Prominence Health Plan

BROKER INFORMATION BOOKLET

Commercial Small Group Plans

For the most current information,
refer to the online version found at
www.prominencehealthplan.com

Prominence℠
Health Plan

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INTRODUCTION

WELCOME TO PROMINENCE HEALTH PLAN …

we're here for you.

Prominence Health Plan was established in Reno, NV, in 1993 as a health maintenance organization. Built on a foundation of excellent customer service, Prominence Health Plan continues to provide a range of health insurance products to residents throughout the state of Nevada.

In 2014, a subsidiary of Universal Health Services, Inc. (UHS) acquired the health plan and renamed it Prominence Health Plan. UHS, through its subsidiaries, owns more than 235 acute care hospitals, behavioral health facilities and ambulatory centers throughout Northern Nevada Medical Center in Sparks and The Valley Health System in Las Vegas and is one of the largest and most respected hospital management companies in the nation.

In 2015, to raise member service and engagement to a new level for its members, Prominence Health Plan entered a long-term partnership with Accolade, the country's leading consumer healthcare engagement and influence company. As a result, members will now have one person – *their person* – to help with anything and everything related to health benefits and healthcare.

VALUES YOU CAN COUNT ON.

We believe in ensuring compassionate, high-quality, affordable health services; strong relationships with our brokers, employers and health care providers; and a level of quality recognized by the National Committee for Quality Assurance (NCQA).

HEALTH PLAN NCQA ACCREDITATION ACCREDITED

Prominence HealthFirst HMO/POS

PLAN INFORMATION

Medical Plans

Prominence Health Plan has the right plans for your clients

Our comprehensive portfolio of health plan options is alive with possibilities and designed to seamlessly fit the needs of any employer group. When considering what plan will work best for your clients, a good place to start is to consider what is best for their needs and the needs of their employees.

HEALTH SUITE SELECT

The Health Suite Select portfolio of health care plans is designed for small businesses of 2 to 50 employees. The concept is to offer maximum choice and flexibility, all within a simple approach and at an affordable cost. The goal is tailor specific plan options to meet the needs of each group and its employees. Customized benefits packages can be selected from any of our plan types and plan designs (see descriptions below) at various price points.

Employers with 5 or more enrolled employees can offer up to five of the available plans without restrictions, many of which would be typically associated with larger employer groups. They can build their own plan suite — select five different plans or perhaps only two. How many plans and plan types they want to offer is completely up to them.

Employers with less than 5 enrolled employees can select their favorite plan to offer.

Employees can then select what plan works best for them and their lifestyle — whether they are a young family, empty-nester or single and on-the-go, it's all about choice. Being empowered to make a decision about their health care offers employees a sense of value, a feeling that they are an active participant in what is right for them.

HEALTH MAINTENANCE ORGANIZATION (HMO)

Prominence Health Plan has a variety of HMO plans for groups of all sizes with low out-of-pocket expenses. Products are comprehensive medical and hospital insurance plans with various plan combinations for employers and their employees. Copays for services like laboratory, outpatient surgeries and emergency room visits inclusive of all charges related to a specific visit. Plus, on our Deductible HMO plans, the deductibles **only** apply to less frequently utilized services, such as hospitalizations and outpatient surgery.

Our HMO network offers your clients access to some of the highest quality hospitals in Nevada including an extensive primary care network of independent physicians. HMO plans in Nevada do not require provider referrals for specialist care.

PREFERRED PROVIDER ORGANIZATION (PPO)

Our fully insured PPO product plans range in price depending on the deductible level, coinsurance level and physician copay that your group chooses. With a PPO plan, members have access to Preferred Health Care Network — a statewide network of providers and hospitals including many of the highest quality providers in Nevada.

Some of the health benefits offered within our PPO plans include routine physical examinations, Well Baby and Well Child visits, a baseline mammogram plus annual mammography exams, annual prostate screenings and more.

Prominence Health Plan is contracted with **First Health** to serve as the national PPO network with a customized hospital network for use outside of Nevada. First Health features an expansive national network that includes more than 5,000 hospitals, 550,000 physicians and 64,000 ancillary providers.

As with other PPO networks, it is the member's responsibility, before services are provided, to validate that a provider they are seeing is in the Prominence Health Plan First Health Network. For a customized Prominence Health Plan First Health provider listing, visit **www.prominencehealthplan.com**.

POINT OF SERVICE (POS) (AVAILABLE IN NORTHERN NV ONLY)

Prominence Health Plan' POS plans combine the convenience and low out-of-pocket expenses of an HMO, greater freedom to choose a PPO provider from a larger panel of health care professionals and complete flexibility to choose any licensed care provider — all in one benefit package.

HMO Level – Members have access to comprehensive health care for copays and no lifetime maximum for medical services.

PPO Level – Members receive care from Preferred Health Care Network, a statewide network of providers that can be accessed without a referral from their PCP. Lifetime maximum benefits for in- and out-of-network medical services are unlimited.

