Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

Nevada Small Group (1-50) Application

Attachment A to the Group Enrollment Agreement ("GEA")

Because the information provided herein initiates the Health Plan of Nevada, Inc. (HPN), and/or Sierra Health and Life Insurance Group, Inc. (SHL) procedures that produce your GEA and billing statement, it is important that you complete this information accurately and return it promptly. Please type or print neatly with black ink. All fields of this Attachment A must be completed.

SECTION 1: Group Profile

☐ Submit a new application ☐ Request change(s) on application for Group # _____	**Requested Effective Date** (mm/dd/yyyy)

Group Legal Name **DBA/Doing Business As** (if applicable)			**Number of Years in Business**
Street Address (PO Box not accepted)	**City**	**State**	**Zip Code**
Billing Address (if different from above)	**City**	**State**	**Zip Code**
Mailing Address (if different from above)	**City**	**State**	**Zip Code**

Phone Number (xxx-xxx-xxxx)	**Federal Tax ID Number**	**SIC No.**	**Nature of Business**

Group Officer Name (Signature in Section 13 must match)	**Group Officer Title**
Group Officer E-mail Address	**Group Officer Phone Number** (xxx-xxx-xxxx)
Enrollment Contact Name (if different from Group Contact)	**Enrollment Contact E-mail Address**
Billing Contact Name (if different from Group Contact)	**Billing Contact E-mail Address** (for electronic billing)

Group Organization Type (select one of the following)

☐ Corporation ☐ Partnership ☐ Limited Liability Corporation (LLC) ☐ Non-Profit
☐ Sub-Chapter S Corporation ☐ Sole Proprietor ☐ Limited Liability Partnership (LLP) ☐ Other _____

Association, Trust or Professional (A/T/P)Employer Organization (please select one of the following)

☐ Associations of Church Plans ☐ Employer Association ☐ Multiple Employer Trust (MET)
☐ Controlled Group ☐ Multiemployer Plan or Taft Hartley Plan ☐ Multiple Employer Welfare Arrangement (non-plan MEWA)

Is your group a Professional Employer Organization (PEO) or other such entity that is a co-employer with your client(s) or client-site employee(s)?
☐ Yes ☐ No

If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that Health Plan of Nevada/Sierra Health and Life will not cover the co-employees under this group policy.

Subject to ERISA Regulation? ☐ Yes ☐ No (if No, please select one of the following):

☐ No, due to Churches–Non-ERISA/Non-Government
☐ No, due to Federal Government
☐ No, due to Indian Health Services–Non-ERISA/Non-Government
☐ No, due to Government/Non-Federal
☐ No, due to Indian Tribe–Non-ERISA/Non-Government
☐ No, due to Foreign Government
☐ No, due to Foreign Embassies–Non-ERISA/Non-Government
☐ No, due to Non-ERISA Other _____

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Are there any other Divisions, Subsidiaries or Affiliates that are part of the Group's business?	☐ Yes (*If yes, complete the information below*)	☐ No		
Name	**Tax ID**	**Physical Address**	**Applying for Coverage with HPN/SHL**	**% ownership**
			☐ Yes ☐ No	
			☐ Yes ☐ No	

☐ *see attached list*

A copy of the Quarterly Wage and Tax Statement must be provided for each to be included for coverage.
If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

SECTION 2: Employer/Employee Contribution(s)/Participation

Description of Eligible Employees:

A. Those persons that are bona fide employees of the Group; and
B. Meet the following criteria:
- Be employed full-time,
- Be in an active employment status,
- Work at least the minimum number of hours per week indicated by the Group in this Attachment A to the GEA (typically thirty (30) hours),
- Meet the applicable waiting period indicated by the Group in this Attachment A to the GEA,
- Enroll during an enrollment period,
- Work for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in this Attachment A to the GEA, and
- Live or physically work in the Service Area (HPN Only)

Minimum Employee Participation Percentage: Small Groups must enroll 75% of all Eligible Employees excluding waivers for other coverage.

