TEE OFF into 2025

Hometown Health

BROKER SUMMIT

LADD/2407-2974847

DEAR BROKER PARTNERS,

Welcome to Hometown Health's Annual Broker Summit! We are thrilled to have you here at The Club at Arrowcreek as we "Tee Off into 2025." The Sales Team and I are looking forward to sharing with you some exciting Hometown Health updates for 2025 and beyond.

This Broker Summit is designed to share our 2025 Commercial Benefit Plans as well as provide you everything needed to present Hometown Health features and benefits to your clients. Just as a caddie studies the course and helps the golfer select the right clubs, we hope to empower you with the knowledge and resources to drive your Hometown Health success for 2025.

A FEW TOPICS WE HAVE TEED UP FOR YOU INCLUDE

- **Cigna National Network**
  We have an exciting announcement regarding expanded out-of-state coverage for PPO members.
- **HMO Evolution**
  We continue our work to make Hometown's HMO offerings an attractive option for companies looking for quality care and value.
- **Strategic Direction**
  Enjoy a sneak peek at Hometown Health's five-year strategic initiatives that are designed to guide the company toward long term success.

We will also enjoy a nice lunch and, for some of you, an afternoon of golf. I can't wait to join you and will bring my max handicap with me.

Finally, I want to thank you for your unwavering support and dedication to Hometown Health. Here's to a productive and inspiring day as we tee off into a 2025 filled with promise and potential, and I am confident together we will finish well under par.

SINCERELY,

Bethany Sexton
Chief Executive Officer,
Hometown Health

LADD/2407-2989105

2025 Underwriting Guidelines

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Small Group Underwriting Guidelines

Effective Plan Years Beginning On or After January 1, 2025

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] NRS 689C.095 & 45 CFR § 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 <u>should not</u> 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; 26 IRC § 414
[7] NRS 689A.615(2)
[8] NRS 689C.065
[9] 26 CFR § 54.4980H-1(a)(21)

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. 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 the broker quoting system 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] 45 CFR § 147.104
[11] 45 CFR § 147.106
[12] Pursuant to 45 CFR § 147.104(a) & 45 CFR § 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;

    Premiums will be charged based on the member's age at renewal. Families with more than three children under age 21, covered under one subscriber, will not be charged for more than three children under age 21.
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] NRS 689C.180

[15] Section 2718 of the Public Health Service Act as added by Section 10101 of the Patient Protection and Affordable Care Act (42 USC § 300gg-16). The IRS has requested comments regarding the law for formulation of regulation, (IRS Notice 2010-63) but no regulation has been issued and enforcement has been delayed (IRS Notice 2011-01). 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] NRS 689C.065
[19] 26 CFR § 54.4980H-1(a)(21)
[20] 26 CFR § 54.4980H-1(a)(15)
[21] 45 CFR § 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]

c. Service Area Eligibility – Some employees who live out of the service area or outside the state may not be eligible for coverage.[24]

   i. HMO Out of Service Area Eligibility – Hometown Health will not offer Small Group HMO coverage to any employee that lives outside of Nevada.

   ii. EPO Out of Service Area Eligibility – Hometown Health will not offer Small Group EPO coverage to any employee that lives outside of Nevada.

   iii. 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]

      1. New Small Groups that have more than 35% 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.

         a. At renewal Small Groups will be audited by Underwriting to ensure that the group has remained within the 35% threshold Hometown Health reserves the right to not renew groups that fall outside the national network guidelines.

ci. 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]

   i. Employees only
   ii. Employees and children;
   iii. Employees, spouses and children; or
   iv. Employees, spouses, domestic partners and children.

[22] NRS 689C.065
[23] 45 CFR § 147.116
[24] 45 CFR § 147.104(c)(i)(1) & NRS 689C.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] NRS 698C.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 iChoose 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] NRS 689C.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] 45 CFR § 147.104(b)(1)(i)(B)
[30] NRS 689C.170(2). See NRS 689C.053 for the types of coverage considered Creditable Coverage.
[31] 45 CFR § 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] 45 CFR § 147.116
[33] 45 CFR § 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.iii 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 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

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 January 1, 2025

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 – Hometown Health will issue the health plans offered to the applicable association to each employer that is a member of the association and who is eligible for the health plan.

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:
   i. Fraud – Misrepresentation of information regarding the employer or its employees;
   ii. Non-payment of premiums;

[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.

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. 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 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 Application and Adoption Agreement – 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 for select AHP's
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. 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 35% 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.
         A. At renewal Small Groups will be audited by Underwriting to ensure that the group has remained within the 35% threshold Hometown Health reserves the right to not renew groups that fall outside the national network guidelines.

ci. Dependent Eligibility – Dependents must meet the eligibility requirements for dependents listed in the Enrollment and Eligibility section of the applicable EOC.

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[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.

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

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,

[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.

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 (*unless the applicable association allows sole proprietors*) 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. 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, 2024

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.

No more than 35% of the enrolled population may reside outside Nevada.

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.

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

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)

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

isolved™

People Cloud™

Whether you are an employer group with over 20 full time employees and/or full time equivalent employees, OR have health benefits through an Association Health Plan, you must offer COBRA coverage to your employees.
Hometown Health and isolved are here to help with COBRA administration that is included with our health benefits and at no cost to you!

Our Account Managers are happy to get you started, we just need the following information:

- Employer Legal Name:
- Employer Address:
- Employer FEIN:
- Confirm Total Number of Eligible Employees:
- Confirm Total Number of Insured Employees:
- Is Employee Navigator being requested?
- Confirm service start date:
- Contract Signer Name:
- Contract Signer email:

isolved™

People Cloud™

Benefit Services

COBRA Administration we keep the IRS out of your business and your business out of court

For more information about our free employer group administrative COBRA services through isolved, please contact the Hometown Health Sales Team (775-982-3100.

Table of Contents

Executive Summary

We realize that you have a business to run, and we are committed to providing leading edge solutions coupled with the most comprehensive level of outsourced service in the marketplace today. We do not take this responsibility lightly and together we will build a long-term partnership. We have the solutions that will allow you to focus on what matters most, your business.

isolved has a solid reputation of delivering the highest levels of superior service. With 30+ years of experience, we know what employers need, and we have addressed these issues in our solution. We invest a great deal of time and resources towards the continuous improvement of our benefits administration products and services.

At the same time, we continue to increase the size of our service team so that each of our clients receives one-on-one support throughout every step of the process. This also allows our staff members to proactively engage with participants to minimize claim denials and provide a better overall experience.

isolved is pleased to present you with this formal proposal for benefits administration and compliance services. We appreciate your consideration of our solution(s) and are confident we can manage your compliance requirements in the most efficient and cost-effective way possible.

We truly take pride in what we do and look forward to working with your business. Begin your administrative services and experience superior service provided by benefit experts!

We welcome the opportunity to be your administrator of choice!

Sincerely,

VICKI BURKE

National Sales Director

Your Benefits and Compliance Partner

Our Heritage

isolved began operations in 1986 as COBRA Compliance Systems, as a direct response to the newly enacted COBRA law and specialized in compliance education and administration of COBRA benefits. As the market evolved and business needs changed, we began to add additional products and services to our portfolio. Today, isolved is a leading nationwide provider of Human Capital Management (HCM) software in the cloud and HR Services. Thirty plus years on, our solution continues to be an industry leader for benefits administration with an enviable and well-earned reputation.

For more information about isolved, please access the following link:

https://www.isolvedhcm.com/

Our Purpose

Our mission is to provide you with a connected future proof platform that transforms your modern workforce for a better today and a better tomorrow – simply put, we promise to provide innovative and easy-to-use solutions that fit your needs and contribute to your success.

Why Companies Choose Us

We are widely recognized as the COBRA compliance and benefits administration authority and are uniquely equipped to help your business stay compliant in an increasingly complex landscape.

- Empowering: Helping our customers to achieve their goals through transformational employee experience
- Experienced: Delivering quality solutions for more than five million people for over 30 years
- Ecosystem: 1,400+ employees, 2,400 partners and brokers, and 145,000 customers represented in all 50 States
- Ease-of-Use: Effortless and productive for employees, managers and service partners alike
- Extensible: Plug-n-play marketplace ensures seamless connectivity to existing systems and data
- Efficient: Fully managed cloud with flexible SLA and per employee subscription model is secure and scalable
- Economical: Rapid time to value

COBRA Administration

Our solution directly addresses the most common concerns employers have with COBRA:

Employer Concerns	isolved's Solution
Time Frames	We track 29 possible time frames per beneficiary
Notice Requirements	Our notices exceed Department of Labor (DOL) notice requirements
Changing Rules & Regulations	We monitor legislation on a daily basis
Documentation	We retain documentation for eight years
Time	Our administration services relieves your employees of a time-consuming responsibility

Your COBRA Administration subscription Includes:

Reporting COBRA Activity to isolved

Options	Detail
Customer Web Portal	Login to report COBRA activity anytime, anywhere
EDT Reporting	Weekly files sent from your benefits enrollment system
Integration with isolved	Real-time COBRA data from isolved People Cloud

COBRA Notices Sent by isolved

Notices
General Notice
Qualifying Event Election Notice
Notice of Unavailability
Extension Notice
Conversion Notice
Early Termination of COBRA Notice
Expiration Notice

COBRA Premium Collection

Included
Welcome letters to existing COBRA participants (at beginning of service)
Process COBRA elections
Mail monthly premium invoice
Collect monthly premiums and determine timeliness of payment
Send Insignificant Premium Underpayment Notice (if necessary)
Remit premiums to customer or carrier
Participant call center to answer inquiries from ex-employees
Send Notice of Early Termination if timely payment not received
Premium Remittance Report provided monthly to account for premiums billed and collected

Included
isolved Benefit Services retains the 2% administration fee

COBRA Eligibility Management

Re-enrolling and dis-enrolling COBRA participants is necessary when a COBRA beneficiary elects and pays for COBRA (re- enrollment) and when COBRA ends (dis-enrollment). There are three ways this can be accomplished with our COBRA Administration solution:

Options	Detail
isolved reports to customer	We provide Daily Status Change Report to customer and customer is responsible for re- enrollment or dis-enrollment. No additional charges apply.
isolved reports to carrier	We provide Daily Status Change Reports to insurance carrier and insurance carrier is responsible for re-enrollment or dis-enrollment (this option necessitates a confirmation from the insurance carrier that they are accepting this responsibility). No additional charges apply.
isolved makes change directly with carrier	We assume responsibility for re-enrollments and dis-enrollments and makes these changes by using our own login credentials directly with the carrier on behalf of the customer. This option may only be used if we obtain carrier login credentials. Additional charges do apply. Please refer to the pricing section in this proposal.

isolved Reporting to Customer

Report Name	Frequency	Detail
Daily Status Change Report	As needed - daily	Report provided to Customer or Carrier instructing receiver to re-enroll or dis-enroll a COBRA participant
Participant Status Report	Monthly	Summarizes monthly activity including notices sent, current CORA participants, beneficiaries currently in election period.