Out-of-Network Provider Level – Benefits will be paid at the appropriate coinsurance rate once members seek services from non-contracted providers and have paid their annual deductible. Out-of-pocket expenses under this benefit plan will be greater than under the HMO or PPO plans and some services are covered under the HMO benefit only.

CONSUMER-DRIVEN HEALTH PLANS (CDHP)

Consumer-Driven health plans are next-generation coverage options designed to help members become aware of the value of health care, maintain control of their finances and make more confident decisions. Wiser health care consumers contribute to lower health care costs over time.

Health Savings Accounts (HSA) – Plans are available with or without embedded deductibles. HSAs are excellent tools to engage members in wise and cost conscious health care utilization and are a great method to save for medical expenses on a pre-tax basis. Contributions are not subject to FICA or FUTA taxes. HSAs must be used in conjunction with a high deductible health plan.

Health Reimbursement Accounts (HRA) – Our HRA products can function as an independent benefit or can be combined with fully insured products. By customizing HRA products with fully insured products, a group-specific product is created that can save money and control enrollee utilization. HRA contributions are a tax-free benefit to members and are tax-deductible to your employer group clients.

PPO BEYOND PLANS

A unique series of PPO plans where consumers get the best of both worlds — the first dollar benefits of an HMO and the choice and flexibility of a PPO plan. PPO Beyond plans offer first-dollar copays for most commonly accessed medical services including: primary care and specialist visits, radiology and lab tests, and emergency room and urgent care visits. Some plans even come with copays for outpatient surgeries.

HMO BEYOND PLANS

Members have first dollar benefits for the most commonly accessed medical services including PCP and specialty visits, radiology and lab tests, emergency room and urgent care visits and outpatient services. By balancing deductible and coinsurance amounts for other services and benefits, a more cost-effective plan can be offered to members. HMO plans in Nevada do not require provider referrals for specialist care.

FLEXFIT PLANS

Designed to grow with the needs of a business and easily adaptable, FlexFit PPO plans are a unique approach to health care and the most cost-effective options we have to offer. FlexFit plans are ideal for businesses of all sizes who want the most affordable plan combined with comprehensive coverage. Members can visit any doctor, specialist or therapist within the PPO network up to five combined times per year for a copay, then their deductible and coinsurance apply.

FREEDOM BEYOND HMO PLANS (NORTHERN NEVADA ONLY)

Freedom Beyond HMO plans offer Prominence Health Plan members the choice and flexibility of a PPO product with the cost savings of an HMO plan. Freedom Beyond plans provide popular design features like first-dollar copays for most commonly accessed medical services including primary care and specialist visits, lab test, and emergency room and urgent care visits. Enrolled members have access to the complete HealthFirst HMO and the First Health National PPO as participating networks for out-of-state coverage.

Benefit Summary Guide

Looking for one source of information on all of our small group plans?
The Health Suite Select guide provides a complete summary of group health plans and detailed plan information for each small group plan offered. Please ask your account executive or account manager for materials and provide a copy to all your new groups. The guide is updated every year with benefit and plan changes, and can also be found on **www.prominencehealthplan.com.**

DENTAL & VISION

Dental

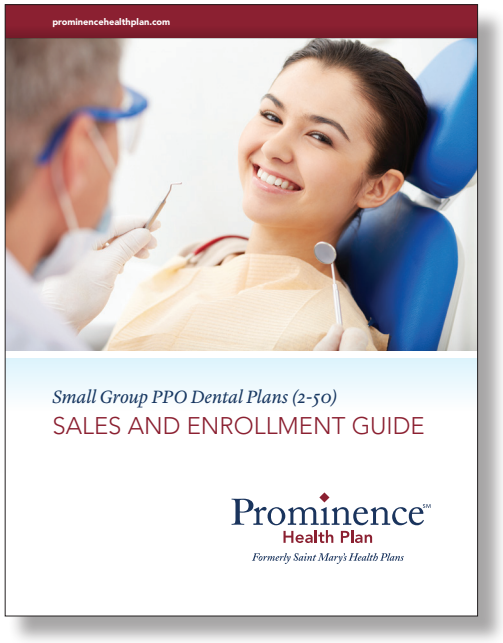
Prominence Health Plan is pleased to offer a variety of dental plan options that provide your group clients with choices in benefit levels and cost. Dental care is an integral part of overall good health, and the ability to offer dental coverage is an important element in attracting and retaining the best employees.

Prominence Health Plan PPO dental plans offer employees access to quality care at discounted fees. **Dental coverage for children to age 19 is included within small group medical plan coverage.**

Through the expansive DentalGuard Preferred network, Prominence Health Plan members enrolled in a dental plan will appreciate the flexibility and freedom of choosing any dentist in the participating statewide and national network.

For a complete list of all available Dental Plan summaries, please visit **www.prominencehealthplan.com.**

If you have additional questions about Prominence Health Plan dental plans, please contact your account executive or account manager.



Vision

Prominence Health Plan offers a vision plan that includes coverage for a vision examination/refraction (must be provided by a duly licensed Vision Care Provider) to determine the presence of vision problems or other abnormalities.