Full Time Equivalent (FTE):
1. Under Nevada law, a Nevada group can determine minimum hours for an employee to be considered full-time; however, the full-time hourly minimum is 30 hours per week or 130 hours of service per month.
2. For each month during the preceding calendar year, count all HOURS worked by part-time employees and divide by 120. Exclude hours worked by a) full-time employees counted under (1) and b) seasonal workers who worked 120 days or fewer. Include seasonal workers who worked in excess of 120 days. A seasonal worker is one who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including retail workers employed only during the holiday season.
3. Add the number resulting from (2) to the number resulting from (1) for each month during the preceding calendar year.
4. Add all resulting figures from (3) together and **divide by the number of months of data that were used**.

Total Number of FTE

_____

Calculating Average Total Number of Employees: Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage. To calculate the annual average, add all the monthly employee totals together, and then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Average Total Number of Employees:

_____ Employees
(applies only to Groups of 150 or less employees)

A. **COBRA**: Under federal law, if your Group had 20 or more employees on your payroll on at least 50% of the Group's working days during a calendar year, you must provide employees with COBRA continuation effective the next calendar year.
Is your company currently subject to COBRA? ☐ Yes ☐ No

B. Which one applies to your Group? ☐ Medicare is primary (groups less than 20 employees) ☐ HPN/SHL plan is primary (groups 20 or more employees)

C. Does your Group offer Workers' Compensation? ☐Yes ☐ No

Participation					Contribution			
** Eligible Employees (including employed owners/officers) work at least 30 hours/week, not including those working on a temporary or substitute basis*		**Product Type**	**# Employees Enrolling**	**# Employees currently waiving Group coverage**		**Minimum Employer Contribution**	**Employer Amount** *(% or $)*	**Employer Amount for Dependent** *(% or $)*
# of Eligible Employees*		Medical			Medical	50% or $150		
# of Ineligible Employees		Dental			Dental			
Total # of Employees		Vision			Vision			
How many work or live outside the state of Nevada?		Number of Employees currently on COBRA?						
Number of Employees currently in the required probationary/waiting period?								

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SECTION 3: Employee Eligibility

Will all current enrolled Eligible Employees be covered on the Effective Date of this Plan?	☐ Yes	☐ No
If no, will they have the same Waiting Period as future Eligible Employees?	☐ Yes	☐ No
Will the Group waive the Group Waiting Period for the initial Enrollment?	☐ Yes	☐ No
Do you have an orientation period?	☐ Yes	☐ No

SECTION 4: Benefit Class Eligibility

Probationary / Waiting Period policy for future Eligible Employees

Specify class name below	Select either Category A or B for your group. Then specify within the chosen category for each class of employees.	
	Category A Date of Hire	*Category B First of Month Following*
All Eligible Employees	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Date of Hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days
Class 1:	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Date of Hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days
Class 2:	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Date of Hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days
Class 3:	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Date of Hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days

If there are special provisions, please list below:

A: Leave of Absence |B: Part Time to Full Time policy |C: Transfer Policy | D: Rehire Policy

Provision Code	Class	Description
Leave of Absence (A)	All Classes (excluding Cobra)	☐ Last Day worked (following the last day worked for the minimum hours required to be eligible) ☐ As stated in group handbook (see attached) ☐ 3 Months (following the last day worked for the minimum hours required to be eligible) ☐ No, we do not offer medical coverage during a leave of absence ☐ Other:_____
Look Back Period	All Classes (excluding Cobra)	☐ None ☐ 30 Days ☐ 60 days ☐ 90 Days ☐ Other:_____

☐ see attached list for additional provisions

SECTION 5: Health Benefit Selection (available to all benefit classes)

Note – Medical plan and Rx plans are built into the Metallic plan.

☐ HMO ☐ EPO ☐ PPO ☐ POS ☐ Balance HMO ☐ HSA	Plan Description 1
☐ HMO ☐ EPO ☐ PPO ☐ POS ☐ Balance HMO ☐ HSA	Plan Description 2
☐ HMO ☐ EPO ☐ PPO ☐ POS ☐ Balance HMO ☐ HSA	Plan Description 3
☐ HMO ☐ EPO ☐ PPO ☐ POS ☐ Balance HMO ☐ HSA	Plan Description 4
☐ HMO ☐ EPO ☐ PPO ☐ POS ☐ Balance HMO ☐ HSA	Plan Description 5

It is the intent of HPN/SHL to provide total replacement of all coverage currently in force with an employer. HPN/SHL does not allow coverage in combination with coverage provided by another carrier.