Report Name	Frequency	Detail
Premium Remittance Report	Monthly	Documents all premiums invoiced, collected, and remitted to customer
Online Date Range Reports	As needed – customer can run anytime online	Various reports available to customer online

Documentation

Type	Detail
Written Procedures	Available online as a service guide and provided to customer in direct response to any audit request from DOL or the Internal Revenue Service.
Customer COBRA Activity	Includes activity reported from customer, copies of notices mailed, elections, and premiums received/premiums remitted

Research

Type
Monitor legislative, regulatory, judicial activity that affects COBRA
Notification to customer of any changes, actions, or other necessary responses required of customer or isolved Benefit Services related to COBRA

Customer Support

Included
Customer Call Center Monday through Thursday 8 a.m. to 8 p.m. ET and Friday 8 a.m. to 6 p.m. ET
CHAT Now availability
Website access to view processed notices, invoices, reports, elections, and payments

Included
COBRA Dashboard available through website

Coordination with isolved FSA Administration Services

Type
Determination of Health FSA inclusion in COBRA offering
Determination of COBRA premium for Health FSA

Technology

Included
Proprietary web-based software
Regular, scheduled system enhancements
Data integration with isolved
Multi-client file feeds from Employee Navigator and EASE
File feeds actively received from over 70 benefits enrollment systems
Data privacy and security compliance

Customer Protection

Included
More than 30 years' experience delivering compliance excellence
National reputation as compliance and COBRA education expert
Over 12 million COBRA notices sent, and zero penalties assessed by IRS/DOL to isolved Benefit Services customers

Carson City Chamber AHP Resources

Hometown Health

CARSON CITY CHAMBER of COMMERCE

HOMETOWN HEALTH IS PROUD TO PARTNER WITH THE CARSON CITY CHAMBER OF COMMERCE

- Savings of up to 20% when compared to Hometown Health Small Employer Group offerings!
- Access all of Hometown Health's amazing products and networks at a significant cost savings (HMO, EPO, and PPO).
- Benefits and plans mirror Hometown Health's other Association Health Plan offerings.
- Provides access to Renown and Carson Tahoe providers.

Contact your Health Insurance Broker to learn more about Hometown Health's Association Health Plans.

Hometown Health • **HometownHealth.com** • **775-982-3100**

Carson City Chamber of Commerce • **carsoncitychamber.com** • **775-882-1565**

NEVADA SMALL BUSINESS OWNERS with 50 or fewer employees can secure discounted insurance plans when they are Carson City Chamber of Commerce members and sign up for Hometown Health's Carson City Chamber of Commerce Association Health Plan.

QUALIFICATIONS AND CRITERIA for the Carson City Chamber of Commerce Association Health Plan

- Must have a valid Nevada State Business License.
- HMO and PPO plans are available to businesses located in Carson City, Douglas, Lyon, Storey and Washoe counties. EPO plans are available to businesses located statewide except for those located in White Pine and Elko counties.
- Available to manufacturing and service businesses with 2-50 employees. Qualification is based on your client's NAICS code. Reach out to your account specialist to see if your client qualifies.
- Each group is subject to underwriting review. Provide a complete census with employee DOB, home zip, and gender for underwriting review. Medical questionnaires are not required!
- Group must be a member of the Carson City Chamber to officially enroll.

Carson City Chamber of Commerce Association Health Plan BENEFITS INCLUDE

- Savings of up to 20% when compared to Hometown Health Small Employer Group offerings!
- Access all of Hometown Health's amazing products and networks at a significant cost savings (HMO, EPO, and PPO).
- Benefits and plans mirror Hometown Health's other Association Health Plan offerings.
- Provides access to Renown and Carson Tahoe providers.
- Creating a community of trustworthy businesses and charities.

Contact your Health Insurance Broker to learn more about Hometown Health's Association Health Plans.

Hometown Health • **HometownHealth.com** • **775-982-3100**

Carson City Chamber of Commerce • **carsoncitychamber.com** • **775-882-1565**

LADD/2308-2477748

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)*
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BUSINESSES WITH "W-2" EMPLOYEES

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

PROVIDE AT LEAST ONE ITEM FROM THE LIST BELOW

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Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

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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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SUMMARY PLAN DESCRIPTION
WRAP DOCUMENT

FOR THE

SERVICE
BENEFIT TRUST FUND
WELFARE BENEFIT PLAN

SPONSORED BY
THE CARSON CITY CHAMBER OF COMMERCE

(Effective October 1, 2023)

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SUMMARY PLAN DESCRIPTION FOR THE

SERVICE BENEFIT TRUST FUND
WELFARE BENEFIT PLAN
SPONSORED BY THE CARSON CITY CHAMBER OF COMMERCE

PARTICIPATING EMPLOYER
INFORMATION AND BENEFITS OFFERED

Name: _____

Address: _____

_____

_____

Phone No.: _____

PREAMBLE

This Summary Plan Description describes the plan benefits provided to you by your employer (identified above). The plan was selected by your employer in its Adoption Agreement with the Trust Fund. The Trust Fund is a Multiple Employer Welfare Arrangement (MEWA) that is administered by the Trustees. Your employer's participation in the Trust Fund does not create a joint employer relationship between it and any other employer.

I. PLAN BENEFITS

A. Health Benefits for Employees

Your employer has elected to provide certain health insurance benefits. A summary of the benefits provided under the Plan are set forth in the attached Evidence of Coverage and Schedule of Benefits documents. The Evidence of Coverage and Schedule of Benefits describe the types of benefits, scope of coverage, prerequisites to being covered and other details regarding the benefits. You must read the Evidence of Coverage and Schedule of Benefits to understand your benefits.

B. Coverage of Employees

The Participating Employer will make contributions for employees who work at least 30 hours per week, as described in the Evidence of Coverage document.

C. Eligibility of Reported Employees

The obligation to contribute for monthly reported employees will begin on the first day of the month following [*employer to select one prior to distribution to employees*]:

( ) the date of hire,
( ) 30 days or one month after the date of hire, whichever is less, or
( ) 60 days or two months after the date of hire, whichever is less.

II. REQUIRED DISCLOSURES

This document, along with the attached Evidence of Coverage and Schedule of Benefits furnished by Hometown Health, is your Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”). This summary highlights your rights and obligations under the SERVICE BENEFIT TRUST FUND WELFARE BENEFIT PLAN ("Plan"). Benefits under the Plan are provided by Hometown Health, which has contracted with the Trust, and are subject to the provisions of the Plan, the Trust Agreement, your employer’s Adoption Agreement and the determination of the plan administrator or Hometown Health.

Since this is only a summary, all of the details of the Plan are not covered, and you should contact the Plan Administrator or health insurance issuer(s) if you still have questions about your coverage. The Plan Sponsor reserves the right to change or discontinue the Plan at any time. This Summary Plan Description does not create a contract of employment.

Noticia de Asistencia de Lenguaje Extranjero: Este folleto contiene un sumario en ingles de sus derechos del plan y los beneficios bajo Service Benefit Trust Fund. Si tiene alguna dificultad entendiendo cualquier parte de este folleto communiquese con el Administrador del plan a su oficina en Hometown Health, 10315 Professional Circle, Reno, Nevada 89521. Horas de oficina son de 8:30 a.m. a 5:00 p.m. de Lunes a Viernes. Tambien se puede comunicar con el Administrador por telefono al (775) 982-3000 para asistencia.

A. Basic Plan Information

1. Name of Plan

SERVICE BENEFIT TRUST FUND WELFARE BENEFIT PLAN (“Plan”).

2. Name and Address of Plan Sponsor

Carson City Chamber of Commerce
1900 S Carson St
Carson City, NV 89701
Phone: (775) 882-1565
EIN: 88-0067398

3. Participating Employer

The Plan allows participation of more than one employer. You may receive upon written request of the Plan Administrator information as to whether a particular employer participates in the Plan.

4. Plan Trust Employer Identification Number (EIN)

93-6527140

5. Plan Number (PN)

501

6. Type of Plan and Funding

This is a welfare benefit plan that provides group medical and supplemental benefits through a multiple employer trust fund. All benefits are fully insured. Contributions are paid by participating employers directly to the insurer. The Plan is not collectively bargained. The trust name is the Service Benefit Trust Fund ("Trust Fund")

7. Plan Administrator and Type of Administration

The Plan is administered by a professional plan administrator. If you have questions about the Plan, please contact:

Hometown Health Administrators
10315 Professional Circle
Reno, Nevada 89521
(775) 982-3000

8. Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Carson City Chamber of Commerce
Attn: Ronni Hannaman
1900 S Carson St
Carson City, NV 89701

Service of legal process may be made upon a plan trustee or the plan administrator.

9. Plan Trustees

The addresses of the Plan Trustee(s) are:

Julie Ann Evans
1027 Ladera Drive
Carson City, NV 89701

James Hardiman
4551 E Fifth St
Carson City, NV 89701

Stephen Jones
400 Eagle Station Lane
Carson City, NV 89701

Kris Wells
605 Sugar Tree Ct
Reno, NV. 89511

10. Named Fiduciary

The Named Fiduciary(ies) for the Plan are the Trustees. The Named Fiduciary may delegate its duties in writing.

The Claims Fiduciary(ies) have generally been designated to act on behalf of the Named Fiduciary for purposes of claims administration.

11. Source of Plan Contributions

Contributions are made by Participating Employers for their employee participants and beneficiaries, including dependents. Contributions are set at amounts needed to pay premiums for coverage and to pay for Plan expenses.

12. Plan Year

The Plan Year is the calendar year.

13. Health and Life Insurance Benefits

Your employer participates in the plans identified in the Evidence of Coverage and Schedule of Benefits.

14. Role of Health Insurance Issuer

The benefits provided under the Plans are insured and underwritten by Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc (together, "Hometown Health"). Administrative services in connection with the health insurance Plan, including payment of claims, are performed by Hometown Health. Should you have any questions for the insurer, you may direct inquiries to:

Hometown Health
10315 Professional Circle
Reno, Nevada 89521
(775) 982-3000

15. Filing a Claim for Benefits

Procedures for submitting claims and obtaining benefits are outlined in the Evidence of Coverage document. Plan Participants and beneficiaries can obtain a copy of these procedures, without charge, from the Plan Administrator.