Refraction exams are limited to one per member per Calendar Year, and a maximum allowance of $40.

Coverage is provided for prescribed corrective lenses and eyeglass frames as follows:

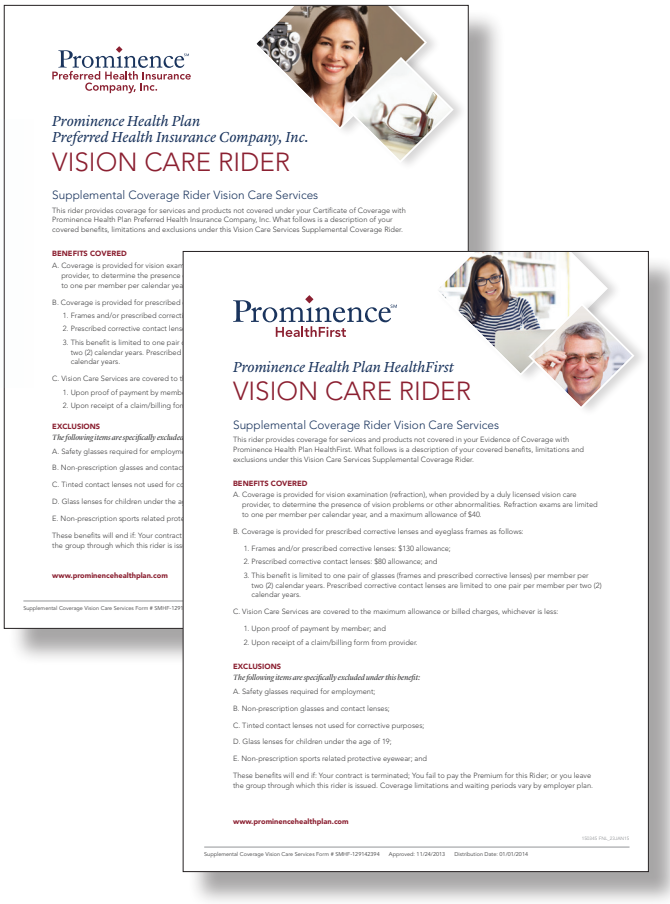
- Frames and/or Prescribed Corrective Lenses: $130 allowance
- Prescribed Corrective Contact Lenses: $80 allowance
- This benefit is limited to one pair of glasses (Frames and Prescribed Corrective Lenses) per member per two (2) Calendar Years. Prescribed corrective contact lenses are limited to one pair per member per two (2) Calendar Years. Children under age 12 will not be limited to the two-year requirement if there is a prescription change of at least 0.5 diopter.

Vision Care Services are covered to the maximum allowance or billed charges, whichever is less:

- Upon proof of payment by member; or
- Upon receipt of a claim/billing form from provider.

Coverage limitations and waiting periods vary by employer plan.

For a complete benefit summary for the Prominence Health Plan vision plan, ask your account executive or account manager or visit **www.prominencehealthplan.com**.


Prominence
Preferred Health Insurance Company, Inc.

Prominence Health Plan
Preferred Health Insurance Company, Inc.
VISION CARE RIDER

Supplemental Coverage Rider Vision Care Services

This rider provides coverage for services and products not covered under your Certificate of Coverage with Prominence Health Plan Preferred Health Insurance Company, Inc. What follows is a description of your covered benefits, limitations and exclusions under this Vision Care Services Supplemental Coverage Rider.

BENEFITS COVERED

EXCLUSIONS

www.prominencehealthplan.com

Prominence
HealthFirst

Prominence Health Plan HealthFirst
VISION CARE RIDER

Supplemental Coverage Rider Vision Care Services

This rider provides coverage for services and products not covered in your Evidence of Coverage with Prominence Health Plan HealthFirst. What follows is a description of your covered benefits, limitations and exclusions under this Vision Care Services Supplemental Coverage Rider.

BENEFITS COVERED

A. Coverage is provided for vision examination (refraction), when provided by a duly licensed vision care provider, to determine the presence of vision problems or other abnormalities. Refraction exams are limited to one per member per calendar year, and a maximum allowance of $40.

B. Coverage is provided for prescribed corrective lenses and eyeglass frames as follows:

1. Frames and/or prescribed corrective lenses: $130 allowance;
2. Prescribed corrective contact lenses: $80 allowance; and
3. This benefit is limited to one pair of glasses (frames and prescribed corrective lenses) per member per two (2) calendar years. Prescribed corrective contact lenses are limited to one pair per member per two (2) calendar years.

