hometown Health Plan Broker Services at 775-982-3100.
Thank you!

STATEMENTS

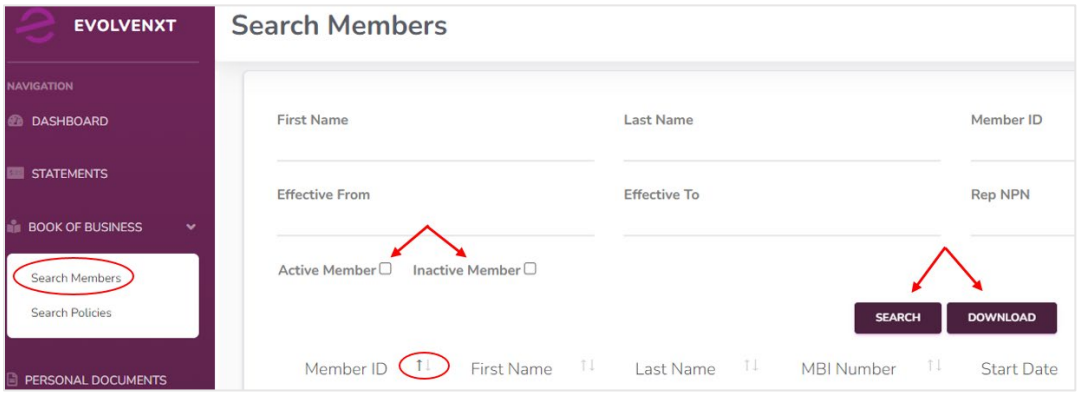
- Select STATEMENTS in the navigation menu
- The arrows ↑↓ on each tab let you ascend/descend
- Statement can be uploaded as PDF or Excel-(this format will have more details)



BOOK OF BUSINESS

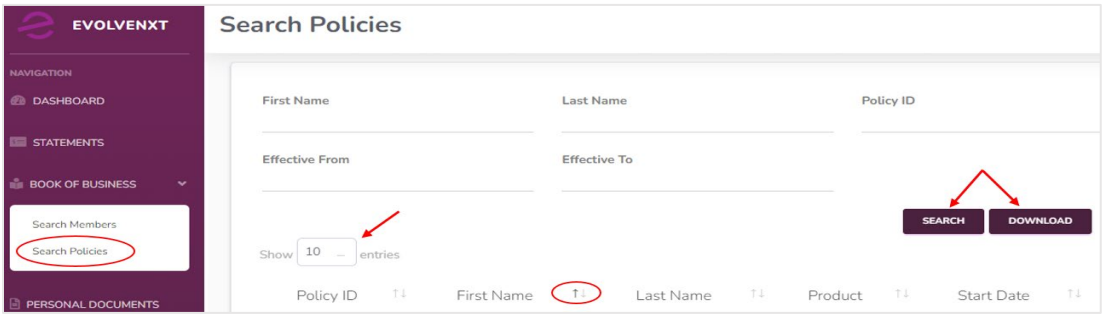
SEARCH MEMBERS (MA ONLY)

- Option to SEARCH by any field, and/or active/inactive members
- The arrows ↑↓ on each tab lets you ascend/descend
- Select DOWNLOAD to see report in an Excel format



SEARCH POLICIES (COMMERCIAL)

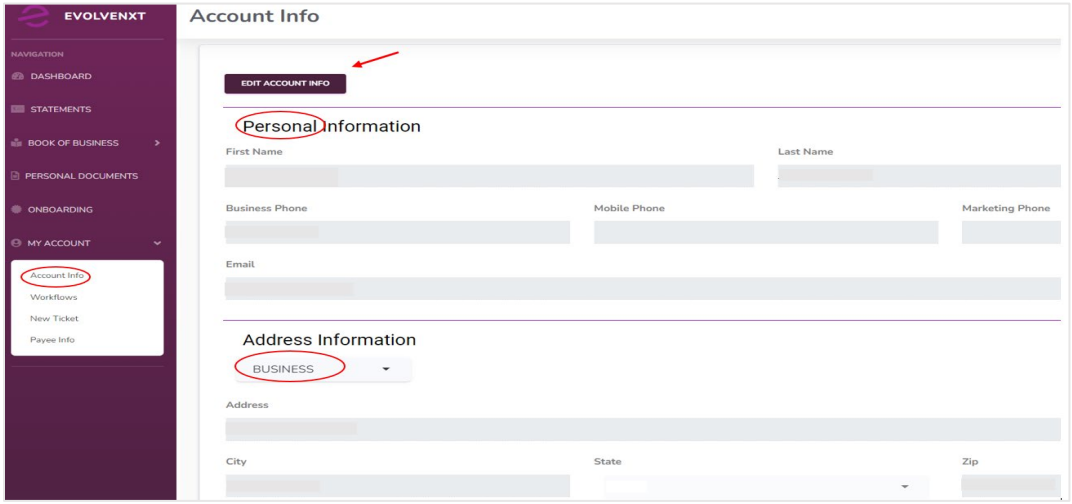
- Option to SEARCH by any field
- The arrows ↑↓ on each tab lets you ascend/descend
- Select DOWNLOAD to see report in an Excel format



MY ACCOUNT

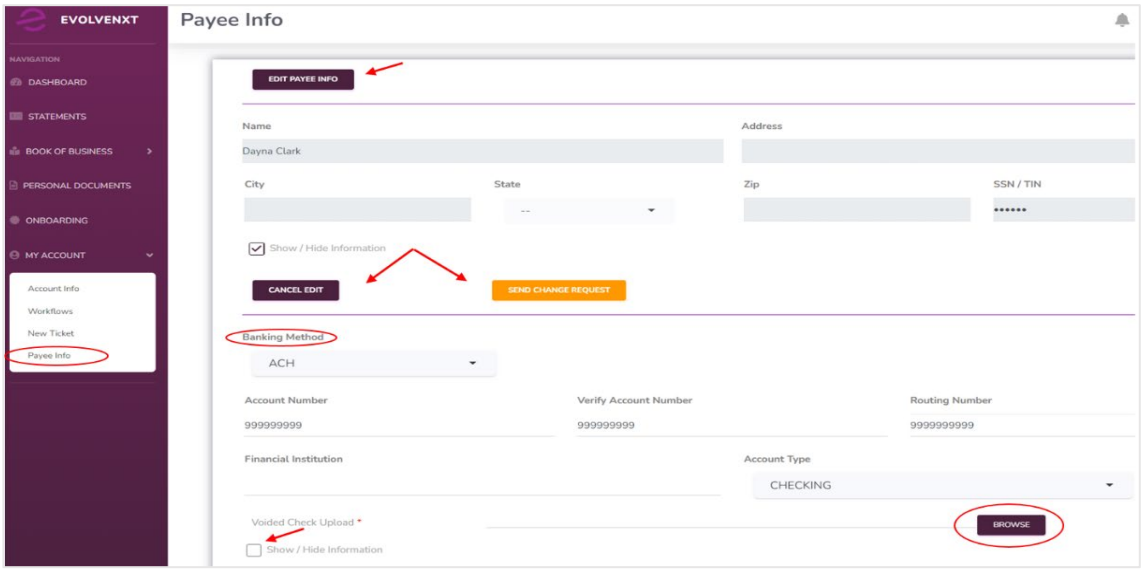
ACCOUNT INFO

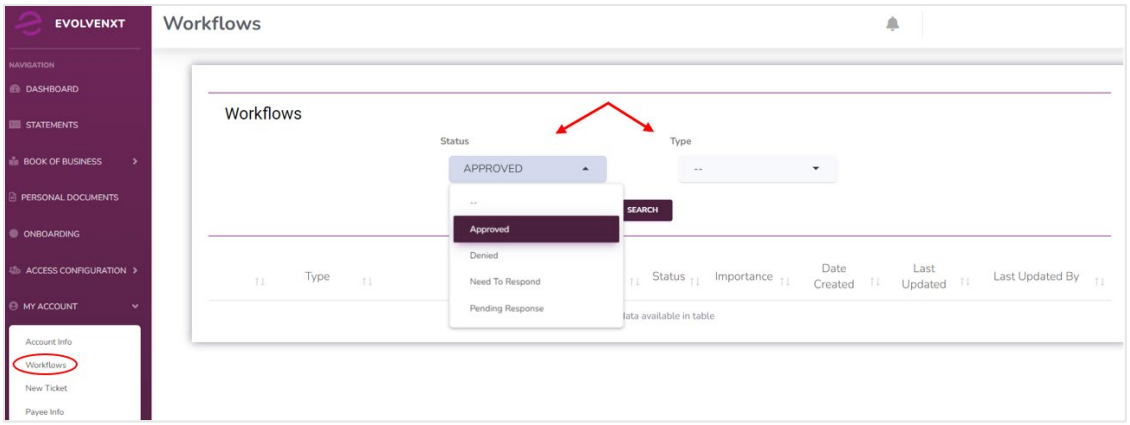
- Select View/Edit to change/update your Personal & Business demographics > SAVE