16. Appealing a Claim Denial

The Trustees have delegated review of denied insurance benefit claims and adverse benefit determinations to the individual health benefit provider(s) identified above ("Claims Fiduciary"). The Claims Fiduciary is responsible for adjudicating claims for benefits under the Plan, and for deciding any appeals of adverse claim determinations. Claims Fiduciary will have the authority, in its discretion, to interpret the terms of the

Plan, including the insurance policies, to decide questions of eligibility for coverage or benefits under the Plan and to make any related findings of fact. All decisions made by the Claims Fiduciary will be final and binding on participants and beneficiaries of the Plan to the full extent permitted by law.

These claims review and appeal procedures will constitute the sole and exclusive procedures under the plan available to a participating employee or beneficiary who is dissatisfied with the disposition of a benefit claim and will comply with the requirements of ERISA. A copy of such procedures can be obtained, without charge, from the Plan Administrator. No lawsuit may be brought with respect to plan benefits until all such administrative procedures have been exhausted for every issue deemed relevant by the participating employee or beneficiary.

17. Continuation of the Plan

The Plan Sponsor and Participating Employers intend to continue the Plan, but reserve the right to terminate or change the Plan at any time.

18. Termination of the Plan

The Plan Sponsor and Participating Employers do not promise the continuation of any benefits nor do they promise any benefit at or during retirement. The Plan may be terminated at any time by the Trustees. Benefits may be terminated also by the Participating Employer's failure to make contributions or by the termination or expiration of the Participating Employer's agreement adopting the Plan.

Upon termination of the Trust Fund, the Trustees will wind up the affairs of the Trust Fund, and any remaining funds will be used to continue payment of benefits to Participants and their beneficiaries under the Plan.

19. Statement of ERISA Rights

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ('ERISA"). ERISA provides that all Plan Participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies;

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report; and

(d) Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If you have executed an Arbitration Agreement and Class Action Waiver, your right to file a claim shall be subject to the terms of that agreement.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you

need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration,

U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

B. Eligibility and Participation Rules

To determine whether you or your spouse and/or dependents are eligible to participate in the Plan, and how to enroll, please read the eligibility section in the attached Evidence of Coverage. The eligibility section also includes rules pertaining to qualified medical child support order ("QMCSO") determinations. Please contact the Plan Administrator if you have any questions regarding your coverage.

1. Open Enrollment

An open enrollment period is a time established by the employer when eligible employees and their eligible family members have the option to enroll in the plan or make changes to current plan coverage. The annual open enrollment period is the month immediately preceding the renewal date of coverage.

2. Termination of Your Insurance

Your coverage will terminate as described in the attached Evidence of Coverage.

3. Eligibility of Dependents

(a) Insuring Dependents.

Eligibility of dependents is subject to the terms outlined in the Evidence of Coverage and the Adoption Agreement. Your employer allows the following category of dependent to be covered under the Plan. [*employer to select one prior to distribution to employees*]:

( ) Employee only
( ) Employees and dependent children
( ) Employees, spouses and dependent children
( ) Employees, spouses, domestic partners and dependent children

Only a person who meets the definition of dependent may become insured for dependents' insurance under the group policy. To become insured, the person must:

(1) Qualify as a dependent;

(2) Be enrolled for the dependents' insurance through your participating employer; and

(3) Reach an eligibility date.

Eligible Dependent – The term "dependent" means only your spouse or domestic partner and unmarried child of an age within the Age Limits for Dependent Children shown below. The definitions of "child" and "dependent" are outlined in the insurance providers' benefit information materials including any child pursuant to a QMCSO. A child shall be deemed, for this insurance, to be a dependent of not more than one person. The term "dependent" does not include a person who is: (a) an eligible employee; or (b) on active duty in any armed forces.

Age Limits for Dependent Children – Dependent health coverage is available to children until the child reaches the age of 26. Eligibility of the child does not depend upon marital status, student status, or tax dependency of the child. Children up to age 26 can stay on their parent's coverage even if they have another offer of coverage through an employer.

Exception to Age Limits – If an unmarried dependent child, when he or she reaches the age limit shown above, is insured under the group policy, chiefly depends on you for support and maintenance, and is continuously unable to get self-sustaining work due to a physical or mental handicap, the child will continue to qualify as a dependent for coverage until the earlier of the following dates: (a) the date he or she recovers from the handicap; and (b) the date he or she no longer chiefly depends on you for support and maintenance. See the Evidence of Coverage for more information.

Eligibility Date – A dependent's eligibility date is the later of: (a) your eligibility date; or (b) the date the person qualifies as your dependent.

(b) Termination of a Dependent's Insurance.

A dependent's insurance will end on the earliest date shown below:

(1) The last day for which premiums are paid for your dependents' insurance;

(2) The last day of the month in which the person no longer qualifies as a dependent; or

(3) The date your employees' insurance ends.

4. Coverage of Former Medicaid or State Children's Health Insurance Program Participants

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides enrollment rights of eligible individuals. The Plan provides the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

(a) An employee or eligible dependent who is covered under Medicaid or the State Children's Health Insurance Program ("SCHIP") and loses coverage under Medicaid or SCHIP because the employee or dependent is no longer eligible for such coverage may request coverage under the Plan within sixty (60) days of the loss of Medicaid or SCHIP coverage. Like other special enrollment rights under the Plan, qualified individuals may enroll in the Plan outside of the regular open enrollment period; and

(b) An employee or eligible dependent who becomes eligible for a premium assistance subsidy in the Plan under Medicaid or SCHIP may request coverage under the Plan within sixty (60) days after such eligibility is determined. State-specific notices will be provided to employees regarding the state-provided subsidy after they have been issued by the Department of Labor and Division of Health and Human Services.

5. HIPAA Special Enrollment Period

HIPAA Special Enrollment Periods apply only to group "Health Coverage", and not to any other Component Benefit Plan offered under this Plan (e.g., life, disability, etc.). If you, your Spouse, and/or eligible Dependents are entitled to special enrollment rights, you may change your group Health Coverage elections to correspond with the special enrollment right. For example, if you declined enrollment in the medical plan offered under this Plan for yourself or your eligible Dependents because you or they had other medical coverage and eligibility for such other coverage is subsequently lost (for example, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA coverage), you may be able to elect medical coverage (and if applicable, dental and/or vision coverage) under the Plan for yourself and your eligible dependents who lost such coverage. You are required to request enrollment in writing within 30 days after your or your Dependents' other coverage ends (or after the Participating Employer stops contributing toward the other coverage).

In addition, you may make a change to your Health Coverage due to your marriage or the birth, adoption, or placement for adoption of a child with you. Written requests received within 30 days of the birth of a child or adoption or placement for adoption of a child with you will permit you, your child(ren) and your eligible Spouse/domestic partner, if elected, to be covered retroactively to the date of birth, adoption or placement for adoption. Written requests received within 30 days of your marriage will permit you, your eligible Spouse/domestic partner and your Dependent children, if elected, to be added to your coverage prospectively on the first day of the month following the date of your written request.

You may also cancel or modify your medical insurance during the current Plan Year if the reason for canceling or modifying your election is on account of your, your Spouse and/or your eligible Dependent (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP. However, to cancel or

modify your medical insurance, you must make a written election to the Plan Administrator no later than 60 days after the loss of coverage or eligibility for premium assistance.

An individual who loses coverage as a result of either a failure to pay premiums on a timely basis or for cause (such as for making a fraudulent claim or an intentional misrepresentation of a material fact in connection with prior health coverage) does not have the right to enroll under this Subsection.

Other Mid-Year Enrollment Changes Period: Generally, you cannot change the enrollment elections you have made after the beginning of the Plan Year, other than during an Annual Enrollment Period or HIPAA Special Enrollment Period. However, there are certain other limited situations when your enrollment elections may be changed during the Plan Year, such as if you experience a change in your employment or family status. Please review your Section 125 Cafeteria Plan, if any, for a more information regarding the events that may permit a mid-year enrollment change under this Plan.

6. Continuing Coverage (COBRA)

You, your spouse, and/or your covered dependents may elect to continue your coverage under the Plan through federal legislation called COBRA. You will be required to pay premiums for this continued coverage. COBRA coverage procedures are explained in the attached Evidence of Coverage.

Questions concerning this Plan, or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the EBSA or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA offices are available through EBSA's website.

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. In addition, even if your dependent children are covered under a QMCSO, you, and/or your spouse should notify this office immediately of his, her or their address(es). You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

7. Continuing Coverage (USERRA)

If you experience a leave of absence from your employment to perform service in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides you with rights to elect to continue your coverage under the Plan that is separate from and in addition to COBRA continuation coverage rights.

Uniformed services mean the Armed Forces, and the Army National Guard, when you are engaged in active duty or training, or inactive duty training. Uniformed services also include full-time National Guard duty, the commissioned corps of the Public Health

Service, and any other persons designated by the President in a time of war or national emergency. Service in the uniformed services means voluntary or involuntary duty, active duty, and inactive duty for training. It also includes periods away from work for an examination to determine fitness to perform duty.

If you are a Participating Employee, you have a right to elect continuation coverage under USERRA for yourself and your covered dependents if you would otherwise lose coverage under the Plan because of service in the uniformed services. Unlike under COBRA, your dependents do not have an independent right to elect USERRA continuation coverage.

Under USERRA, you may elect to continue coverage under the Plan up to the lesser of (a) 24 months or (b) the date you return or should have returned to active employment, or, if applicable, applied for reemployment. Unlike COBRA, there are no additional qualifying events that would entitle you to extend the period of continuation coverage beyond the 24-month period. In addition, there is no entitlement under USERRA for any extension based on your disability or the disability of a qualified beneficiary. USERRA continuation coverage is identical to coverage provided under the Plan to similarly situated individuals.

USERRA continuation coverage is similar to COBRA continuation coverage, but it is not identical, and there are important differences. If you elect both USERRA and COBRA continuation coverage, they will run concurrently. If you elect continuation coverage under both federal laws, you will be provided with the coverage that is most favorable to you. For example, if your COBRA continuation coverage terminates at the end of an 18-month period, you may continue to receive continuation coverage under USERRA up to a total of 24 months. Similarly, if your COBRA continuation coverage terminates before the maximum period because you become covered under another employer's plan, you may continue USERRA continuation coverage up to a total of 24 months.