C. Vision Care Services are covered to the maximum allowance or billed charges, whichever is less:

1. Upon proof of payment by member; and
2. Upon receipt of a claim/billing form from provider.

EXCLUSIONS

The following items are specifically excluded under this benefit:

A. Safety glasses required for employment;

B. Non-prescription glasses and contact lenses;

C. Tinted contact lenses not used for corrective purposes;

D. Glass lenses for children under the age of 19;

E. Non-prescription sports related protective eyewear; and

These benefits will end if: Your contract is terminated; You fail to pay the Premium for this Rider; or you leave the group through which this rider is issued. Coverage limitations and waiting periods vary by employer plan.

www.prominencehealthplan.com

Supplemental Coverage Vision Care Services Form # SMHP-129142394 Approved: 11/24/2013 Distribution Date: 01/01/2014

BROKER ONLINE TOOLS

Take advantage of reduced paperwork, automated client management, and 24/7 access to vital information, and leave yourself more time to focus on growing your business.

eRenewal

eRenewal allows easy online access to your Small Group renewal information. Here are a few steps to help you get started:

- Visit **www.prominencehealthplan.com.**
- At the first screen – select **Brokers** and then click on **eRenewal** (located in the white area on the lower left portion of the screen).This will take you to the sign-in screen.
- In order to access eRenewal you must have a login user name and password. If you have not had one assigned to you or have forgotten the login and/or password, please contact Kelly McGuire-Shay at **kelly.mcguire-shay@uhsinc.com** or by phone at **775.770.9225**.
  Please note that there is one user name and password per agency or individual agent. Once you have logged into eRenewal you are ready to view the renewal information for your group(s).
- Select **Clients** on the menu on the left side to see a rolling 18-month list of months/years. To find your group(s), click on the month your group is renewing. This will display all groups renewing in that month. Select the name of the group to proceed. **Remember: Only Small Groups appear in eRenewal.**
- The **Documents** portal includes the following:
  - Rates become available at least 60 days prior to renewal. To view the rates, click **RATES**. Open this screen to the maximum and you will see tabs at the bottom of the page. Each tab provides group-specific information and what plans are available.
  - Renewal election form. This form must be completed by the group to note the plan(s) they wish to renew.
  - A copy of the renewal letter. This is the letter that will be sent to your group with their renewal rates.
- The two other portals include: **General Documents** which contains various forms and Underwriting Guidelines; and **General Links** which offers direct access to the Dental Provider network and Prominence Health Plan.

For eRenewal questions, contact Kelly McGuire-Shay at **kelly.mcguire-shay@uhsinc.com** or **775.770.9225**. For questions regarding renewals that are not answered in eRenewal, please contact your account manager.

ACom3

Our online commission tool for brokers provides secure access to commission statements and other commission related information.

Prominence Health Plan brokers will be pre-assigned a login to access the secure broker portal. Communications were sent either directly to you or your agency with login information about how to access the site. If you have not received secure login access information, please contact Kelly McGuire-Shay at **kelly.mcguire-shay@uhsinc.com** or call **775.770.9225**.

A feature of the ACom3 commission tool is the ability to email commission statements as opposed to receiving paper format. Email statements are not required. If you would like to change the statement delivery method or confirm the name and email address of the person we have on file for your agency please email **kelly.mcguire-shay@uhsinc.com**.

Also through ACom3, brokers can obtain PDF copies of their commission statements.

The following pages provide a brief overview about how to navigate the commission portal and tips for making your online experience simple and effective.

HOME PAGE

- You can view your most recent commission statement by clicking on the "View Statement" box at the top of your home page.
- The Producer Dashboard displays your current ranking (Gold, Silver, Bronze) based on our Commission Schedule.
- There is a graph that displays, by month, the Cumulative Premium Billed vs Cumulative Premium Received, Cumulative Commissions Paid, and Monthly Medical Member Counts. You can change what the graph displays by clicking on the appropriate header.
- The graph at the bottom of the page displays group specific data. Clicking on a group name will populate data for that group in the graph.

REPORTS TAB

Commission Payment Summary

- Enter start and end date and click **"Run Report"**.
- The report will be displayed on the screen and can be exported to Excel or PDF formats.
- The report includes the total commissions paid, by process period, by financial entity (Health Choice/HealthFirst).

Book of Business

- Enter start and end date and click "Run Report".
- The report will be displayed on the screen and can be exported to Excel or PDF formats.
- The report includes name and group number of groups "owned" by broker, the effective & term date of group, effective & term date of producer, and the percentage of ownership by the broker. (Note: the effective date of producer was entered in the new system as 7/1/2011, true effective date may be earlier.)
- You can click on the group number to pull up the client specific payment details.

Producer Appointment Details

- The report will be displayed on the screen and can be exported to Excel or PDF formats.
- The report shows the HealthFirst and Health Choice appointment details. (Note: the effective date of appointment was entered in the new system as 7/1/2011, true effective date may be earlier.)

Producer License Details

- The report will be displayed on the screen and can be exported to Excel or PDF formats.
- The report shows the NV license data we have on file.

Producer Performance Metrics

- The report will be displayed on the screen and can be exported to Excel or PDF formats.
- The report gives a breakdown of the broker ranking (Gold, Silver, Bronze) by month.