PAYEE INFO

- Select View/Edit to update/change Payee or Banking information
- Click ☐ to Show/Hide information
- Select ACH and Upload Voided Check
- Click CANCEL EDIT or SEND CHANGE REQUEST





Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Hometown Health

BUSINESS ASSOCIATE AGREEMENT

This **BUSINESS ASSOCIATE AGREEMENT** (this "BA Agreement") is made by and between **HOMETOWN HEALTH PLAN INC.**, a Nevada non-profit corporation located at 10315 Professional Circle, Reno, NV 89521 and **HOMETOWN HEALTH PROVIDER'S INSURANCE COMPANY, INC.**, a Nevada non-profit corporation located at 10315 Professional Circle, Reno, NV 89521 (collectively hereinafter the "Company") and _____ a _____, located at _____ ("Business Associate"), effective _____ ("Effective Date"). Terms used in this BA Agreement without definition shall have the respective meanings assigned to such terms by the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act and their implementing regulations as amended from time to time (collectively, "HIPAA").

RECITALS

WHEREAS, Company and Business Associate desire to enter into discussions about a possible relationship which may require Business Associate to have access to Protected Health Information.

NOW THEREFORE, in consideration of the mutual premises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Company and Business Associate agree as follows:

AGREEMENT

I. GENERAL PROVISIONS

Section 1.1. Effect. The provisions of this BA Agreement shall control with respect to Protected Health Information that Business Associate receives from or on behalf of Company.

Section 1.2. No Third Party Beneficiaries. The parties have not created and do not intend to create by this BA Agreement any third party rights, including, but not limited to, third party rights for Company's patients.

Section 1.3. Independent Contractor. Company and Business Associate acknowledge and agree that Business Associate is at all times acting as independent contractor of Company under this BA Agreement and not as an employee, agent, partner or joint venturer of Company.

Section 1.4. HIPAA Amendments. The parties acknowledge and agree that the Health Information Technology for Economic and Clinical Health Act and its implementing regulations impose requirements with respect to privacy, security and breach notification applicable to Business Associates (collectively, the "HITECH BA Provisions"). The HITECH BA Provisions and any other future amendments to HIPAA affecting Business Associate agreements are hereby incorporated by reference into this BA Agreement as if set forth in this BA Agreement in their entirety, effective on the later of the effective date of this BA Agreement or such subsequent date as may be specified by HIPAA.

Section 1.5. Regulatory References. A reference in this BA Agreement to a section in HIPAA means the section as it may be amended from time-to-time.

II. OBLIGATIONS OF BUSINESS ASSOCIATE

Section 2.1. Use and Disclosure of Protected Health Information. Business Associate may use and disclose Protected Health Information as permitted or required under this BA Agreement or as Required by Law, but shall not otherwise use or disclose any Protected Health Information. Business Associate shall not and shall assure that its employees, other agents and contractors do not use or disclose Protected Health Information received from Company in any manner that would constitute a violation of HIPAA if so used or disclosed by Company (except as set forth in Sections 2.1(a), (b) and (c) of this BA Agreement). To the extent Business Associate carries out any of Company's obligations under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to Company in the performance of such obligations. Without limiting the generality of the foregoing, Business Associate is permitted to use or disclose Protected Health Information as set forth below:

(a) Business Associate may use Protected Health Information internally for Business Associate's proper management and administrative services or to carry out its legal responsibilities.

(b) Business Associate may disclose Protected Health Information to a third party for Business Associate's proper management and administration or to carry out its legal responsibilities, provided that (1) the disclosure is Required by Law, (2) Business Associate makes the disclosure pursuant to an agreement consistent with Section 2.6 of this BA Agreement or (3) Business Associate makes the disclosure pursuant to a written confidentiality agreement under which the third party is required to (i) protect the confidentiality of the Protected Health Information, (ii) only use or further disclose the Protected Health Information as Required by Law or for the purpose for which it was disclosed to the third party and (iii) notify Company of any acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted by the confidentiality agreement.

(c) Business Associate may use Protected Health Information to provide Data Aggregation services relating to the Health Care Operations of Company if required during the Parties' discussions or required under this BA Agreement.

(d) Business Associate may use Protected Health Information to create deidentified health information in accordance with the HIPAA de-identification requirements. Business Associate may disclose health information that has been deidentified in accordance with HIPAA if required for purposes of the Parties' discussions.

Section 2.2. Safeguards. Business Associate shall use appropriate safeguards to prevent the use or disclosure of Protected Health Information other than as permitted or required by this BA Agreement. In addition, Business Associate shall implement Administrative
Safeguards, Physical Safeguards and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Company. Business Associate shall comply with the HIPAA Security Rule with respect to Electronic Protected Health Information.

Section 2.3. Minimum Necessary Standard. To the extent required by the "minimum necessary" requirements of HIPAA, Business Associate shall only request, use and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use or disclosure. Business Associate shall comply with the minimum necessary guidance to be issued by the Secretary pursuant to HIPAA and, to the extent practicable, shall not request, use or disclose any Direct Identifiers (as defined in the limited data set standard of HIPAA).

Section 2.4. Mitigation. Business Associate shall take reasonable steps to mitigate, to the extent practicable, any harmful effect (that is known to Business Associate) of a use or disclosure of Protected Health Information by Business Associate in violation of this BA Agreement or HIPAA.

Section 2.5. Trading Partner Agreement. Business Associate shall not take any of the following actions: (a) change the definition, Data Condition, or use of a Data Element or Segment in a Standard; (b) add any Data Elements or Segments to the maximum defined Data Set; (c) use any code or Data Elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standard's Implementation Specification(s); or (d) change the meaning or intent of the Standard's Implementation Specification(s).

Section 2.6. Subcontractors. Business Associate shall enter into a written agreement meeting the requirements of 45 C.F.R. §§ 164.504(e) and 164.314(a)(2) with each Subcontractor (including, without limitation, a Subcontractor that is an agent under applicable law) that creates, receives, maintains or transmits Protected Health Information on behalf of Business Associate. Business Associate shall ensure that the written agreement with each Subcontractor obligates the Subcontractor to comply with restrictions and conditions that are at least as restrictive as the restrictions and conditions that apply to Business Associate under this BA Agreement.

Section 2.7. Reporting Requirements.

(a) Business Associate shall, without unreasonable delay, but in no event later than five business days after becoming aware of any acquisition, access, use, or disclosure of Protected Health Information in violation of this BA Agreement by Business Associate, its employees, other agents or contractors or by a third party to which Business Associate disclosed Protected Health Information (each, an "Unauthorized Use or Disclosure"), report such Unauthorized Use or Disclosure to Company.

(b) Business Associate shall, without unreasonable delay, but in no event later than five business days after becoming aware of any Security Incident, report it to Company, provided that this Section constitutes notice by Business Associate to Company of the ongoing existence and occurrence of attempted but unsuccessful security incidents, for which no additional notice to Company shall be required, including but not limited to pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Protected Health Information.

(c) Business Associate shall, without unreasonable delay, but in no event later than five business days after discovery of a Breach of Protected Health Information (whether secure or unsecured), report such Breach to Company in accordance with 45 C.F.R. § 164.410.