USERRA continuation coverage terminates when any one of the following events occurs:

(a) The date on which you fail to return from military service to active employment or apply, if applicable, for reemployment as required under USERRA;

(b) The end of the maximum 24-month period, beginning on the date on which your military leave of absence began;

(c) You fail to make a timely payment for your continuation coverage;

(d) The date on which you are discharged from military service under other than honorable conditions, or under conditions that prohibit your reinstatement under USERRA; or

(e) The Participating Employer no longer provides group health coverage to any employees.

To qualify for USERRA continuation coverage, you must provide your employer with advanced notice of your military service, as required under USERRA. You will receive a notice from the Plan Administrator regarding USERRA continuation coverage and an Election Form. Like COBRA, you must elect USERRA continuation coverage by returning the election form to the Plan Administrator within the 60-day period identified in the election form. If you fail to return the election form during this time period, you will lose the right to continuation coverage under USERRA. There are limited exceptions when it would be unreasonable or impossible under the circumstances to provide a timely notice, such as military emergency.

Like under COBRA, you must pay the entire cost of continuation coverage under USERRA for your coverage and coverage for any dependents. In addition, you will be required to pay a 2 percent administration fee along with each premium payment.

The costs of continuation coverage will be identified in the Election Form provided to you by the Plan Administrator. Like COBRA continuation coverage, your initial premium payment(s) must be made within 45 days of your electing USERRA continuation coverage. Subsequent payments must be made on a monthly basis. You will be provided a grace period of 30 days after the first day of the coverage period to make each monthly payment. Failure to pay premium costs before the end of the grace period will result in the loss of continuation coverage.

If your coverage under the Plan is terminated as a result of your service in the uniformed services, your coverage will be reinstated upon your return to active employment under the requirements of USERRA.

Questions concerning your rights to USERRA continuation coverage should be addressed to the Plan Administrator. For more information on your rights under USERRA, contact the nearest office of the Department of Labor Veterans' Employment and Training Service ("VETS") or access the VETS website at www.dol.gov/vets.

To protect your and your dependents' rights under USERRA, you should keep the Plan administrator informed of any changes in your or the addresses of family members. You should also keep a copy, for your records, of any notices or form that you send to the Plan Administrator.

8. Participation During FMLA Leave

If your Participating Employer is a large employer subject to the Family and Medical Leave Act of 1993, you will have the right to continue any Health Coverage during the period of leave if Health Coverage was in effect prior to the date on which the leave began. However, you have different options with regard to your Health Coverage, depending upon whether the FMLA Leave is paid leave or unpaid leave and you will be responsible for any premium payments during the leave. You will need to arrange for payment of premiums during your FMLA leave with your Participating Employer. For

information regarding continuation of coverage under Component Benefit Plans other than Health Coverage during FMLA Leave, contact your Participating Employer.

9. Other Paid and Unpaid Leaves

Employees in California may be eligible for leave under the California Family Rights Act (CFRA), Pregnancy Disability Leave Law (or PDL), or other California laws. In some instances, these state laws may allow employees to continue their group health coverage during these leave periods.

Furthermore, in some cases, Participating Employers may allow an employee to go on a leave of absence that is not subject to FMLA, CFRA, USERRA, or PDL; in these instances, the employee may no longer satisfy the eligibility requirements of the Plan, including the Component Benefit Plans, and Plan participation and benefits will terminate.

The Plan Documents for each Component Benefit Plan describe in more detail any rights, limitations, and obligations Participants may have to benefits while on paid or unpaid leave, including FMLA, CFRA, USERRA, or PDL leave. Participants should contact their Participating Employer for additional information about any rights they may have to leave and to benefits while on leave.

Participation Upon Rehire: If you terminate your employment with your Participating Employer and are then rehired, you may be permitted to resume participation in the Component Benefit Plans, if and when you satisfy the eligibility requirements applicable to those Component Benefit Plans. Please check with your Participating Employer for more information.

10. Maternity Benefits

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11. Qualified Medical Child Support Order

A Qualified Medical Child Support Order ("QMCSO") issued by a court or a state agency requires the Plan to provide health coverage to the child(ren) of a Plan participant. The Plan has adopted Qualified Medical Child Support Order Procedures to determine whether a particular order qualifies as a QMCSO. Plan participants and beneficiaries can

obtain, without charge, a copy of these procedures from the Plan Administrative Manager.

Participating employers that receive a QMCSO or a National Medical Support Notice from a state agency should provide affected participants with the following forms available from the Department of Child Support Services website: Statement of Obligor's Rights and Procedures Regarding a National Medical Support Notice (NMSN) or Health Insurance Assignment Order; Request and Notice of Hearing Regarding Health Insurance Assignment; and Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment.

12. No Assignment

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances. An insurer or Claims Fiduciary may pay benefits under the Plan directly to a provider. Such direct payment may not be interpreted or relied upon as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of healthcare services/items.

13. Restrictions on Lifetime Limits for Coverage of Benefits

Individuals whose medical coverage ended because they reached a lifetime limit under the Plan are eligible to enroll in the Plan if they meet eligibility requirements.

Individuals have 30 days from the date of notice to request enrollment. For more information, contact the Plan Administrator.

14. Patient Protection Disclosure

The Plan provides certain patient protection under the Patient Protection and Affordable Care Act. If the Plan requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health insurance issuer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or health insurance issuer or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in

obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

15. Mental Health Parity Act.

The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan's financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

16. Special Rule for Women's Health

If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

17. HIPAA Privacy and Security

The Plan will use and disclose protected health information (PHI), as defined in 45 CFR § 160.103, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as defined in the Plan HIPAA Privacy Notice (as defined in 45 CFR § 164.520) distributed to Participants and as otherwise permitted by the HIPAA privacy rules.

18. Compliance with Other Laws

The Plan will comply with applicable laws, including the Genetic Information Nondiscrimination Act and the Consolidated Appropriations Act of 2021.

19. Coordination of Benefits; Subrogation and Reimbursement

If your spouse or dependents are enrolled in a medical or dental coverage under this Plan as well as another employer-sponsored plan, such as your spouse's plan at work, the medical or dental coverage under this Plan coordinates its coverage with the other

plan. See the attached Evidence of Coverage for the coordination of benefits provisions that apply.

The attached Evidence of Coverage contains information about the Plan's right to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan to the fullest extent permitted by law. The Plan reserves the right to be made whole without offsets for attorney's fees, to the extent permitted by law. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurer, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurer, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurer. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

20. Nondiscrimination Policy.

The Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Trust Fund provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The Trust Fund also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Hometown Health. If you believe that the Trust Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Hometown Health, 10315 Professional Circle, Reno, Nevada 89521 or phone (775) 982-3000.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Hometown Health is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department

of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

21. Governing Law.

To the extent not preempted by ERISA, questions concerning the proper interpretation of the terms of this summary plan description shall be determined in accordance with the law of the State of Nevada. It is intended that this Plan meet all applicable requirements of the Internal Revenue Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, article, or provision of this Plan and the Code or ERISA, the provisions of the Code or ERISA shall be deemed controlling, and any conflicting part, clause, article, or provision of this Plan shall be deemed superseded to the extent of the conflict.

22. Language Access.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(775) 982-3000.

Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-(775) 982-3000.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(775) 982-3000.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(775) 982-3000.

Korean: 번으로 전화해 주십시오.주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-(775) 982-3000.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-(775) 982-3000.

Persian (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید. تماس 1(800) 274-4550 با ف می باشد.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(775) 982-3000.

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-(775) 982-3000.（まで、お電話にてご連絡ください。

Arabic: ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-(775) 982-3000.

Panjabi: ਿ◌ਧਆਨ ਿ◌ਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿ◌ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-(775) 982-3000 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer (Cambodian): লয্ কর নঃ িযদ আিপন বাংলা, কথা বেলত পা◌েরন, তা◌েহল ি◌নঃখরচায় ভাষা সহায়তা িপেরষবা উপল ◌েআছ্। ◌েফান কর ন ১ 1-(775) 982-3000

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-(775) 982-3000

Hindi: ध्यान द: यद आप हद बोलते ह तो आपके ि◌लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-(775) 982-3000 पर कॉल कर।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-(775) 982-3000.

SUMMARY PLAN DESCRIPTION
WRAP DOCUMENT

FOR THE

MANUFACTURING
BENEFIT TRUST FUND
WELFARE BENEFIT PLAN

SPONSORED BY
THE CARSON CITY CHAMBER OF COMMERCE

(Effective October 1, 2023)

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SUMMARY PLAN DESCRIPTION FOR THE

MANUFACTURING BENEFIT TRUST FUND
WELFARE BENEFIT PLAN
SPONSORED BY THE CARSON CITY CHAMBER OF COMMERCE

PARTICIPATING EMPLOYER
INFORMATION AND BENEFITS OFFERED

Name: _____

Address: _____

_____

_____

Phone No.: _____

PREAMBLE

This Summary Plan Description describes the plan benefits provided to you by your employer (identified above). The plan was selected by your employer in its Adoption Agreement with the Trust Fund. The Trust Fund is a Multiple Employer Welfare Arrangement (MEWA) that is administered by the Trustees. Your employer's participation in the Trust Fund does not create a joint employer relationship between it and any other employer.

I. PLAN BENEFITS

A. Health Benefits for Employees

Your employer has elected to provide certain health insurance benefits. A summary of the benefits provided under the Plan are set forth in the attached Evidence of Coverage and Schedule of Benefits documents. The Evidence of Coverage and Schedule of Benefits describe the types of benefits, scope of coverage, prerequisites to being covered and other details regarding the benefits. You must read the Evidence of Coverage and Schedule of Benefits to understand your benefits.

B. Coverage of Employees

The Participating Employer will make contributions for employees who work at least 30 hours per week, as described in the Evidence of Coverage document.

C. Eligibility of Reported Employees

The obligation to contribute for monthly reported employees will begin on the first day of the month following [*employer to select one prior to distribution to employees*]:

( ) the date of hire,
( ) 30 days or one month after the date of hire, whichever is less, or
( ) 60 days or two months after the date of hire, whichever is less.

II. REQUIRED DISCLOSURES

This document, along with the attached Evidence of Coverage and Schedule of Benefits furnished by Hometown Health, is your Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”). This summary highlights your rights and obligations under the MANUFACTURING BENEFIT TRUST FUND WELFARE BENEFIT PLAN ("Plan"). Benefits under the Plan are provided by Hometown Health, which has contracted with the Trust, and are subject to the provisions of the Plan, the Trust Agreement, your employer’s Adoption Agreement and the determination of the plan administrator or Hometown Health.

Since this is only a summary, all of the details of the Plan are not covered, and you should contact the Plan Administrator or health insurance issuer(s) if you still have questions about your coverage. The Plan Sponsor reserves the right to change or discontinue the Plan at any time. This Summary Plan Description does not create a contract of employment.