HISTORY TAB

Statements

- This page displays a list of the statements that have been produced, by process period.
- Click on the word **"Statement"** in the last column on the right to open a PDF version of the statement for that process month.
- Click on the **"Pay Entity ID #"**or **"Pay Entity Name"** to open a screen with details on the Pay Entity.
- Click anywhere else on the row to open the Statement Detail, which shows the email address the statement was emailed to as well as other details.

Transaction History

- This page displays a searchable list of transactions by period, by group.
- Income Transactions show the premium received and commission paid; Contract Counts show member counts and premium billed.
- Click on the **"Group/Contract ID"** or **"Name"** to open a screen with the Group Details.
- Click anywhere else on the row to open the Transaction History Detail.

Performance Metrics

- This page displays the broker ranking history by month (Gold, Silver, Bronze).

Letter History

- This page displays copies of any letters generated by ACom3 to the broker.

DEMOGRAPHICS TAB

Addresses

- This page displays the address and contact info we have on file for broker.

Broker Entity Attachments

- This page displays any attachments we have added to the broker record in ACom3.

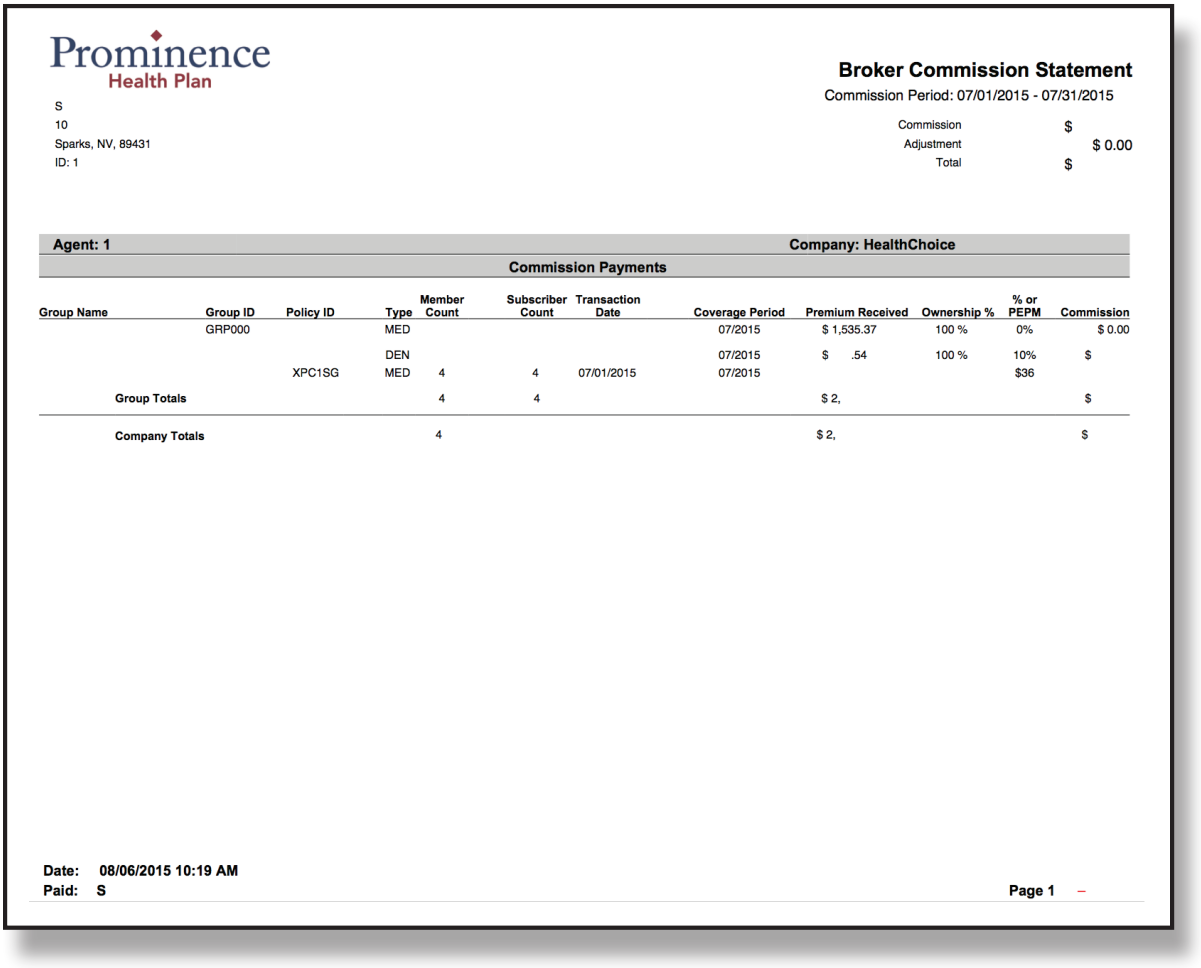
Licenses

- This page displays the NV license data we have on file.

Appointments

- This page displays the HealthFirst and Health Choice appointment details. (Note: the effective date of appointment was entered in the new system as 7/1/2011, true effective date may be earlier.)