Does this group fund a HSA Plan? ☐ Yes ☐ No

If this group funds a HSA Plan, please answer the following below:	Benefit Option (select one):
Are you contributing toward the cost of a HSA? ☐ Yes ☐ No Contribution: _____ Name of Bank: ☐ Optum Bank ☐Other:_____	☐ EAP ☐ TLC

SECTION 6: Health Plan of Nevada/Sierra Health and Life Ancillary Benefit Selection

Dental	Vision

SECTION 7: Riders/Optional Benefits Selection

Health Plan of Nevada/Sierra Health and Life Riders/Optional Benefits *(group level)*

☐

☐

SECTION 8: Prior Group Health Benefit Coverage

Does this Health Benefit replace current coverage?	If Yes, Carrier is/was:	Termination Date is/was (mm/dd/yyyy)
Health ☐ Yes ☐ No		
Dental ☐ Yes ☐ No		
Vision ☐ Yes ☐ No		

SECTION 9: Employee Certificates and Group Plan Documents

Employee Certificates:
All Employee documents (EOC / COC / SBC / etc.) will be provided electronically. Members will individually have the option to request printed copy documentation of plan documents once they have enrolled.

Group Plan Documents:
___ (Please initial here) I agree to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life electronically in the future.

Set your delivery preferences. Opt-in to receive information electronically, request paper documents or update your information. Visit myHPNonline.com or mySHLonline.com and sign in. First-time users will need to create an account using their member ID.

SECTION 10: General Agreement

I, the undersigned, understand and agree that this application is for the healthcare coverage offered by Health Plan of Nevada, and/or Sierra Health and Life Insurance Company, Inc., and will form a part of any Agreement issued in reliance upon it; and acceptance of the Group for coverage and the final rates are based upon the above information and the census of actual enrollees; and any material misrepresentation therein, will permit HPN and/or SHL to terminate such coverage. I represent that the information contained herein is true and correct. I acknowledge that my Representative has explained the coverage, limitations and exclusions, and other details of the coverage for which I applied. I understand and agree it is my responsibility to offer coverage to all Eligible Employees and their Eligible Family Members; and I will provide to HPN, and/or SHL, an Enrollment Form or a Waiver Form signed by each employee within thirty-one (31) days of his/her eligibility date; and collect any employee contribution(s) toward any payments/premium due (these documents will become part of this application). I understand and agree that my Group must maintain a minimum participation and contribution level for the coverage to continue under this Agreement (with the exception of Open Enrollment Periods November 15 – December 15).

If the information regarding SHL's high deductible Health Benefit Plan is determined to be inaccurate, my Group may be subject to a rate and/or Health Plan change to maintain compliance with SHL's underwriting requirement.

It is also understood that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. A one-month deposit is being submitted, to be held without obligation until this application is approved. If the application is approved, the deposit will be applied to the first month's Prepayment Fees/Premium under this Agreement. If coverage does not become effective, the deposit will be refunded. I understand that persons not eligible for coverage are not entitled to enroll in the Plan.

SECTION 11: Representative (Agent/Broker)

I have explained the coverage, limitations, and exclusions of the coverage for which my client has applied including the Managed Care guidelines and provisions of the (s) with my client.

Representative (Agent/Broker) 1

Agent/Broker Name			
Agency Name			Federal Tax ID or Social Security Number
Email Address			
Address	City	State	Zip Code
Phone Number (xxx-xxx-xxxx)	Fax Number (xxx-xxx-xxxx)		
Signature			Date (mm/dd/yyyy)

SECTION 12: CAA Rx Reporting Requirements

Form 5500 Plan ID (if applicable)	Group Legal Name (if applicable)

Does your Group offer a Carve-out Wellness Plan? ☐ Yes ☐ No If yes, total annual amount paid in claims: _____

Wellness Carrier Name: _____ Wellness Carrier EIN: _____

Please provide any additional carrier information below.