Section 2.8. Access to Protected Health Information. Within ten business days of a request by Company for access to Protected Health Information about an Individual contained in any Designated Record Set of Company maintained by Business Associate, Business Associate shall make available to Company such Protected Health Information for so long as Business Associate maintains such information in the Designated Record Set. If Business Associate receives a request for access to Protected Health Information directly from an Individual, Business Associate shall forward such request to Company within five business days.

Section 2.9. Availability of Protected Health Information for Amendment. Within ten business days of receipt of a request from Company for the amendment of an Individual's Protected Health Information contained in any Designated Record Set of Company maintained by Business Associate, Business Associate shall provide such Protected Health Information to Company for amendment and incorporate any such amendments in the Protected Health Information (for so long as Business Associate maintains such information in the Designated Record Set) as required by 45 C.F.R. § 164.526. If Business Associate receives a request for amendment to Protected Health Information directly from an Individual, Business Associate shall forward such request to Company within five business days.

Section 2.10. Accounting of Disclosures. Within ten business days of notice by Company to Business Associate that it has received a request for an accounting of disclosures of Protected Health Information (other than disclosures to which an exception to the accounting requirement applies), Business Associate shall make available to Company such information as is in Business Associate's possession and is required for Company to make the accounting required by 45 C.F.R. § 164.528.

Section 2.11. Availability of Books and Records. Business Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Company available to the Secretary for purposes of determining Company's and Business Associate's compliance with HIPAA.

Section 2.12. Restrictions; Limitations in Notice of Privacy Practices. Business Associate shall comply with any reasonable limitation in Company's notice of privacy practices to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information. Business Associate shall comply with any reasonable restriction on the use or disclosure of Protected Health Information that Company has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Section 2.13. Indemnification. Business Associate shall reimburse, indemnify and hold harmless Company for all costs, expenses (including reasonable attorney's fees), damages and other losses resulting from any breach of this BA Agreement, Unauthorized Use or Disclosure, Security Incident or Breach of Protected Health Information maintained by Business Associate or Business Associate's agent or subcontractor, including, without limitation: fines or settlement amounts owed to a state or federal government agency; the cost of any notifications to Individuals or government agencies; credit monitoring for affected Individuals; or other mitigation steps taken by Company to comply with HIPAA or state law. This Section 2.13 shall survive the expiration or earlier termination of this BA Agreement.

Section 2.14. Insurance. Business Associate shall maintain technical errors and omissions insurance with coverage for Breaches of Protected Health Information with coverage limits of at least $1 million per incident and $1 million in the annual aggregate. Business Associate shall add Company as an additional insured on the insurance policy.

III. TERMINATION OF AGREEMENT

Section 3.1. Termination Upon Breach of this BA Agreement. Company may terminate this BA Agreement upon 30 days advance written notice to Business Associate in the event that Business Associate breaches this BA Agreement in any material respect and such breach is not cured to the reasonable satisfaction of Company within such 30-day period provided, however, that in the event that termination of this BA Agreement is not feasible, in Company's sole discretion, Company may report the breach to the Secretary.

Section 3.2. <u>Return or Destruction of Protected Health Information upon Termination</u>. Upon expiration or earlier termination of this BA Agreement, Business Associate shall either return or destroy all Protected Health Information received from Company or created or received by Business Associate on behalf of Company and which Business Associate still maintains in any form. Notwithstanding the foregoing, to the extent that Company reasonably determines that it is not feasible to return or destroy such Protected Health Information, the terms and provisions of this BA Agreement shall survive termination and such Protected Health Information shall be used or disclosed solely for such purpose or purposes which prevented the return or destruction of such Protected Health Information.

IV. COUNTERPARTS

This BA Agreement may be executed in two counterparts, each of which shall be deemed an original but both of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile transmission or scanned and sent by email are deemed to be originals for purposes of execution and proof of this Agreement.

THE REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the date first set forth above.

HOMETOWN HEALTH PROVIDERS INSURANCE COMPANY, INC. and **HOMETOWN HEALTH PLAN, INC.**	**BUSINESS ASSOCIATE**
Signature: _____	Signature: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

PRODUCER AGREEMENT

This Producer Agreement ("Agreement") is entered into effective this _____ ("Effective Date") by and between Hometown Health Plan Inc., and Hometown Health Providers Insurance Company, Inc., both Nevada nonprofit corporations (collectively hereinafter referred to as "Hometown Health"), and _____ a health insurance Producer duly licensed by the State of Nevada or non-resident health insurance Producer licensed by the State of Nevada [choose one or the other] (hereinafter referred to as "Producer") and is based on the following:

A. Hometown Health Plan, Inc. is a Nevada nonprofit corporation and is licensed by the State of Nevada as a health maintenance organization pursuant to Chapter 695C of the Nevada Revised Statutes and offers prepaid healthcare programs;

B. Hometown Health Providers Insurance Company, Inc. is licensed by the State of Nevada pursuant to Chapter 695B of the Nevada Revised Statutes as an insurance company offering hospital, medical and dental insurance coverage's to employers, unions and other identifiable groups;

C. Producer is an individual, firm or corporation who is duly licensed by the State of Nevada or is a non-resident health insurance PRODUCER duly licensed by the State of Nevada [PICK ONE OR ANOTHER] and appointed by Hometown Health to solicit applications for insurance; and;

D. The parties desire to enter into this Agreement to set forth their respective rights and responsibilities.

1. Obligations of PRODUCER.

Producer may introduce prospective groups or individual policy holders to Hometown Health without being appointed by Hometown Health but Hometown Health will not enroll members and provide ongoing services to groups or individual policy holders until Hometown Health agrees to appoint Producer upon Hometown Health's review and approval of appointment paperwork submitted by Producer. Producer shall have no authority to bind coverage, alter rates, conditions or terms of Hometown Health's policies, applications or evidences of coverage. No contracts, proposals or agreements made by Hometown Health may be modified or altered by Producer.

All funds received by the Producer on behalf of or for the account of Hometown Health shall at all times be segregated from the assets of the Producer and shall be promptly transferred to Hometown Health no later than five (5) business days following receipt of the same by the Producer.

Producer shall provide Hometown Health with Producer's most current State of Nevada license. Producer agrees to promptly notify Hometown Health of any 2 disciplinary proceedings, suspension, or termination related to the license initiated by the State of Nevada. Producer agrees to comply with requirements for appointment and on-boarding using Hometown Health's quoting and commission software system.

2. Commissions.
In consideration for the services to be performed for Hometown Health by Producer, Hometown Health agrees to pay commissions to the Producer in accordance with the Commission Schedule outlined in the Addenda to this Agreement. The terms of the Commission Schedule as outlined in Addenda are to be incorporated into this Agreement in full. By signing below, Producer signifies his/her/its acceptance of and agreement to the payment, conditions and restrictions set forth in the Addenda.

3. Relationship of Parties. In the performance of Producer's obligation under this Agreement, Producer will at all times be acting as an independent contractor and not as an employee of Hometown Health. Nothing contained in this Agreement shall be construed as an employer/employee relationship, joint venture, or partnership neither expressly nor implied and Producer shall not be entitled to accrue leave, retirement, insurance, worker's compensation, bonding, or any other benefits afforded to employees of Hometown Health. Producer shall not, except at his or her own expense, voluntarily make any payment, assume any liability, or incur any expenses on behalf of Hometown Health without the prior written consent of Hometown Health.

4. Term and Termination.
This Agreement shall commence on the Effective Date which coincides with the first sold business for Hometown Health and for an initial term of one (1) year ("Initial Term"), This Agreement shall renew automatically for successive one (1) year terms ("Successive Term") unless during the Initial Term or any Successive Terms, either party provides thirty (30) days written notice of its desire to terminate this Agreement pursuant to one of the following termination provisions. Such termination shall be effective on the first day of the month following the completion of the thirty (30) day notice period:

A. Termination for Cause. This Agreement shall terminate automatically in the event either party fails to comply with applicable law, loss of licensure as required by this Agreement, becomes insolvent or is adjudicated as bankrupt. Either party may terminate this Agreement for a material breach of this Agreement upon thirty (30) days written notice provided that the material breach is not cured within the thirty (30) day notice period.