PROMINENCE HEALTH PLAN BROKER COMMISSION STATEMENT SAMPLE



Prominence Health Plan

S
10
Sparks, NV, 89431
ID: 1

Broker Commission Statement
Commission Period: 07/01/2015 - 07/31/2015

Commission	$
Adjustment	$ 0.00
Total	$

Agent: 1 **Company: HealthChoice**

Commission Payments

Group Name	Group ID	Policy ID	Type	Member Count	Subscriber Count	Transaction Date	Coverage Period	Premium Received	Ownership %	% or PEPM	Commission
	GRP000		MED				07/2015	$ 1,535.37	100 %	0%	$ 0.00
			DEN				07/2015	$ .54	100 %	10%	$
		XPC1SG	MED	4	4	07/01/2015	07/2015			$36	
Group Totals				4	4			$ 2,			$
Company Totals				4				$ 2,			$

Date: 08/06/2015 10:19 AM
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Page 1 –

Broker Commission Timing

- Statements and checks should be generally received by brokers by the 12th of each month

SMALL GROUP UNDERWRITING GUIDELINES

I. Underwriting Overview

II. Small Group Quoting and New Case Submissions

III. Business Documentation Requirements

IV. Plan Changes for New Groups

V. Plan Changes for Renewals

Important!

NOTICE TO BROKERS AND AGENCIES

This document provides current general Group Underwriting Guidelines for Prominence Health Plan.

The final decision to accept or decline a case or determine a group's rates can only be authorized in writing by the Prominence Health Plan Underwriting Department. Please note that brokers, agents or agency personnel are not authorized to bind or guarantee any coverage, a specific rate or effective date.

Please advise all groups who have applied for coverage with us or those with intent to apply for coverage **to keep their current health plan coverage in place** until they are notified that they have been accepted for coverage by Prominence Health Plan.

Underwriting Guidelines

I. Underwriting Overview

1. Small groups are employers with two (2) to fifty (50) full-time, common law employees (an employee with a W-2 who is not an owner, spouse or domestic partner) with verifiable income, per ACA regulations. **Please note: One (1) and two (2) person groups consisting of spouses or domestic partners no longer accepted.**

2. Newly formed businesses that have been in business for at least six (6) weeks, with at least two (2) full time employees, may be considered upon verification of the following information:

   - **Sole Proprietor** – copy of business license
   - **Partnership or Limited Liability Partnership** – copy of the partnership agreement
   - **LLC** – copy of the articles of organization and the operating agreement to include signature pages of all officers
   - **Corporation** – copy of articles of incorporation to include the signature pages of all officers (must be followed up with copy of statement of information within 30 days of filing with the state)
   - Certificate of Qualification if the business was incorporated in a state other than the headquarter state

   Also required:

   - Proof of Employer Identification Number/Federal Tax I.D. Number (SSN if sole proprietorship)
   - Quarterly Wage & Tax statement (QW&T)

   For a new business, if a QW&T statement is not available, the employer must provide the following documentation:

   - The most recent two consecutive weeks of payroll records and/or copies of **cancelled** payroll checks report for every eligible employee enrolling with hours worked
   - Taxes withheld
   - Check number and wages earned or;
   - A letter from a CPA with the following information:
     - List of all employees (include owners, partners and officers [full and part-time])
     - Number of hours worked by each employee
     - Weekly salary for each employee
     - Date of hire for each employee

3. Groups with five (5) or more enrolled employees may offer up to five (5) plans from our Health Suite Select portfolio of products. No rating loads apply. Groups of two (2) to four (4) enrolled employees may select the single option that best fits their needs from our Health Suite Select portfolio. Not all plans must have enrolled members. All members will move to the appropriate age rate at renewal.

4. If composite rates are selected, rates provided prior to the effective date will be a "best guess" estimate of what the group's rate will be under the composite rating structure. ACA requires that the composite-rated premiums match the age-rate premium as of the effective date. Therefore the composite rates must be calculated according to the enrolled census in each plan as of the group's effective date.

   Any group selecting composite rates must submit their plan selection(s) and enrollment prior to the effective date and no changes may be made after this time.

5. Groups with ten (10) or more enrolled employees may offer a PPO or Freedom Beyond HMO plan from our Health Suite Select portfolio to their out-of-state employees as long as the group is **domiciled within Nevada** and no more than 25 percent of the group's total members reside out-of-state.

6. All small group proposals are contingent upon Prominence Health Plan being the only medical coverage offered by the group.

7. All groups must meet the following participation requirements:

Number of eligible employees:	**Percent that must enroll:**
2 to 3	100%
4 or more	75%

   If a group does not meet these participation requirements, then the group may enroll during a special small group market enrollment period, which will occur each year between November 15 to November 30 for a December 1 effective date and December 1 to December 15 for a January 1 effective date per ACA regulations. The group will be expected to meet our participation requirements on or before their renewal date. If they do not meet our participation requirements the group will be terminated as of their renewal date.