Noticia de Asistencia de Lenguaje Extranjero: Este folleto contiene un sumario en ingles de sus derechos del plan y los beneficios bajo Manufacturing Benefit Trust Fund. Si tiene alguna dificultad entendiendo cualquier parte de este folleto communiquese con el Administrador del plan a su oficina en Hometown Health, 10315 Professional Circle, Reno, Nevada 89521. Horas de oficina son de 8:30 a.m. a 5:00 p.m. de Lunes a Viernes. Tambien se puede comunicar con el Administrador por telefono al (775) 982-3000 para asistencia.

A. Basic Plan Information

1. Name of Plan

MANUFACTURING BENEFIT TRUST FUND WELFARE BENEFIT PLAN (“Plan”).

2. Name and Address of Plan Sponsor

Carson City Chamber of Commerce
1900 S Carson St
Carson City, NV 89701
Phone: (775) 882-1565
EIN: 88-0067398

3. Participating Employer

The Plan allows participation of more than one employer. You may receive upon written request of the Plan Administrator information as to whether a particular employer participates in the Plan.

4. Plan Trust Employer Identification Number (EIN)

93-6527143

5. Plan Number (PN)

501

6. Type of Plan and Funding

This is a welfare benefit plan that provides group medical and supplemental benefits through a multiple employer trust fund. All benefits are fully insured. Contributions are paid by participating employers directly to the insurer. The Plan is not collectively bargained. The trust name is the Manufacturing Benefit Trust Fund ("Trust Fund")

7. Plan Administrator and Type of Administration

The Plan is administered by a professional plan administrator. If you have questions about the Plan, please contact:

Hometown Health Administrators
10315 Professional Circle
Reno, Nevada 89521
(775) 982-3000

8. Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Carson City Chamber of Commerce
Attn: Ronni Hannaman
1900 S Carson St
Carson City, NV 89701

Service of legal process may be made upon a plan trustee or the plan administrator.

9. Plan Trustees

The addresses of the Plan Trustee(s) are:

Stacy Woodbury
400 Eagle Station Lane
Carson City, NV 89701

Peter Fishburn
1008 Pioche Street
Carson City, NV 89701

Gordon Gagnon
3000 Arrowhead Dr.
Carson City, NV 89706

Pete Gilbert
31 Keystone Ave
Reno, NV 89503

Lisa Lee
3640 Gordon St.
Carson City, NV 89701

10. Named Fiduciary

The Named Fiduciary(ies) for the Plan are the Trustees. The Named Fiduciary may delegate its duties in writing.

The Claims Fiduciary(ies) have generally been designated to act on behalf of the Named Fiduciary for purposes of claims administration.

11. Source of Plan Contributions

Contributions are made by Participating Employers for their employee participants and beneficiaries, including dependents. Contributions are set at amounts needed to pay premiums for coverage and to pay for Plan expenses.

12. Plan Year

The Plan Year is the calendar year.

13. Health and Life Insurance Benefits

Your employer participates in the plans identified in the Evidence of Coverage and Schedule of Benefits.

14. Role of Health Insurance Issuer

The benefits provided under the Plans are insured and underwritten by Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc (together, "Hometown Health"). Administrative services in connection with the health insurance Plan, including payment of claims, are performed by Hometown Health. Should you have any questions for the insurer, you may direct inquiries to:

Hometown Health
10315 Professional Circle
Reno, Nevada 89521
(775) 982-3000

15. Filing a Claim for Benefits

Procedures for submitting claims and obtaining benefits are outlined in the Evidence of Coverage document. Plan Participants and beneficiaries can obtain a copy of these procedures, without charge, from the Plan Administrator.

16. Appealing a Claim Denial

The Trustees have delegated review of denied insurance benefit claims and adverse benefit determinations to the individual health benefit provider(s) identified above ("Claims Fiduciary"). The Claims Fiduciary is responsible for adjudicating claims for benefits under the Plan, and for deciding any appeals of adverse claim determinations. Claims Fiduciary will have the authority, in its discretion, to interpret the terms of the

Plan, including the insurance policies, to decide questions of eligibility for coverage or benefits under the Plan and to make any related findings of fact. All decisions made by the Claims Fiduciary will be final and binding on participants and beneficiaries of the Plan to the full extent permitted by law.

These claims review and appeal procedures will constitute the sole and exclusive procedures under the plan available to a participating employee or beneficiary who is dissatisfied with the disposition of a benefit claim and will comply with the requirements of ERISA. A copy of such procedures can be obtained, without charge, from the Plan Administrator. No lawsuit may be brought with respect to plan benefits until all such administrative procedures have been exhausted for every issue deemed relevant by the participating employee or beneficiary.

17. Continuation of the Plan

The Plan Sponsor and Participating Employers intend to continue the Plan, but reserve the right to terminate or change the Plan at any time.

18. Termination of the Plan

The Plan Sponsor and Participating Employers do not promise the continuation of any benefits nor do they promise any benefit at or during retirement. The Plan may be terminated at any time by the Trustees. Benefits may be terminated also by the Participating Employer's failure to make contributions or by the termination or expiration of the Participating Employer's agreement adopting the Plan.

Upon termination of the Trust Fund, the Trustees will wind up the affairs of the Trust Fund, and any remaining funds will be used to continue payment of benefits to Participants and their beneficiaries under the Plan.

19. Statement of ERISA Rights

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ('ERISA"). ERISA provides that all Plan Participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies;

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report; and

(d) Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If you have executed an Arbitration Agreement and Class Action Waiver, your right to file a claim shall be subject to the terms of that agreement.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you

need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration,

U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

B. Eligibility and Participation Rules

To determine whether you or your spouse and/or dependents are eligible to participate in the Plan, and how to enroll, please read the eligibility section in the attached Evidence of Coverage. The eligibility section also includes rules pertaining to qualified medical child support order ("QMCSO") determinations. Please contact the Plan Administrator if you have any questions regarding your coverage.

1. Open Enrollment

An open enrollment period is a time established by the employer when eligible employees and their eligible family members have the option to enroll in the plan or make changes to current plan coverage. The annual open enrollment period is the month immediately preceding the renewal date of coverage.

2. Termination of Your Insurance

Your coverage will terminate as described in the attached Evidence of Coverage.

3. Eligibility of Dependents

(a) Insuring Dependents.

Eligibility of dependents is subject to the terms outlined in the Evidence of Coverage and the Adoption Agreement. Your employer allows the following category of dependent to be covered under the Plan. [*employer to select one prior to distribution to employees*]:

( ) Employee only
( ) Employees and dependent children
( ) Employees, spouses and dependent children
( ) Employees, spouses, domestic partners and dependent children

Only a person who meets the definition of dependent may become insured for dependents' insurance under the group policy. To become insured, the person must:

(1) Qualify as a dependent;

(2) Be enrolled for the dependents' insurance through your participating employer; and

(3) Reach an eligibility date.

Eligible Dependent – The term "dependent" means only your spouse or domestic partner and unmarried child of an age within the Age Limits for Dependent Children shown below. The definitions of "child" and "dependent" are outlined in the insurance providers' benefit information materials including any child pursuant to a QMCSO. A child shall be deemed, for this insurance, to be a dependent of not more than one person. The term "dependent" does not include a person who is: (a) an eligible employee; or (b) on active duty in any armed forces.

Age Limits for Dependent Children – Dependent health coverage is available to children until the child reaches the age of 26. Eligibility of the child does not depend upon marital status, student status, or tax dependency of the child. Children up to age 26 can stay on their parent's coverage even if they have another offer of coverage through an employer.

Exception to Age Limits – If an unmarried dependent child, when he or she reaches the age limit shown above, is insured under the group policy, chiefly depends on you for support and maintenance, and is continuously unable to get self-sustaining work due to a physical or mental handicap, the child will continue to qualify as a dependent for coverage until the earlier of the following dates: (a) the date he or she recovers from the handicap; and (b) the date he or she no longer chiefly depends on you for support and maintenance. See the Evidence of Coverage for more information.

Eligibility Date – A dependent's eligibility date is the later of: (a) your eligibility date; or (b) the date the person qualifies as your dependent.

(b) Termination of a Dependent's Insurance.

A dependent's insurance will end on the earliest date shown below:

(1) The last day for which premiums are paid for your dependents' insurance;

(2) The last day of the month in which the person no longer qualifies as a dependent; or

(3) The date your employees' insurance ends.

4. Coverage of Former Medicaid or State Children's Health Insurance Program Participants

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides enrollment rights of eligible individuals. The Plan provides the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

(a) An employee or eligible dependent who is covered under Medicaid or the State Children's Health Insurance Program ("SCHIP") and loses coverage under Medicaid or SCHIP because the employee or dependent is no longer eligible for such coverage may request coverage under the Plan within sixty (60) days of the loss of Medicaid or SCHIP coverage. Like other special enrollment rights under the Plan, qualified individuals may enroll in the Plan outside of the regular open enrollment period; and

(b) An employee or eligible dependent who becomes eligible for a premium assistance subsidy in the Plan under Medicaid or SCHIP may request coverage under the Plan within sixty (60) days after such eligibility is determined. State-specific notices will be provided to employees regarding the state-provided subsidy after they have been issued by the Department of Labor and Division of Health and Human Services.

5. HIPAA Special Enrollment Period

HIPAA Special Enrollment Periods apply only to group "Health Coverage", and not to any other Component Benefit Plan offered under this Plan (e.g., life, disability, etc.). If you, your Spouse, and/or eligible Dependents are entitled to special enrollment rights, you may change your group Health Coverage elections to correspond with the special enrollment right. For example, if you declined enrollment in the medical plan offered under this Plan for yourself or your eligible Dependents because you or they had other medical coverage and eligibility for such other coverage is subsequently lost (for example, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA coverage), you may be able to elect medical coverage (and if applicable, dental and/or vision coverage) under the Plan for yourself and your eligible dependents who lost such coverage. You are required to request enrollment in writing within 30 days after your or your Dependents' other coverage ends (or after the Participating Employer stops contributing toward the other coverage).

In addition, you may make a change to your Health Coverage due to your marriage or the birth, adoption, or placement for adoption of a child with you. Written requests received within 30 days of the birth of a child or adoption or placement for adoption of a child with you will permit you, your child(ren) and your eligible Spouse/domestic partner, if elected, to be covered retroactively to the date of birth, adoption or placement for adoption. Written requests received within 30 days of your marriage will permit you, your eligible Spouse/domestic partner and your Dependent children, if elected, to be added to your coverage prospectively on the first day of the month following the date of your written request.