B. Termination without Cause. Either party may terminate this Agreement without cause at any time upon thirty (30) days prior written notice to the other party. In the event of termination without cause, Producer shall continue to receive commissions for the remainder of the term of any group's then existing contract currently in force and which Producer acted on behalf of the group attached to those existing contracts.

5. Promotional Material.
Producer shall not broadcast, publish nor distribute any advertisements or other promotional materials referring to Hometown Health that are not created and/or approved by Hometown Health or that are not Hometown Health's most current advertisement or other material produced or published by Hometown Health without written approval from Hometown Health.

6. Indemnification.
Producer agrees to defend, indemnify and hold Hometown Health harmless from any and all liability which arises directly or indirectly out of any unauthorized action, misuse of materials or advertisements produced by Hometown Health, statements or misstatements by Producer or Producer's employees or any other act directly or indirectly related to Producer's obligations under this Agreement.

7. Insurance.
Producer agrees to obtain and maintain errors and omissions insurance from an insurer licensed in the State of Nevada. Producer agrees to provide Hometown Health with evidence of such insurance coverage upon initial appointment and upon renewal of such insurance coverage at least annually.

8. Records.
All enrollment forms, applications or other Hometown Health materials furnished to the Producer by Hometown Health shall remain the property of Hometown Health and shall be returned to Hometown Health upon the termination of this Agreement or upon demand by Hometown Health.

9. Miscellaneous.
A. Notices. Any notices required or permitted to be given under this Agreement shall be deemed given when mailed to a party by certified mail, return

receipt requested, to the address set forth following the signatures of the parties herein, or to such other address as a party shall give the other from time to time.

B. Assignment. Nothing contained in this Agreement shall be construed to permit the assignment or transfer by Producer of Producer's rights or responsibilities under this Agreement, and such assignment is expressly prohibited.

C. Successor in interest. Subject to the provision regarding assignment, this Agreement shall be binding upon, and inure to the benefit and detriment of the successors in interest and permitted assigns of the parties hereto.

D. Amendments. This Agreement contains the entire understanding between the parties with reference to the matters contained herein, there being no terms, conditions, warranties, or representations other than those contained herein, and no amendments hereto shall be valid unless made in writing and signed by both parties to this Agreement. The parties agree to take such action as is necessary to amend this Agreement and applicable Addendums from time to time as is necessary for a Covered Entity to comply with the requirements of the Privacy and Security Rules, and HIPAA.

E. Governing Law. This Agreement shall be construed in accordance with the laws of the State of Nevada.

F. Severability. To the extent that any provision hereof shall be finally determined by a court of competent jurisdiction to be void, illegal or otherwise unenforceable, the same shall have no effect upon the enforceability of the remaining provisions of this Agreement.

Producer Commission – Addendum A-IFP **(Producer Name)**_____

Individual and Family Plans	Annual Member Sales	First Year Initial Sale	Renewal
Tier 4	100+	14% of Premium	5% of Premium
Tier 3	25 to 99	12% of Premium	5% of Premium
Tier 2	10 to 24	10% of Premium	5% of Premium
Tier 1	1 to 9	9% of Premium	5% of Premium
On-Exchange Members	Any	$26 PMPM	

Producer Commission – Addendum A-Group

	Tier 1 (<500 total members)	Tier 2 (501-999 total members)	Tier 3 (1000 or more total members)
Small Group <50	$28.00 PMPM	$31.00 PMPM	$34.00 PMPM
Large Group >51	Commission as negotiated per group, noted in EQuote	Commission as negotiated per group, noted in EQuote	Commission as negotiated per group, noted in EQuote
Association Health Plans	$28.00 PMPM	$31.00 PMPM	$34.00 PMPM

All commissions are paid the first of the month following new enrollment or renewal of a group. Commission payment is subject to the following terms, limitations and exclusions:

All Producers must have a current license issued by the State of Nevada and in good standing, and evidence of insurance for errors and omissions through an insurer licensed by the State of Nevada. Hometown Health will provide an electronic system for producer on-boarding during the initial appointment and all licensing and insurance information including the signed agreement must be submitted via the electronic system prior to appointment. Producers will be paid a full month's commission for each month that the Producer is appointed by Hometown Health and has a valid, current license and policy of insurance for errors and omissions.

All Producers must be appointed by Hometown as a Producer of Record for an assigned piece of business and the appointment must be made by Hometown Health with the

Nevada Division of Insurance. Commissions will not be paid for months in which the Producer was not appointed with Hometown Health, nor will commission be paid for months prior to the license effective date. In the event a producer does not complete the on-boarding process or license and insurance renewal process, commissions may be suspended until an updated copy of the producer license and insurance policy are received.

When enrolling groups for coverage, Producer agrees to accept premium funds on behalf of plans, subscribers or groups and only in the form of a check made payable to Hometown Health. Producer further agrees to forward all checks to Hometown Health by the close of the business day following receipt of all checks.
Producers will complete a W-9 for tax withholding and agree to abide by Hometown Health policies and procedures concerning new group sales and renewals.

Producer commissions are paid based on the tier structure outlined above. The total commission paid to a Producer or Producers is based on the appropriate commission tier and is calculated for both (1) new groups applying to and approved for coverage by Hometown Health; and, (2) renewing groups with a signed renewal rate page and completed enrollment. If a Producer works for or is affiliated with a firm or agency, the tier classification will be based on the total number of enrolled Hometown Health members for the entire firm or agency and not just the members attached to an individual Producer.

Commissions will be paid to an individual or a firm or agency as identified in this Agreement. In the event there are multiple Producers attached to a single group, the Producer Agency will be responsible for distributing individual payments to its affiliate Producers. Hometown Health reserves the right to offset all commissions payable under this Agreement for any debt owed from the Producer to Hometown Health and may at any time deduct payment of the offset amount from any future monies due from Hometown Health to the Producer and/or due from the Producer to other persons or entities on behalf of Hometown Health.

Adjustments to group membership (additions or terminations) will result in a corresponding adjustment to the Producer commission payment and are valid up to 90 days from the effective date of the change. Payment adjustments will be made on the first of the month following notification to Hometown Health and will be reflected in the subsequent commission statement to the Producer or agency. In no event will retroactive commission adjustments be made for activity more than 180 days in arrears. Hometown Health reserves the right to amend any or all of the terms of the Commission Schedule upon 30 day notice to the Producer.

ACCEPTED:
Hometown Health requires that you submit an electronic signature agreeing to the terms of this Producer Agreement. By typing your complete name below and clicking "Confirm Signature" you certify that you have reviewed and agree to the Producer Agreement terms set forth above.

By: _____ Date: _____
PRODUCER

□ My signature above represents that I am authorized to execute this Agreement on behalf of the Producer or Firm named herein.

Firm or Agency Name (if applicable): _____

Make Commission payable to:

_____

_____
Address City/State/Zip Code

Telephone: (___) _____

Fax: (___) _____

E-mail: _____

TAX I.D. NUMBER
(Commission cannot be paid without this number)

_____

HOMETOWN HEALTH PLAN, INC. and
HOMETOWN HEALTH PROVIDERS INSURANCE COMPANY, INC.

By: _____ Date: _____
(Chief Executive Officer)

☐ My signature above represents that I am authorized to execute this Agreement on behalf of Hometown Health.

COMPLIANCE PROGRAM AND CODE OF CONDUCT ACKNOWLEDGEMENT STATEMENT

Hometown Health/Renown Health is committed to providing high quality of care in compliance with all applicable state and federal laws and regulations, professional and ethical Code of Conduct, and Hometown Health/Renown Health policies and procedures. It is Hometown Health/Renown's expectation that all employees, physicians, medical staff, Board members, and contractors share this commitment and will adhere to all federal and state legal requirements and the standards set forth in the Compliance Program and Code of Conduct. As such, I attest that:

a) I have received the Hometown Health/Renown Health Compliance Program and Code of Conduct.

b) I understand it is my responsibility to read, understand and abide by the Compliance Program and Code of Conduct and to perform my job duties in compliance with all applicable laws, regulations, and professional and ethical standards.

c) I attest that I have brought forth any and all concerns that I have regarding noncompliance with the Compliance Program, Code of Conduct and applicable laws and regulations to the Chief Compliance Officer (1-775-982-5596) or the Anonymous Hotline (1-800-611-5097).