Medical Carrier Name: _____ Medical Carrier EIN: _____

Fully insured ☐ Self-Funded ☐

Pharmacy Benefit Manager (PBM) Carrier Name: _____ PBM EIN: _____

Behavioral Health Carrier Name: _____ Behavioral Health Carrier EIN: _____

SECTION 13: Signatures

Signature of Group Officer (Name in Section 1 must match)	Date (mm/dd/yyyy)

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance Group for the purpose of defrauding or attempting to defraud the Group, penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance Group or agent of an insurance Group, who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

Glossary Terms

Associations of Church Plans: An Association of Church Plans is a group of churches or synagogues that join together under federal law and sponsor a single group health plan. Examples include Catholic Dioceses and Lutheran Synods. Church employees may be employed by either the local church or by the parent organization, i.e., the dioceses or the synod depending on their structure.

Controlled Group: A controlled group of businesses is a group of related businesses (corporations, partnerships) that have common ownership and control. If a controlled group exists as defined by the IRS, the group is eligible to sponsor a single group health plan.

Corporation: A legal entity created under state or federal law to conduct business or another lawful purpose. The income of a corporation is taxed separately from its owners. Also known as a C Corporation.

Employer Association: An employer association is a group of employers in the same trade or industry. The association must generally have a representational interest in the member-employers beyond just health insurance. There are employer associations in both the private sector (trade associations) and the public sector (groups of cities, counties, agencies when permitted by law.) Both types of employer associations are permitted to be the sponsor of a single group health plan.

Limited Liability Partnership (LLC): The LLC is an unincorporated entity, created under state law. The goal is to have an entity which limits the liability of its owners (members) and to "pass through" taxation so that income is only taxed once (Not twice as is the case corporations). The member's liability in the LLC is limited to his or her investment in the business. The LLC will be taxed at the federal level either as a corporation or a partnership. LLCs are suited for real estate companies, hedge funds, certain health care entities (IPAs), as well as professional firms. State law regarding LLCs continues to evolve.

Limited Liability Partnership (LLP): A limited liability partnership (LLP) is a partnership in which some or all partners (depending on the jurisdiction) have limited liabilities. It therefore exhibits elements of partnerships and corporations. In an LLP, one partner is not responsible or liable for another partner's misconduct or negligence.

Multiemployer Plan or Taft Hartley: A multiemployer plan is a bona fide collectively bargained plan (i.e., Teamsters, Bricklayers) where employees of more than one employer participate in the plan.

Multiple Employer Trust (MET): A Multiple Employer Trust (MET) is a group of ten or more employers who form a trust in order to minimize the tax implications of providing certain types of benefits for their employees, particularly life insurance.

MEWA: A multiple employer welfare arrangement or MEWA is a group health plan offering benefits to the employees of two or more employers, except this term does not include a Taft Hartley collectively bargained plan (e.g., multiemployer plan.)

Non-Profit: A nonprofit organization (NPO, also known as a non-business entity) is an organization with the purpose of which is something other than making a profit. The nonprofit landscape is highly varied, although many people have come to associate NPOs with charitable organizations.

Professional Employer Organization (PEO): A PEO is a firm that provides employee management tasks such as benefits, payroll, workers compensation, and job training. Many times the PEO exercises control over the work performed by the hired individual. When that happens, the labor law considers the PEO to be a co-employer of the hired individual and the PEO may be the sponsor of a single group health plan.

Sole Proprietor: A sole proprietorship, also known as the sole trader or simply a proprietorship, is a type of business entity that is owned and run by one natural person and in which there is no legal distinction between the owner and the business.

Sub-Chapter S Corporation: Subchapter S (S Corporation) is a form of corporation that meets specific Internal Revenue Code requirements, giving a corporation with 100 shareholders or less the benefit of incorporation while being taxed as a partnership.