You may also cancel or modify your medical insurance during the current Plan Year if the reason for canceling or modifying your election is on account of your, your Spouse and/or your eligible Dependent (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP. However, to cancel or

modify your medical insurance, you must make a written election to the Plan Administrator no later than 60 days after the loss of coverage or eligibility for premium assistance.

An individual who loses coverage as a result of either a failure to pay premiums on a timely basis or for cause (such as for making a fraudulent claim or an intentional misrepresentation of a material fact in connection with prior health coverage) does not have the right to enroll under this Subsection.

Other Mid-Year Enrollment Changes Period: Generally, you cannot change the enrollment elections you have made after the beginning of the Plan Year, other than during an Annual Enrollment Period or HIPAA Special Enrollment Period. However, there are certain other limited situations when your enrollment elections may be changed during the Plan Year, such as if you experience a change in your employment or family status. Please review your Section 125 Cafeteria Plan, if any, for a more information regarding the events that may permit a mid-year enrollment change under this Plan.

6. Continuing Coverage (COBRA)

You, your spouse, and/or your covered dependents may elect to continue your coverage under the Plan through federal legislation called COBRA. You will be required to pay premiums for this continued coverage. COBRA coverage procedures are explained in the attached Evidence of Coverage.

Questions concerning this Plan, or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the EBSA or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA offices are available through EBSA's website.

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. In addition, even if your dependent children are covered under a QMCSO, you, and/or your spouse should notify this office immediately of his, her or their address(es). You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

7. Continuing Coverage (USERRA)

If you experience a leave of absence from your employment to perform service in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides you with rights to elect to continue your coverage under the Plan that is separate from and in addition to COBRA continuation coverage rights.

Uniformed services mean the Armed Forces, and the Army National Guard, when you are engaged in active duty or training, or inactive duty training. Uniformed services also include full-time National Guard duty, the commissioned corps of the Public Health

Service, and any other persons designated by the President in a time of war or national emergency. Service in the uniformed services means voluntary or involuntary duty, active duty, and inactive duty for training. It also includes periods away from work for an examination to determine fitness to perform duty.

If you are a Participating Employee, you have a right to elect continuation coverage under USERRA for yourself and your covered dependents if you would otherwise lose coverage under the Plan because of service in the uniformed services. Unlike under COBRA, your dependents do not have an independent right to elect USERRA continuation coverage.

Under USERRA, you may elect to continue coverage under the Plan up to the lesser of (a) 24 months or (b) the date you return or should have returned to active employment, or, if applicable, applied for reemployment. Unlike COBRA, there are no additional qualifying events that would entitle you to extend the period of continuation coverage beyond the 24-month period. In addition, there is no entitlement under USERRA for any extension based on your disability or the disability of a qualified beneficiary. USERRA continuation coverage is identical to coverage provided under the Plan to similarly situated individuals.

USERRA continuation coverage is similar to COBRA continuation coverage, but it is not identical, and there are important differences. If you elect both USERRA and COBRA continuation coverage, they will run concurrently. If you elect continuation coverage under both federal laws, you will be provided with the coverage that is most favorable to you. For example, if your COBRA continuation coverage terminates at the end of an 18-month period, you may continue to receive continuation coverage under USERRA up to a total of 24 months. Similarly, if your COBRA continuation coverage terminates before the maximum period because you become covered under another employer's plan, you may continue USERRA continuation coverage up to a total of 24 months.

USERRA continuation coverage terminates when any one of the following events occurs:

(a) The date on which you fail to return from military service to active employment or apply, if applicable, for reemployment as required under USERRA;

(b) The end of the maximum 24-month period, beginning on the date on which your military leave of absence began;

(c) You fail to make a timely payment for your continuation coverage;

(d) The date on which you are discharged from military service under other than honorable conditions, or under conditions that prohibit your reinstatement under USERRA; or

(e) The Participating Employer no longer provides group health coverage to any employees.

To qualify for USERRA continuation coverage, you must provide your employer with advanced notice of your military service, as required under USERRA. You will receive a notice from the Plan Administrator regarding USERRA continuation coverage and an Election Form. Like COBRA, you must elect USERRA continuation coverage by returning the election form to the Plan Administrator within the 60-day period identified in the election form. If you fail to return the election form during this time period, you will lose the right to continuation coverage under USERRA. There are limited exceptions when it would be unreasonable or impossible under the circumstances to provide a timely notice, such as military emergency.

Like under COBRA, you must pay the entire cost of continuation coverage under USERRA for your coverage and coverage for any dependents. In addition, you will be required to pay a 2 percent administration fee along with each premium payment.

The costs of continuation coverage will be identified in the Election Form provided to you by the Plan Administrator. Like COBRA continuation coverage, your initial premium payment(s) must be made within 45 days of your electing USERRA continuation coverage. Subsequent payments must be made on a monthly basis. You will be provided a grace period of 30 days after the first day of the coverage period to make each monthly payment. Failure to pay premium costs before the end of the grace period will result in the loss of continuation coverage.

If your coverage under the Plan is terminated as a result of your service in the uniformed services, your coverage will be reinstated upon your return to active employment under the requirements of USERRA.

Questions concerning your rights to USERRA continuation coverage should be addressed to the Plan Administrator. For more information on your rights under USERRA, contact the nearest office of the Department of Labor Veterans' Employment and Training Service ("VETS") or access the VETS website at www.dol.gov/vets.

To protect your and your dependents' rights under USERRA, you should keep the Plan administrator informed of any changes in your or the addresses of family members. You should also keep a copy, for your records, of any notices or form that you send to the Plan Administrator.

8. Participation During FMLA Leave

If your Participating Employer is a large employer subject to the Family and Medical Leave Act of 1993, you will have the right to continue any Health Coverage during the period of leave if Health Coverage was in effect prior to the date on which the leave began. However, you have different options with regard to your Health Coverage, depending upon whether the FMLA Leave is paid leave or unpaid leave and you will be responsible for any premium payments during the leave. You will need to arrange for payment of premiums during your FMLA leave with your Participating Employer. For

information regarding continuation of coverage under Component Benefit Plans other than Health Coverage during FMLA Leave, contact your Participating Employer.

9. Other Paid and Unpaid Leaves

Employees in California may be eligible for leave under the California Family Rights Act (CFRA), Pregnancy Disability Leave Law (or PDL), or other California laws. In some instances, these state laws may allow employees to continue their group health coverage during these leave periods.

Furthermore, in some cases, Participating Employers may allow an employee to go on a leave of absence that is not subject to FMLA, CFRA, USERRA, or PDL; in these instances, the employee may no longer satisfy the eligibility requirements of the Plan, including the Component Benefit Plans, and Plan participation and benefits will terminate.

The Plan Documents for each Component Benefit Plan describe in more detail any rights, limitations, and obligations Participants may have to benefits while on paid or unpaid leave, including FMLA, CFRA, USERRA, or PDL leave. Participants should contact their Participating Employer for additional information about any rights they may have to leave and to benefits while on leave.

Participation Upon Rehire: If you terminate your employment with your Participating Employer and are then rehired, you may be permitted to resume participation in the Component Benefit Plans, if and when you satisfy the eligibility requirements applicable to those Component Benefit Plans. Please check with your Participating Employer for more information.

10. Maternity Benefits

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11. Qualified Medical Child Support Order

A Qualified Medical Child Support Order ("QMCSO") issued by a court or a state agency requires the Plan to provide health coverage to the child(ren) of a Plan participant. The Plan has adopted Qualified Medical Child Support Order Procedures to determine whether a particular order qualifies as a QMCSO. Plan participants and beneficiaries can

obtain, without charge, a copy of these procedures from the Plan Administrative Manager.

Participating employers that receive a QMCSO or a National Medical Support Notice from a state agency should provide affected participants with the following forms available from the Department of Child Support Services website: Statement of Obligor's Rights and Procedures Regarding a National Medical Support Notice (NMSN) or Health Insurance Assignment Order; Request and Notice of Hearing Regarding Health Insurance Assignment; and Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment.

12. No Assignment

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances. An insurer or Claims Fiduciary may pay benefits under the Plan directly to a provider. Such direct payment may not be interpreted or relied upon as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of healthcare services/items.

13. Restrictions on Lifetime Limits for Coverage of Benefits

Individuals whose medical coverage ended because they reached a lifetime limit under the Plan are eligible to enroll in the Plan if they meet eligibility requirements.

Individuals have 30 days from the date of notice to request enrollment. For more information, contact the Plan Administrator.

14. Patient Protection Disclosure

The Plan provides certain patient protection under the Patient Protection and Affordable Care Act. If the Plan requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health insurance issuer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or health insurance issuer or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in

obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

15. Mental Health Parity Act.

The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan's financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

16. Special Rule for Women's Health

If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

17. HIPAA Privacy and Security

The Plan will use and disclose protected health information (PHI), as defined in 45 CFR § 160.103, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as defined in the Plan HIPAA Privacy Notice (as defined in 45 CFR § 164.520) distributed to Participants and as otherwise permitted by the HIPAA privacy rules.

18. Compliance with Other Laws

The Plan will comply with applicable laws, including the Genetic Information Nondiscrimination Act and the Consolidated Appropriations Act of 2021.

19. Coordination of Benefits; Subrogation and Reimbursement

If your spouse or dependents are enrolled in a medical or dental coverage under this Plan as well as another employer-sponsored plan, such as your spouse's plan at work, the medical or dental coverage under this Plan coordinates its coverage with the other

plan. See the attached Evidence of Coverage for the coordination of benefits provisions that apply.

The attached Evidence of Coverage contains information about the Plan's right to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan to the fullest extent permitted by law. The Plan reserves the right to be made whole without offsets for attorney's fees, to the extent permitted by law. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurer, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurer, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurer. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

20. Nondiscrimination Policy.

The Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Trust Fund provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The Trust Fund also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Hometown Health. If you believe that the Trust Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Hometown Health, 10315 Professional Circle, Reno, Nevada 89521 or phone (775) 982-3000.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Hometown Health is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department

of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

21. Governing Law.

To the extent not preempted by ERISA, questions concerning the proper interpretation of the terms of this summary plan description shall be determined in accordance with the law of the State of Nevada. It is intended that this Plan meet all applicable requirements of the Internal Revenue Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, article, or provision of this Plan and the Code or ERISA, the provisions of the Code or ERISA shall be deemed controlling, and any conflicting part, clause, article, or provision of this Plan shall be deemed superseded to the extent of the conflict.

22. Language Access.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(775) 982-3000.

Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-(775) 982-3000.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(775) 982-3000.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(775) 982-3000.