_____ _____

Signature *Date*

_____

Print Name and Title

COMPLIANCE PROGRAM
AND
CODE OF CONDUCT

Approved:
03.02.15

Review/Revision Dates:
01.22.19
08.09.19
01.21.20
01.22.21

Table of Contents:

LETTER FROM CEO

Dear Renown Colleague:

Renown Health has been taking care of northern Nevadans for generations and has been an integral part of the community for over 150 years. We pride ourselves on quality care, which means providing safe, accessible, evidence-based, patient-centered care while focusing on continuous improvement for the best outcome for our patients and community. Renown embraces the Triple Aim approach to healthcare – improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations. This is accomplished by establishing quality processes focused on clinical excellence, patient safety, care coordination, and regulatory compliance.

Renown has a comprehensive Compliance Program and Code of Conduct that not only adhere to federal guidelines, but is also a vital part of our organization's culture related to our Triple Aim approach. Because this rests on our foundation, this level of integrity has become incorporated into our approach to caring for our patients, our communities, and our colleagues. Our organization aggressively pursues its goal that all business activities are in compliance with applicable laws and regulations.

The Compliance Program sets forth Renown's programmatic approach to compliance and is supplemented annually with a Compliance and Audit Work Plan. The Code of Conduct contains resources to help resolve any questions about appropriate conduct in the work place to uphold the integrity of the organization. Please review it thoroughly. Your observance to its contents is absolutely critical to Renown.

If you have questions regarding this document or encounter any situation that you believe violates the Compliance Program or provisions of the Code of Conduct, please contact the Chief Compliance Officer (**775-982-5596**), your supervisor, Compliance Liaison, or the Compliance Hotline (**800-611-5097**). You may also file a report on the Confidential Reporting Form found on the Corporate Compliance web page on Renown's intranet. You have our personal assurance there will be no retaliation for, in good faith, asking questions or raising concerns, or for reporting possible improper conduct.

Thank you for your dedication to Renown and helping ensure that the integrity of operations is upheld to the highest standard for our colleagues, patients, and the community.

Sincerely,
Hometown Health/Renown Health

RENOWN COMPLIANCE PROGRAM

I. *Introduction.*

Renown Health ("Renown") is committed to providing high quality care in compliance with all applicable state and federal laws and regulations, professional and ethical Codes of Conduct, and Renown policies and procedures. To that end, Renown has implemented a Compliance Program ("the Program") to demonstrate its commitment to preventing and detecting fraud, waste and abuse. The Program establishes guidelines for ensuring all Renown business is conducted in an honest and ethical manner.

The Program was developed based on the Federal Sentencing Guidelines, guidance from the Office of Inspector General ("OIG") and applicable federal and state laws and regulations. All employees, physicians, medical staff, agents, Board members, and contractors (collectively "employees") are responsible for understanding how these laws and regulations affect their jobs and for performing their jobs in a manner consistent with the law, professional and ethical Codes of Conduct, and all Renown policies and ethical standards. This Compliance Program Document is a fundamental part of the Program and details Renown's compliance efforts. Compliance policies and procedures will expand upon the topics addressed in the Compliance Program Document.

The Program recognizes that certain services in an integrated delivery system may have additional Compliance requirements. For example, a Health Plan contracted with the Center for Medicare Services has specific requirements that are set forth in supplemental policies and procedures.

II. *Laws and Regulations.*

Renown and its employees are required to comply with a wide range of federal and state laws and regulations, including the requirements for participating in state and federally funded health care programs. Renown devotes significant resources to ensure compliance with these laws, regulations and requirements. The Program is designed to address fraud and abuse laws, false statements and false claims, privacy and security, and Medicare and Medicaid requirements. The health care laws and regulations that apply to Renown's business activities include, but are not limited to:

- Anti-Kickback Statute,
- Civil Monetary Penalties ("CMP") Act,
- Emergency Medical Treatment and Active Labor Act ("EMTALA"),
- Federal False Claims Act (FCA)
- Fraud Enforcement and Recovery Act of 2009 (FERA),
- Health Insurance Portability and Accountability Act ("HIPAA"),
- Health Information Technology for Economic and Clinical Health ("HITECH") Act,
- Nevada Submission of False Claims to State or Local Government Act,
- Physician Self-Referral ("Stark") Law, and

- Patient Protection and Affordable Care Act (ACA)

Employees violating these laws, regulations or requirements not only risk individual criminal prosecution and penalties, civil penalties, and administrative exclusion but also subject Renown to the same risks and penalties. Any employee who violates a law, regulation or requirement may be subject to disciplinary action up to and including termination of employment. Employees also have a duty to report any suspected violation of law, regulation or other requirement to their supervisor, manager, the Chief Compliance Officer, Compliance Liaison, the Confidential Reporting Form found on the Corporate Compliance web page on Inside Renown, and/or the Compliance Hotline (**800-611-5097**).

III. *Structure – Chief Compliance Officer, System Divisions, and the Audit and Compliance Committee.*

Compliance starts at the highest level of Renown and shall be an active part of the business culture. Renown's Board of Directors and the President and CEO of Renown shall have joint authority to appoint and terminate a Chief Compliance Officer ("Chief Compliance Officer"), who is ultimately responsible and accountable for creating and maintaining a comprehensive approach to ensuring compliance with federal and state regulations and Renown policies. Renown's Board of Directors ("the Board") has charged the Audit and Compliance Committee to assist the Chief Compliance Officer in the development, implementation and maintenance of the Program.

Chief Compliance Officer

The Chief Compliance Officer shall have sufficient authority to fulfill the responsibilities of the position and shall have direct reporting access to the President and CEO and the Board. The Chief Compliance Officer shall administratively report to the President and CEO of Renown and provide an update to the Board annually, at a minimum, on the state of the Program.

The Chief Compliance Officer is responsible for the day-to-day operation and oversight of Program activities. The Chief Compliance Officer will oversee the implementation and maintenance of the Program and all Renown compliance policies, compliance education and training, auditing and monitoring activities, and resolution of compliance issues. The Chief Compliance Officer shall have access to all documents and information related to compliance activities and may seek advice from General Counsel or retain consultants or experts, when necessary. The Chief Compliance Officer may request additional staff, as deemed necessary, to assist in the performance of compliance activities.

Audit and Compliance Steering Committee

Audit and Compliance Steering Committee members are comprised of Leaders from: Acute Care, Transitional Care, the Network, and Home Town Health.

System Divisions

The Chief Compliance Officer will work with leaders in Renown's System Divisions to ensure consistent application of the Compliance Program throughout Renown. The

System Divisions include Acute Care, Transitional Care, Hometown Health and the Network. The Chief Compliance Officer will work with these System Divisions to ensure consistent application of compliance standards and Renown's vision throughout the organization. Representatives from all System Divisions will work with the Chief Compliance Officer to develop and execute a Compliance and Audit Work Plan ("Work Plan"). The Work Plan will be based on an annual risk assessment; the risk assessment will be performed using the OIG Work Plan, government enforcement trends, internally identified risk areas, and other compliance resources. Hometown Health maintains its own Compliance Committee.

Compliance Liaisons

The Chief Compliance Officer will appoint Compliance Liaisons to assist in the integration of compliance throughout Renown and to serve as a departmental-level resource for employees. The Compliance Liaisons will provide support in executing compliance initiatives within the facilities and will report to the Chief Compliance Officer regarding compliance related topics.

Audit and Compliance Committee

The Audit and Compliance Committee is a Committee of the Board and is charged with the governance of Audit and Compliance matters. The Audit and Compliance Committee shall include members of senior management and members of the Board and will meet on a regular basis. The Audit and Compliance Committee shall provide oversight of the Audit and Compliance Department activities which include, but are not limited to, evaluating problems encountered, identifying potential areas of concern, and initiating corrective action, as appropriate.