   Eligible employees waiving Prominence Health Plan coverage with other creditable coverage will not be included in the group's participation calculation. However, waivers for eligible employees who waive Prominence Health Plan coverage without creditable coverage will be counted against the group's participation requirements. Proof of other creditable coverage is required.

8. In addition to a medical plan, all groups can select a stand alone Prominence Health Plan Dental Plan. Vision coverage may be included as a rider in conjunction with their group health plan. The vision rider cannot be purchased as an independent benefit and cannot be cancelled except at renewal.

9. Families with three (3) or more dependent children up to and including age 20 will have the child premium capped at three (3) times child rates.

10. Management carve-outs are allowed as long as there are at least five (5) managers enrolled. In addition, the specific job titles of the eligible managers must be provided. The number of eligible managers enrolled in the plan will determine group size for participation requirements. If the group has fewer than five (5) enrolled managers at renewal, it is no longer eligible for coverage as a management carve-out. Note: At this time ACA has not mandated "carve out" situations; this is subject to change.

11. Groups with 19 or fewer employees that have a **Grandfathered plan** will have both Medicare and non-Medicare rates in their contract when they choose age-banded rates. Medicare eligible employees must provide Prominence Health Plan with proof of coverage for both Parts A and B in order to receive the benefit of the Medicare primary rates.

12. 1099 employees may be included in a group under the following conditions:

    - The group must have at least two regular W-2 employees enrolled.
    - The 1099 employees must be exclusively contracted on a year-round basis with the one employer.
    - No more than 50 percent of the enrolled employees can be 1099 employees.
    - All other regular employee requirements apply (e.g., 30 hours per week, year round employment, provisions in group contract, etc).
    - The employer must contribute the same amount towards 1099 employees' premiums as contributed towards regular W-2 employees' premiums.
    - All 1099 employees that meet the above criteria will be included in determining the group's participation requirements.
    - Upon renewal, above mentioned criteria applies.
    - Supply a list of employees who are 1099.

    Employer representative must sign 1099 Affirmation statement.

    It is the employer's responsibility to ensure that all workers who are "1099" as contractors cannot be reclassified by the IRS as their "common-law employees." If you pay a worker as an independent contractor "off the payroll," and that worker is later reclassified as an employee, you may have violated your ACA requirements. If your organization pays several people as contractors and classifies them as 1099, you must be certain that those classified 1099 contractors are not common-law employees.

    Q: How is contract labor treated in relation to the count of FTEs? How do 1099 employees work for a company but are independent contractors at the same time?

    A: Properly classified independent contractors are not considered employees, and are not included in the calculation of the number of FTEs for ACA employer shared responsibility purposes.

    Important Note: Employers should take great care in the proper classification of individuals as employees vs. independent contractors. The Internal Revenue Service and Department of Labor have launched an aggressive campaign to identify employers who misclassify individuals as independent contractors when, based on the relationships, they should be treated as employees.

II. Small Group Quoting and New Case Submissions

To allow adequate time to underwrite and process the group, the cut-off date for submissions is the last business day of the month prior to the proposed effective date. If missing paperwork is received after the 5th of the month following the proposed effective date, the group's effective date will be moved to the following month and rates will change accordingly.

Paperwork required for final submission includes:

- Completed Prominence Health Plan Small Group (2-50) Master Application;
- Completed Prominence Health Plan Member Enrollment forms that include all enrolling dependents (if eligible) with date of birth for all;
- Completed Prominence Health Plan waivers and copies of other carrier's ID cards for proof of acceptable creditable coverage for all eligible employees not enrolling on the plan (subject to participation requirements);
- The **most recent** QW&T reconciled to indicate whether each employee is fulltime, part-time or terminated. **If owners are not on the QW&T please provide a completed Sole Proprietor, Partner or Corporate Officer Statement form, along with any paperwork listed on the form.** New employees not listed on the QW&T must have name and date of hire indicated on the QW&T and provide two weeks of payroll records and/or copies of cancelled payroll checks; and
- A check for the first month's estimated premium.

Important note: Final rates will not be produced until **all** submission paperwork is completed and received by underwriting.

All employees must work at least thirty (30) hours per week and be subject to Federal, State and FICA withholding and verifiable by payroll records if requested, unless the group qualifies for coverage of 1099 employees.

III. Business Documentation Requirements

Documentation Requirements for Each Business Type		
Groups must be a partnership, corporation, subsidiary or an associated firm, provided such firm has authority to purchase group health coverage for the employees of the applicant group. In some instances, an employer or corporation may control several subsidiary companies whose employees may be covered under the parent company's group policy.		
Business Type	**In business more than 90 days**	**In business less than 90 days**
C Corporation	Nevada Employer's QW&T Report	• Payroll records • Articles of Incorporation
S Corporation	Nevada Employer's QW&T Report or K-1 for shareholder's income	• Payroll records • 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 QW&T	• Partnership Agreement and SS-4 (application for tax ID) • Payroll records
Limited Liability Company, LLC	May file as either a C Corporation or Partnership **(refer to above)**	May file as either a C Corporation or Partnership **(refer to above)**
Sole Proprietorship	• Schedule SE and Schedule C filed 1040 (tax return) • Nevada Employer's QW&T for salaried employees • Sole Proprietor Form	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 and or 1065B	• Payroll records
Non-Profit Organization	Form 940 or Form 990	• Articles of Incorporation • IRS confirmation of non-profit status
Start-Up Groups	Not applicable	• Payroll Records • Business license • Articles of Incorporation A new business cannot be accepted until payroll records are available

Enrollment note: Please note that dependents (if eligible) who have not provided proof of marriage or birth certificates, etc., will be added to the plan for **30** days, and then terminated off the plan back to the original enrollment date pending receipt of the required information.