Korean: 번으로 전화해 주십시오.주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-(775) 982-3000.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-(775) 982-3000.

Persian (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید. تماس 1(800) 274-4550 با ف می باشد.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(775) 982-3000.

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-(775) 982-3000.（まで、お電話にてご連絡ください。

Arabic: ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-(775) 982-3000.

Panjabi: ਿ◌ਧਆਨ ਿ◌ਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿ◌ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-(775) 982-3000 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer (Cambodian): লয্ কর নঃ িযদ আিপন বাংলা, কথা বেলত পা◌েরন, তা◌েহল ি◌নঃখরচায় ভাষা সহায়তা িপেরষবা উপল ◌েআছ্। ◌েফান কর ন ১ 1-(775) 982-3000

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-(775) 982-3000

Hindi: ध्यान द: यद आप हद बोलते ह तो आपके ि◌लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-(775) 982-3000 पर कॉल कर।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-(775) 982-3000.

Carson City Chamber of Commerce
Manufacturing & Service Benefit Trust Funds
Guidelines for SPD Distribution

As a participating employer in Carson City Chamber of Commerce Manufacturing Benefit Trust Fund and Service 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 Hometown Health Evidence of Coverage and Schedule of Benefits for your applicable plan. If you offer other benefits, you should contact your HR or benefits expert to ensure you comply with the requirements 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 keep a record of the method of distribution of the SPD, Evidence of Coverage and Schedule of Benefits in each employee's file.

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:

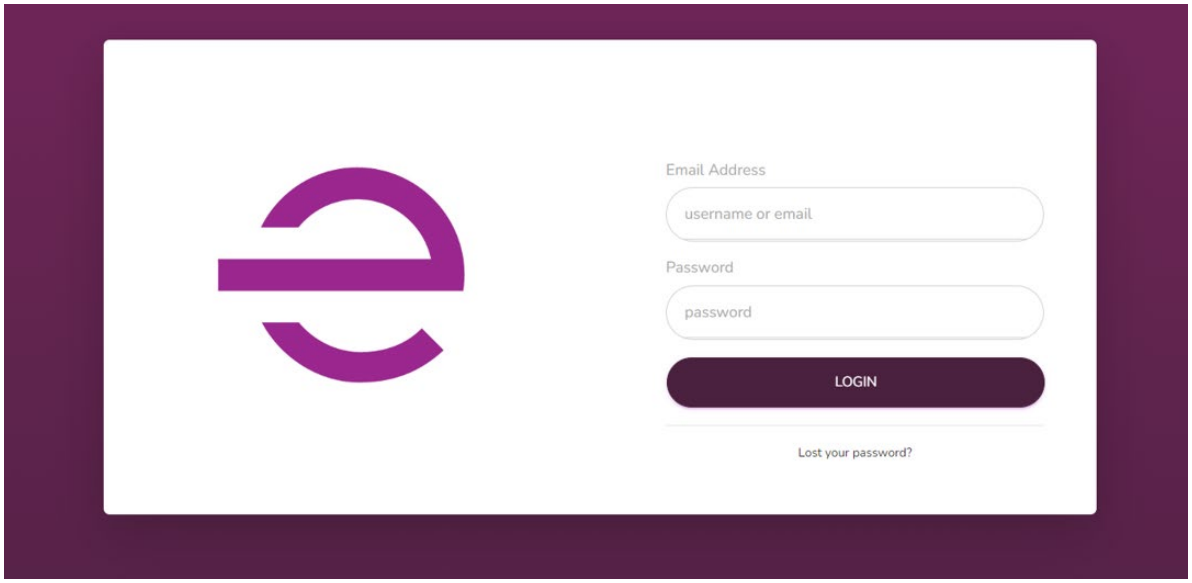
- ☐ Banking information (if paid directly)
- ☐ America's Health Insurance Plan (if selling MA)
- ☐ Error and Omissions Certificate
- ☐ License
- ☐ W9

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).



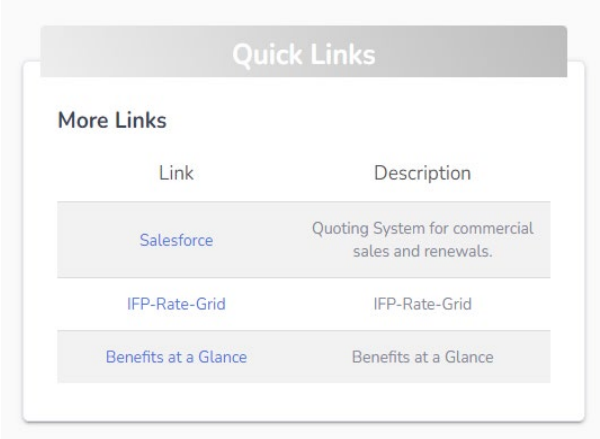
EVOLVE PORTAL GUIDE

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

AGENT/AGENCY DASHBOARD

Quick Links

Helpful URL links to access quickly

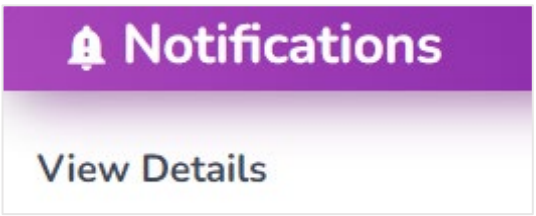


Commissions

Graphical View of commissions earned

Notifications

Click View Details to see messages



My Downline's Credentials (Agency Only)

Graphical View of commission

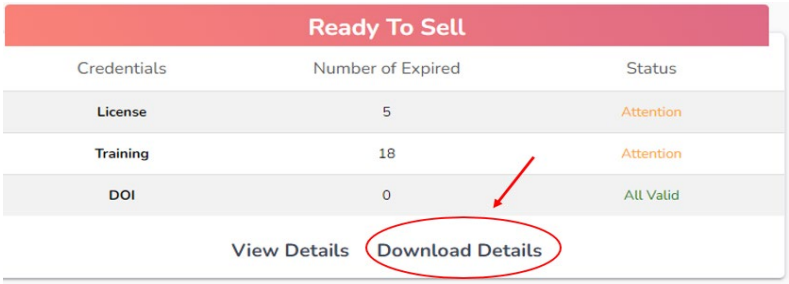
Book of Business

Graphical View of MA and Commercial

Ready to Sell (Agency Only)

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

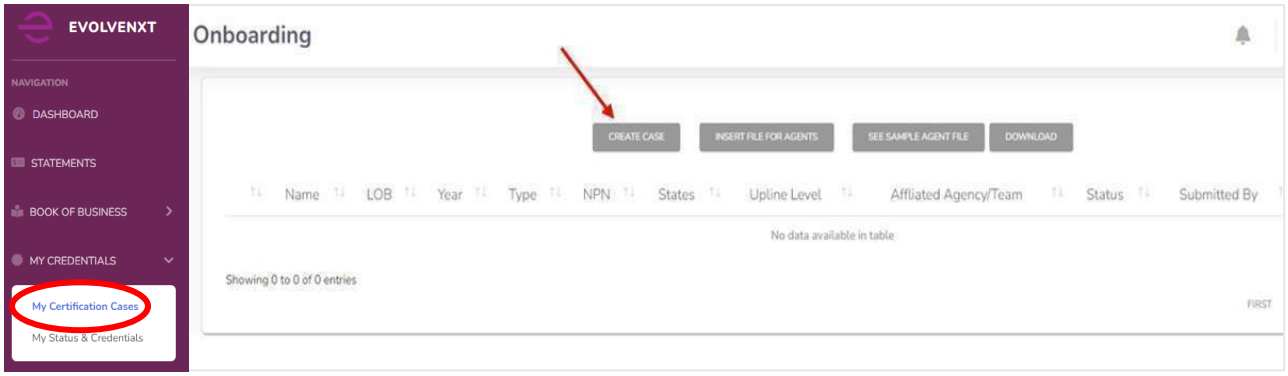
- Select Download Details > Excel report will generate > select the tabs to view



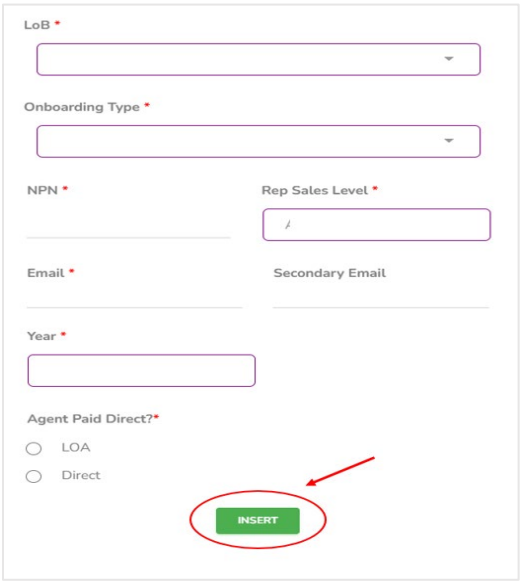
ONBOARDING

AGENCY CREATING NEW ONBOARDING CASE

- Select MY CREDENTIALS tab > My Certification Cases > 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,

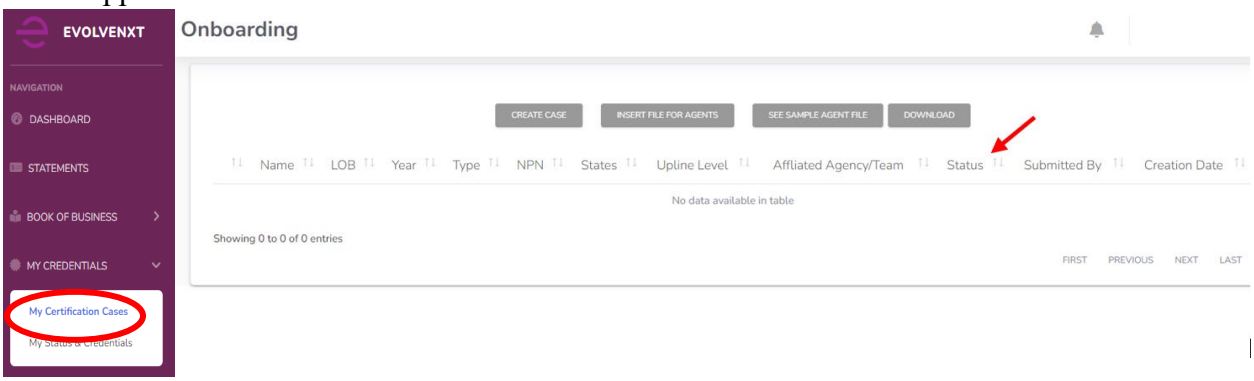
Please use the link below in order to complete your contract and 2022 certification for Hometown Medicare Advantage and Commercial Group Plans.