IV. *Written Policies and Procedures.*

All Renown business must be conducted in accordance with federal, state and local laws and regulations, rules of professional conduct, applicable state and federally funded health care program regulations, and Renown policies. The Renown Code of Conduct and compliance policies and procedures will serve as the foundation for operations and to create the standards for employees. Employees shall be responsible for understanding and complying with the standards that govern their legal and ethical conduct in performing their daily tasks.

The Renown Code of Conduct and compliance policies:

- Describe compliance expectations,
- Provide guidance to employees and others on dealing with potential compliance issues,
- Identify how to appropriately report compliance issues, and
- Describe how potential compliance problems will be investigated and resolved.

The Code of Conduct and compliance policies are not intended to cover every situation that may be encountered, Employees are expected to comply with all applicable laws and

regulations whether they are specifically addressed by policy or not. Any questions or concerns about the employee's legal or ethical responsibilities should be directed to the employee's supervisor, manager/director, Compliance Liaison, or the Chief Compliance Officer. Laws and regulations frequently change. As such, the Code of Conduct and compliance policies will be reviewed and updated annually, or as needed. Any changes to a policy will be communicated to employees in a timely manner, and a copy of the revised policy will be made available for review.

V. *Education and Training.*

All employees will receive a copy of the Compliance Program and Code of Conduct. Additionally, a copy of the Compliance Program Document, Code of Conduct and all compliance-related policies and procedures will be placed in a central repository accessible to all employees on the Inside Renown website. Employees are encouraged to read the Compliance Program Document in its entirety and ask questions, if needed, to better understand the Program and their individual responsibilities.

All Renown employees are required to complete compliance education upon new hire and on a continuing basis, at least annually. Completion of annual compliance education will be documented in the employee's record and will be required as part of the employee's annual performance evaluation.

Employees whose job duties may affect Renown's regulatory compliance will receive additional, job-specific training, as indicated. This specialized training may focus on complex areas or on areas that the Chief Compliance Officer has determined pose a high risk.

In addition, the Board shall receive annual compliance education. Education provided to the Board shall focus on the Program and the duties and responsibilities of the Board.

VI. *Auditing and Monitoring.*

Renown will conduct periodic audits to identify potential deficiencies in its systems and processes, including the claim development and submission processes and Renown's various physician arrangements. Renown will implement audit procedures designed primarily to determine accuracy and validity of coding and billing submitted to Medicare, Medicaid, other federal and state health care programs and other payers, and to detect any instances of potential misconduct. Renown will also implement audit procedures designed to determine the accuracy, validity, and viability of its contractual arrangements with community and employed physicians. Renown will use identified areas for improvement in the annual update of compliance education and training.

Auditors and reviewers shall have appropriate access to information and documents necessary to complete their review. Auditors and reviewers shall also maintain the confidentiality of the information received. The Chief Compliance Officer will receive the results of all audits and will provide summary reports to the Audit and Compliance Steering Committee, and the Audit and Compliance Committee of the Board. Based on

the results of the audits, if applicable, repayment will occur within the required timeframe based on CMS requirements and/or payor contracts. Based on the results of physician arrangement audits, recommendations regarding contracting processes, physician alignment strategies, and self-disclosures (in coordination with the Legal Department/counsel) may be made. Renown will implement a follow-up audit process to ensure all identified issues are thoroughly addressed in a timely manner. Any needed education based on audit results will be provided in a timely manner and documented.

VII. *Reporting Compliance Concerns.*

Compliance is every employee's responsibility. Renown encourages and actively maintains open lines of communication between its employees, the Compliance Liaisons, and the Chief Compliance Officer. Employees are the eyes and ears of the organization and are often aware of potential compliance concerns. To encourage employees to come forward with their concerns, Renown's Compliance Department has an "open-door policy." Additionally, multiple lines of communication have been established and are always available. Finally, Renown has a robust Non-Retaliation policy for reporting compliance concerns.

Employees are responsible for ensuring their work activities comply with applicable laws, regulations and policies, and for reporting any suspected acts of noncompliance. Any individual found to have knowledge of an act of noncompliance but who failed to report it will be subject to disciplinary action.

Employees may notify their supervisor, manager, Compliance Liaison or the Chief Compliance Officer (**775-982-5596**) directly of any concerns. Employees can also report a concern using the Confidential Reporting Form found on the Corporate Compliance website on Inside Renown. Alternatively, the employee may use the Compliance and Ethics Hotline (**800-611-5097**) to report their concerns anonymously. Every effort will be made to preserve the anonymity of the individual reporting the concern. However, employees must understand that circumstances may arise in the course of an investigation in which their identity may become known.

Renown has a Non-Retaliation policy that strictly prohibits retaliation against anyone reporting a concern in good faith. Anyone found to have committed a retaliatory act will be subject to disciplinary action, up to and including termination of employment.

VIII. *Responding to Detected Offenses and Implementing Corrective Action.*

All reports or reasonable indications of fraud, waste or abuse, violations of other applicable laws or regulations, or violations of Renown policy will be promptly investigated. The results of an investigation may identify the need for additional training, corrective action, and/or implementation of additional procedures to ensure future compliance.

Upon receipt of a reported compliance concern, the Chief Compliance Officer or his/her designee will investigate to determine whether any conduct inconsistent with Renown policy or in violation of law occurred. The Chief Compliance Officer may consult with

Renown leadership, General Counsel or external consultants in the course of an investigation to obtain expertise or advice. The Chief Compliance Officer may also conduct interviews of employees or review documents to determine whether a violation has occurred.

If a violation is found to have occurred, the Chief Compliance Officer will consult with Human Resources and General Counsel, as appropriate, to determine the most appropriate course of action. A summary of all compliance reports, any subsequent investigations, and their resolutions will be reported to the Audit and Compliance Committee. Any confirmed reports of a compliance violation and all subsequent follow up will be reported to the Board.

IX. *Enforcement and Discipline.*

Renown may subject an employee who intentionally or unintentionally violates a law, regulation or established policy to disciplinary action. Employees may also be subject to disciplinary action for failure to report a suspected violation. Disciplinary actions may include, but are not limited to, the loss of privileges, contract penalties, suspension or termination of employment, and in some cases, civil and/or criminal prosecution. All possible disciplinary actions will be taken in accordance with Renown disciplinary guidelines.

X. *Risk Assessment*

Maintaining a robust, effective compliance program requires continuous assessment of compliance risks and identification of areas for improvement. The Chief Compliance Officer, Audit and Compliance Steering Committee, and the Audit and Compliance Committee will continuously monitor and assess the state of the Program to ensure it is operating at the highest level.

Additionally, Renown will conduct an annual risk assessment to identify the areas that present the highest risk to the organization and develop an annual Work Plan. The risk assessment will include, but is not limited to, review of the annual OIG Work Plan, analysis of recent government enforcement trends, and review of concerns identified internally by the Chief Compliance Officer and the Audit and Compliance Steering Committee. The Chief Compliance Officer will oversee interviews of key personnel to ensure all pertinent information is obtained to evaluate the level of risk presented by each identified risk item.

The Work Plan will document both operational and audit areas of focus. For each area of focus, the Work Plan will include the reason for concern identified with that area of focus, a timeframe for completion of the audit or review, and the party responsible for completing the audit or review. The Work Plan will be reviewed and approved by the Audit and Compliance Committee and forwarded to the Board for final approval. The Chief Compliance Officer will be responsible for providing periodic updates to the Audit and Compliance Committee and an annual summary to the Board.

XI. *Compliance Program Effectiveness*

The Program is intended to be flexible and readily adaptable to changes in regulatory requirements and in the healthcare system as a whole. This Compliance Program Document shall be reviewed and modified, as necessary. Additionally, the effectiveness of the Program will be reviewed on an as needed basis based on major revisions by the Chief Compliance Officer, the Audit and Compliance Committee and the Board.