IV. Plan Changes

ACA mandates that all contracts be issued for 12 months without plan changes.

A plan change may only by made mid-year when an out-of-state PPO is required for a newly eligible employee.

SALES SUPPORT

One of our primary goals at Prominence Health Plan is to ensure that open communication is at the forefront of all that we do. We welcome your phone calls, emails and faxes.

Northern Nevada
1510 Meadow Wood Lane
Reno, NV 89502
775.770.9393 or **888.840.9080**

Southern Nevada
2475 Village View Drive, Ste. 100
Henderson, NV 89074
702.260.3012

Sales Leadership Team

Glen Padula, Vice President Sales & Marketing
glen.padula@uhsinc.com

Nelson Leatherwood, Account Mgmt. Director
nelson.leatherwood@uhsinc.com

Account Executives

Account executives manage the underwriting process between Prominence Health Plan and brokers/consultants in the sale of new business:

Northern NV Account Executive
Maureen Henkes
maureen.henkes@uhsinc.com

Southern NV Account Executives
Ralphael Beaver
ralphael.beaver@uhsinc.com

Joe Wilson
joe.wilson@uhsinc.com

Account Managers

Account managers are responsible for overall account management including renewals and sales of additional lines of coverage:

Northern NV Account Managers
Lori Dayer
lori.dayer@uhsinc.com

Joyce Toste
joyce.toste@uhsinc.com

Southern NV Account Management
Linda Valenzuela
linda.valenzuela@uhsinc.com

Associate Account Manager

For claims eligibility, billing and commission issues, brokers and employer groups can contact:

Michael Wilson
michael.wilson2@uhsinc.com

Sales & Marketing Specialists

Sales & marketing specialists serve as the main contact for small group quotes and can be reached at:

Kelly McGuire-Shay, Supervisor (Northern Nevada)
kelly.mcguire-shay@uhsinc.com

Jennifer Young (Northern Nevada)
jennifer.young@uhsinc.com

eRenewal Information

For eRenewal questions and Broker of Record letters, contact:

Kelly McGuire-Shay, Supervisor
kelly.mcguire-shay@uhsinc.com

Enrollment

For enrollment related issues, you and your employer clients call or email additions, deletions or enrollment forms to your assigned enrollment analyst. They are:

Groups A – F
Laura F. Marshall, Enrollment Analyst
laura.marshall@uhsinc.com

(o) 775.770.9224 (f) 775.770.9365

Groups G – P
Noel Argall, Enrollment Analyst
noel.argall@uhsinc.com

(o) 775.770.9249 (f) 775.770.9365

Groups Q – Z
Dawn Arnett, Enrollment Analyst
dawn.arnett@uhsinc.com

(o) 775.770.9222 (f) 775.770.9365

Premium Billing

The premium billing representative processes and collects current and past-due premium payments; assists with premium billing and statement questions; and offers support for general COBRA questions.

Your premium billing contact is:

Aleta Hobbs-Disel, Premium Biller
aleta.hobbs-disel@uhsinc.com

(o) 775.770.9345

CONTACT US

Sales

888.840.9080
Monday through Friday, 8 a.m. to 5 p.m. PST

Northern Nevada
1510 Meadow Wood Lane
Reno, NV 89502
775.770.9393

Southern Nevada
2475 Village View Drive, Ste. 100
Henderson, NV 89074
702.260.3012

Premium Billing

775.770.9345
Monday through Friday, 8 a.m. to 5 p.m. PST

ACCOLADE®

New! *Member Service Support Powered by Accolade*

Through membership with Prominence Health Plan, individuals and families will have one person to address all their healthcare needs, big or small. An Accolade Personal Health Assistant® will help members:

- Understand benefits and payments options
- Find and access the right provider
- Manage health and care coordination needs
- Resolve any health or health benefits concerns

Members can call the Prominence Member Services number on the back of their ID card to be auto-routed to Accolade. From then on, the member has the option to call either Prominence or Accolade directly.

Members can reach Accolade Health Assistants Monday through Friday from 8 a.m. to 7 p.m. PST

Prominence Health Plan Member Services
Monday through Friday, 8 a.m. to 5 p.m., PST

HMO/POS Members	**800.863.7515**
PP0 Members	**800.433.3077**
Exchange Members	**844.238.2292**