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 My Credentials 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

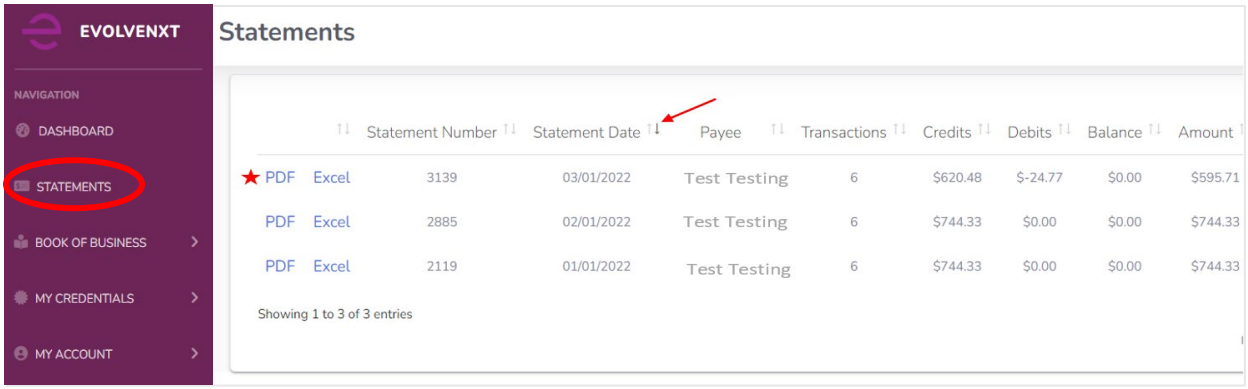
Dear Test Testing,

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

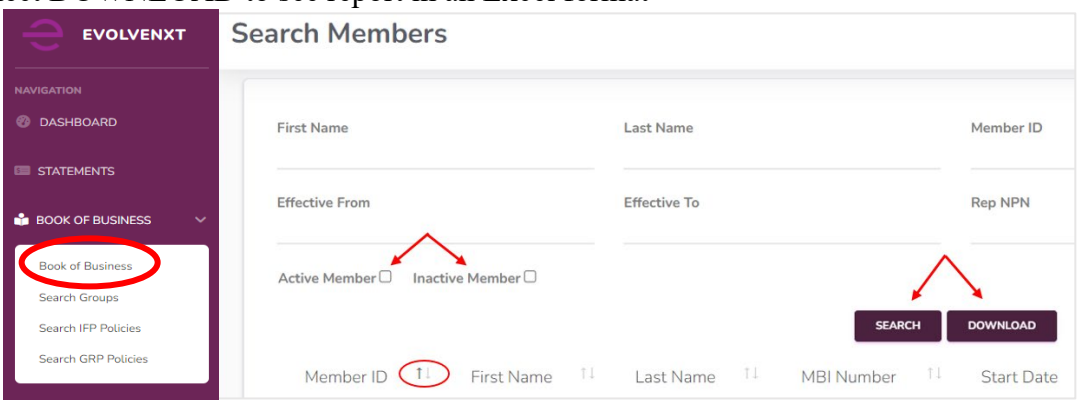
- Select STATEMENTS in the navigation menu > SEARCH
- The arrows ↑↓ on each tab let you ascend/descend
- Statement can be uploaded as PDF or Excel-(this format will have more details)



BOOK OF BUSINESS

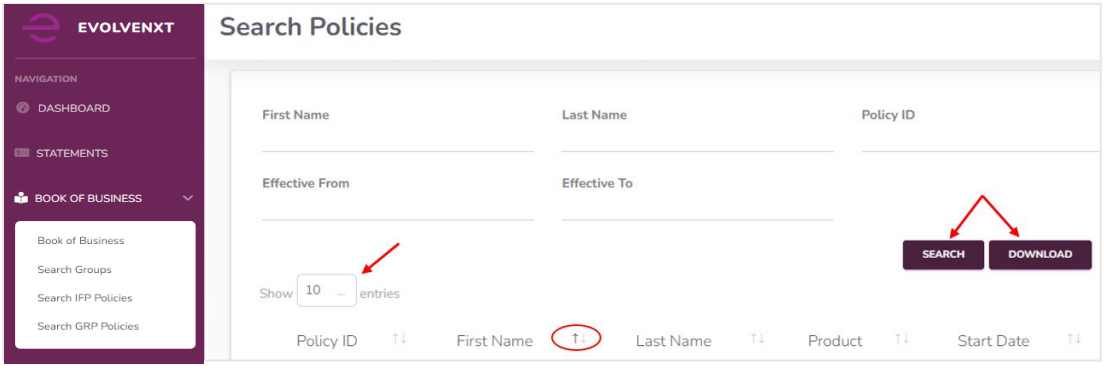
MEDICARE BOOK OF BUSINESS

- Select Book of Business for Medicare Only > SEARCH
- Filter 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



COMMERCIAL BOOK OF BUSINESS

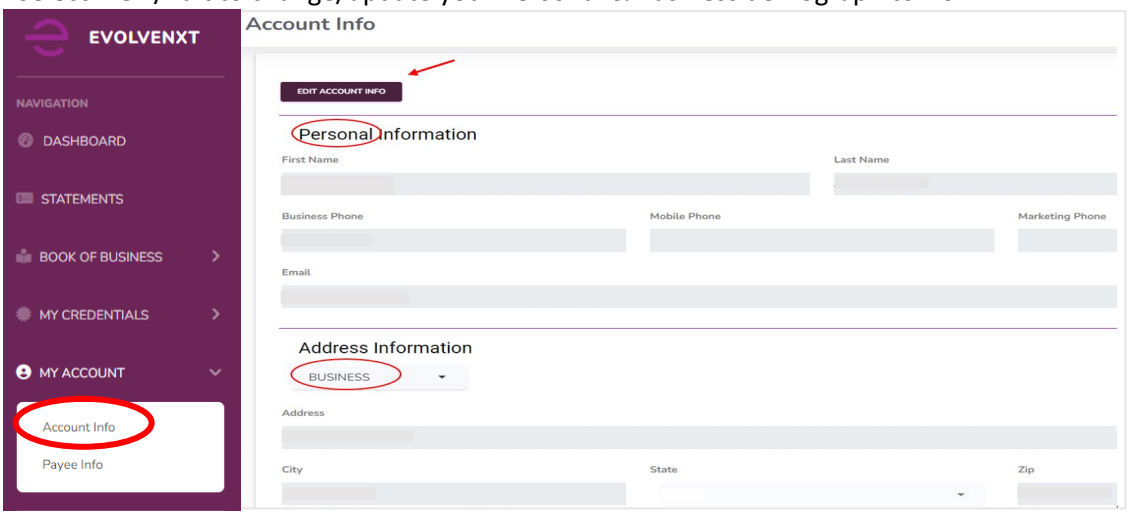
- Select "Group or IFP" > SEARCH
- Filter by any field, and/or active/inactive members
- The arrows ↑↓ on each tab lets you ascend/descend
- Select DOWNLOAD to see report in an Excel format



MY ACCOUNT

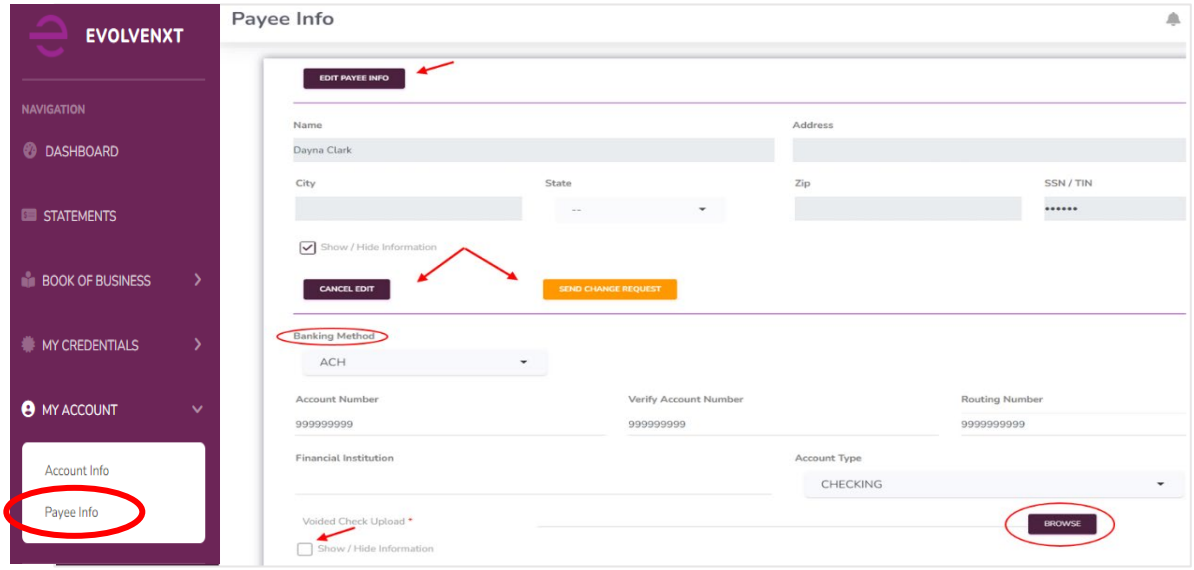
ACCOUNT INFO

- 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.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities 3—

A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities C—

A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a) J—

A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

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

Senior Care Plus

2025 Broker Commission Structure

New to Senior Care Plus New to Medicare Advantage	$626 Upfront $52.17 Chargeback per month unfulfilled
New to Senior Care Plus Renewal to Medicare Advantage	$313 Upfront $26.08 Chargeback per month unfulfilled
Renewal to Senior Care Plus	$26.08 per month

For broker onboarding information, please visit SeniorCarePlus.com

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

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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.

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Your Important **Contacts**

HOMETOWN HEALTH SALES & RETENTION

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

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Hometown Health

BROKER INFORMATION

For Questions Regarding Commissions Contact:
brokerupdates@hometownhealth.com

ELIGIBILITY/ENROLLMENT

Phone 775-982-3118 Fax 775-982-3749
enrollment@hometownhealth.com

PREMIUM ACCOUNTING

For Copies of Bills or Billing Questions:
premiumaccounting@hometownhealth.com
Fax 775-982-3749

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

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

TDD (Hearing Impaired):
775-982-3240

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

Senior Care Plus:
775-982-3100
SeniorCarePlus.com

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