Regarding Compliance Program effectiveness, HCCA and the OIG have published a document titled "Measuring Compliance Program Effectiveness: A Resource Guide." Additionally, the U.S. Department of Justice has published and regularly updates a document titled "Evaluation of Corporate Compliance Programs." These two resources provide essential roadmaps for Renown Health's evaluation of the effectiveness of its Compliance Program. The following three general questions should guide any inquiry into a compliance initiative's effectiveness:

1. Is the compliance program well designed?
2. Is the program being applied earnestly and in good faith? I.e., is the program adequately resourced and empowered to function effectively?
3. Does the compliance program work in practice?

XII. *Self-Reporting*

If credible evidence of misconduct is discovered and, after reasonable inquiry, it is determined that the misconduct may have resulted in a violation of criminal, civil, or administrative law, the legal office/counsel shall be contacted promptly to determine self-reporting requirements and appropriate next steps.

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RENOWN CODE OF CONDUCT

I. Introduction.

The purpose of the Code of Conduct is to serve as an ongoing reminder to all employees of our commitment to excellence and provide guidance on conducting business and patient care activities with integrity and in compliance with all applicable laws. The Code of Conduct sets forth Renown's expectations for the conduct of all employees. It is each employee's responsibility to be familiar with and abide by the standards set forth in the Code of Conduct and all other Renown policies and procedures. The Code of Conduct cannot address every possible circumstance or situation you may encounter in performing your duties; you are expected to use good judgment and consult your supervisor or the Chief Compliance Officer when appropriate.

II. Duty to Report.

Compliance is every employee's responsibility. As a Renown employee, you play an important role in ensuring that all Renown activities are performed in compliance with all applicable laws, regulations, standards, policies and procedures. Renown encourages you to ask questions or seek clarification, when needed, to better understand your compliance responsibilities. If you discover a problem or suspect an inappropriate practice is occurring, it is your duty to report your concerns to your supervisor, the Chief Compliance Officer (**775-982-5596**), the Compliance Liaison, or the Compliance Hotline (**800-611-5097**). Employees also can report a concern using the Confidential Reporting Form. This Form can be found on the Corporate Compliance web page on Inside Renown. When reporting your concerns, you may choose to remain anonymous. During an investigation, your anonymity and the confidentiality of any information you provide will be protected to the extent reasonably possible.

Renown is committed to doing the right thing and will not tolerate any form of retaliation or acts of retribution against an employee who, in good faith, reports suspected wrongdoing or a potential compliance violation. The Renown Non-Retaliation Policy prohibits retaliation or retribution and provides for disciplinary sanctions against any individual who violates the policy.

III. Compliance Code of Conduct.

Standard 1: Compliance with Laws and Regulations

Healthcare is a highly regulated business that requires compliance with many federal and state laws and regulations. It is important to stay informed and be diligent about the work you perform. Renown provides many opportunities for learning and retention of important compliance information. It is your duty to be aware of potential risks, to work within the

confines of the law and Renown's policies, and to report any suspected wrongdoing or potential violations.

- **Fraud, Waste and Abuse.** There are several state and federal laws that govern the conduct of health care providers. These laws provide guidelines for the provision of care, appropriate claim submission, and relationships between health care providers. Some of the laws that address activities that could constitute fraud include the False Claims Act, the Anti-Kickback Statute, and the Stark Law.

    - **Anti-Kickback Statute.** The Anti-Kickback Statute is a federal law which imposes criminal and, particularly in association with the federal False Claims Act, civil liability on those that knowingly and willfully offer, solicit, receive, or pay any form of remuneration in exchange for the referral of services or products covered by any federal healthcare program (i.e., Medicare and Medicaid). Neither Renown nor its employees may offer, give or receive anything of value or provide "rewards" in exchange for referrals from other businesses or providers. Bribes or kickbacks of any kind are strictly prohibited.

    - **False Claims Act (FCA) and Fraud Enforcement and Recovery Act of 2009 (FERA)**. FCA and FERA prohibit anyone from submitting claims they know, or should know, are false or misleading to the government or other third party payors. It is important to completely and accurately document all services rendered. Claims should only be submitted when there is sufficient documentation in the medical record to support billing the service. An employee should never submit a claim for a service that he/she knows was not provided, was provided at a lower level than coded, or was not medically necessary. If you believe a claim is inaccurate, it is your responsibility to fix the claim or report it to your supervisor prior to the claim being submitted to the payor.

    - **Physician Self-Referral (Stark) Law.** The Stark law prohibits referrals when a financial relationship exists between the provider (or his/her immediate family member) and the entity, unless an approved exception is met. The Stark law applies to doctors of medicine and osteopathy, dentists and oral surgeons, optometrists, chiropractors, and their immediate family members. Renown providers may not refer a patient for designated health services payable by Medicare or Medicaid to an entity with which the provider has ownership, an investment interest or a compensation arrangement unless an exception is met.

- **Government Investigations.** A government investigation does not necessarily indicate that wrongdoing has occurred. Renown is committed to compliance with all laws and regulations, including appropriate cooperation with any government investigations. If you are approached by a government official or receive a subpoena or other legal inquiry, you should immediately notify the Chief Compliance Officer. The Chief Compliance Officer will coordinate Renown's

response to the inquiry and involve General Counsel when appropriate. For additional information about your rights and responsibilities in a government investigation, please refer to the Renown Government Investigations policy.

- **Tax Status.** Renown has received tax-exempt status from the Internal Revenue Service for many of its lines of business. When Renown is a tax-exempt entity, Renown is required to follow specific rules and regulations relating to provision of services for charitable purposes, payment for goods and services, and other financial considerations. Transactions entered into must be in the best interest of Renown and negotiated at arms-length for fair market value. Employees must not use Renown resources or property for any private use or private gain.

- **Antitrust.** All Renown employees must comply with applicable federal and state antitrust laws regulating competition. Conduct prohibited by such laws include, but are not limited to, price-fixing, boycotts, price discrimination agreements, bribery, deception, or intimidation. An employee faced with a situation that appears questionable should consult with his/her supervisor or the Renown Chief Compliance Officer. Any suspected violations of law should be reported to the Chief Compliance Officer immediately.

- **Exclusion List.** Renown will not employ or do business with any person or business who appears on any federal or state government exclusion list. Any existing relationship will be terminated upon discovery of the business or individual being excluded.

Standard 2: Quality of Care

Renown is committed to providing high quality, medically necessary care to all patients. Renown will provide a safe health care environment for all employees, patients, families and visitors.

All patients are to be treated equally with dignity and respect regardless of their ability to pay. When possible, patients should be involved in medical decisions and the plan of care. Team members should strive to always act in the best interest of the patient, provide compassionate care and to provide the appropriate level of care. Renown's health care provider shall perform medically necessary services in the safest, most effective manner. Proper documentation of all services rendered is critically important to maintaining high quality of care that is in line with accreditation standards.

Renown will provide emergency treatment in accordance with the Emergency Medical Treatment and Active Labor Act ("EMTALA") regardless of the individual's ability to pay. An emergency medical screening examination and any necessary stabilizing treatment will be provided to all patients seeking emergency treatment.

Standard 3: Workplace Conduct and Employment Practices

Each employee has the right to work in an environment free of disruptive behavior, harassment or discrimination.

- **Safe Workplace.** Renown is committed to providing a work environment that is safe and free from physical harm and has a zero tolerance policy for violence in the workplace. Renown employees are responsible for creating and maintaining a safe environment for all employees, patients, and visitors. All reports of possible workplace violence will be taken seriously and will be investigated and resolved promptly.

- **Harassment.** No form of harassment will be permitted. Harassment includes any verbal, nonverbal or physical conduct intended to intimidate or threaten another individual. Verbal harassment includes an offensive or unwelcome comment about the individual's gender, sexual orientation, race, religion, nationality, age or disability. Nonverbal harassment includes distribution or display of graphic or potentially offensive materials. Any allegation of harassment will be promptly investigated in accordance with Renown Human Resources policies.

- **Discrimination**. Renown believes in the fair treatment of all employees. It is a policy of Renown to treat employees, without regard to the race, color, religion, gender, ethnic origin, age or disability of such person, sexual orientation or any other classification prohibited by law. It is a policy of Renown to recruit, hire, train, promote, assign, transfer, layoff, recall, and terminate employees based on their own ability, achievement, experience and conduct, without regard to race, color, religion, gender, ethnic origin, age or disability, sexual orientation or any other classification prohibited by law. Any allegation of discrimination will be promptly investigated in accordance with Renown Human Resources policies.

Standard 4: Privacy and Confidentiality

The protection of patient privacy and the confidentiality of information created and/or obtained in the course of Renown business are of the utmost importance. It is your duty to use this information responsibly and to report any potential breaches to your supervisor, the Chief Compliance Officer (**775-982-5596**), Compliance Liaisons, the Confidential Reporting Form found on the Corporate Compliance web page on Inside Renown, or the Compliance Hotline (**800-611-5097**).

- **Protected Health Information.** Due to the nature of our business, we have access to personal information about our patients' health. It is our responsibility to safeguard this information in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") of 1996. You may only access, use, or disclose a patient's protected health information ("PHI") as needed to perform your job duties. Please refer to Renown's HIPAA policies and procedures to fully understand patient rights and your responsibilities with respect to PHI and HIPAA.

- **Personal Information.** Personal employee information, including salary, benefits and personnel file information, is treated as confidential and should only be accessed and/or used when appropriate for Renown business purposes.

- **Proprietary Information.** Confidential information about Renown business or operations, such as financial information, business strategy, or other proprietary information, should not be shared unless there is a valid business purpose. Employees may not utilize inside information for any business activity conducted by or on behalf of Renown. Information, ideas and intellectual property assets are important to organizational success. Employees should exercise care to ensure that intellectual property rights, such as patents, trademarks, copyrights and software, are carefully maintained and managed to preserve and protect their value. If you have questions about whether information you have received is proprietary and confidential, please contact the Chief Compliance Officer. If you receive a request from the media, please decline comment and refer them to the Renown media contact.

- **Security.** All employees are responsible for the appropriate use of the security measures at their disposal, including confidential login credentials, passwords, access badges, and/or keys. Renown's security policies and procedures detail the guidelines for using and safeguarding system identification and passwords as well as physical access to secure areas. All communication systems, including, but not limited to, personal computers, printers/copiers, electronic mail, Intranet, Internet access, telephone and voicemail, are the property of Renown; users should assume these communications are not private.

- **Social Media.** Social media presents a special challenge for health care providers. You are expected to use social media, such as Facebook, Twitter, LinkedIn, etc., responsibly and in compliance with the Renown policies and procedures related to privacy, confidentiality and security. Never post patient information or photographs to a web site or social media page.

Standard 5: Business and Personal Conduct

Renown is committed to conducting business in a professional and ethical manner. Employees are expected to act in the best interest of Renown; interactions with patients, visitors, colleagues, and business partners should reflect Renown's values and standards. Inappropriate or disruptive conduct will not be tolerated and will be subject to Renown's disciplinary guidelines.

- **Conflicts of Interest.** Employees are expected to act in the best interest of Renown and its patients at all times. Employees may not use their position or knowledge as a Renown employee for personal gain. A conflict of interest may exist if an employee has a relationship or a personal interest that affects, or may affect, his/her job performance or ability to make a decision related to Renown or its patients. It is the employee's responsibility to disclose any potential conflict of

interest to Renown. The Renown Conflict of Interest policy provides guidance as to what may constitute a conflict of interest and who is responsible for disclosing potential conflicts.

- **Gifts and Gratuities.** Renown prohibits employees from receiving gifts or gratuities from patients and families. Gifts and gratuities may include cash, gift cards, services, entertainment, or anything of value. Employees are also prohibited from accepting gifts, services, entertainment, or other things of value to the extent that decision making or actions affecting Renown might be influenced. If a patient wishes to present a monetary gift, he/she should be referred to the Renown Foundation. Please refer to the Renown Gifts, Gratuities and Business Courtesies policy for additional guidance on monetary tips or gratuities.

- **Outside Activities.** Employees must not engage in outside activities during working hours. Use of hospital equipment, including computers, supplies or information in connection with any outside activity is prohibited. Self-employment or employment by others is permissible only if it does not adversely affect the employee's job performance for Renown Health or create a conflict with Renown Health. An employee of Renown Health must not become an officer or director of, or accept a position of responsibility with, any other company in competition with Renown without the approval of his or her supervisor.

- **Educational Programs.** Employees are, with the permission of their supervisor, encouraged to participate as faculty and speakers at educational programs and functions. If the employee uses personal time to prepare and provide the presentation, the employee may keep the honoraria as long as it does not create a conflict of interest. If the preparation and presentation occurs during work hours, the honoraria are to be turned over to Renown Health.

- **Family Members.** No employee may be hired or promoted where the results will be that an employee will directly supervise a member of his or her own family.

Professional boundaries. Employees are expected to maintain professional boundaries with patients. Employees are not permitted to enter into romantic relationships with patients they are treating. Employees will also avoid engaging in behaviors such as keeping secrets for patients, behavior that may be viewed as flirting with patients, or sharing intimate/personal information with patients that is unrelated to the patient's care.

Standard 6: Financial Reporting

It is important to utilize Renown's assets and resources in the most efficient and effective manner. Documentation and reporting of Renown's financial information, including the use of tax-exempt earnings, should be complete and accurate. Renown is responsible for timely and accurate submission of any required reports to regulatory agencies. Failure to maintain appropriate records may result in financial, legal and/or reputational harm to Renown.

Standard 7: Government Relations and Political Activities

Renown must comply with all laws and regulations governing participation in government relations and political activities. Renown funds or resources are not to contribute directly to political campaigns. It is important to separate personal and corporate political activities in order to comply with laws and regulations relating to lobbying or attempting to influence government officials. Any use of Renown resources is inappropriate for personally engaging in political activity.

Standard 8: Research, Investigations and/or Clinical Trials

Renown will follow the highest ethical standards in full compliance with laws and regulations in any research, investigations, and/or clinical trials conducted by employees. This includes all research performed in conjunction with the University of Nevada School of Medicine. Any employee performing research, investigations, or clinical trials must follow all applicable research guidelines and privacy policies and maintain the highest standards of ethics and accuracy.

Standard 9: Community Relationships

Community relationships are valued, as exemplified through community involvement and feedback through various Renown Health Boards, the Renown Health Membership, and formal and informal research activities. Marketing practices and contract negotiations are accurate and reflective of the organization's vision and mission. It is Renown's goal that this organization be recognized as a true and trusted community asset.

Senior Care Plus

2024 Broker Commission Structure

Quick Start New to Senior Care Plus New to Medicare Advantage	$40 Bonus $611 Upfront $50.92 Chargeback per month unfulfilled
New to Senior Care Plus Renewal to Medicare Advantage	$306 Upfront $25.50 Chargeback per month unfulfilled
Renewal to Senior Care Plus	$25.50 per month

For broker onboarding information, please visit SeniorCarePlus.com

Notes

Notes

Your Important **Contacts**

HOMETOWN HEALTH SALES & RETENTION

Phone 775-982-3100 Fax 775-982-3090

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Hometown Health

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Eligibility/Enrollment

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Phone 775-982-3118 Fax 775-982-3749
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PREMIUM ACCOUNTING

Pat Edwall
Premium Accounting Supervisor
775-982-3181

Carol Chambers
Premium Accounting (A-E) and (T-Z)
775-982-7496

Sara Eke
Premium Accounting (F-M) and (IFP)
775-982-3810

Tonya Granata
Premium Accounting (N-S)
775-982-3187

Fax 775-982-3749

For copies of bills or billing questions
premiumaccounting@hometownhealth.com

BENEFIT, ELIGIBILITY, CLAIMS INQUIRIES, REFERRALS, POLICY & PROCEDURE (EOC) INFORMATION

Customer Services Representatives
775-982-3232 Fax 775-982-3741
customer_service@hometownhealth.com

Toll-Free Hometown Health
1-800-336-0123
hometownhealth.com

TDD (Hearing Impaired)
775-982-3240

Senior Care Plus
775-982-3158
SeniorCarePlus.com