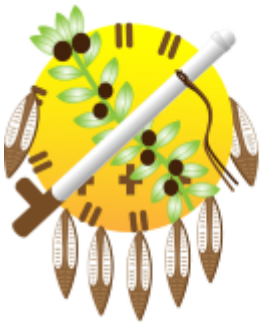

OPEH&W Health Plan
www.opehw.com

New Employer Group

Participation Application Form

For Administration Office Use Only

EffDt 0 1 2 0 1 PlnID OkID Lf

Vsn VsnID MdID RxID

Employer Group Details

Employer's Name

Organization Type

FEIN*

Physical Address*

City, State, ZIP*

Mailing Address
(if different from above)

City, State, ZIP

Designated Board Representative (if a county, this must be an elected official)

Name*

Title*

Phone* FAX

Email

Primary Person Responsible for Benefits Administration (if different from above)

Name*

Phone* FAX*

Email*

Address*

City, State, ZIP*

Backup Person Responsible for Benefits Administration

Name

Phone FAX

Email

Address

City, State, ZIP

Workman's Compensation Carrier

If ACCO or OMAG, check here, otherwise please provide details ◯

Name

Phone FAX

Address

City, State, ZIP

Section 125 (Cafeteria) Plan

The Health Plan's administration office can provide a free Section 125 (Cafeteria) Plan for the Health Plan's employer groups. A Section 125 (Cafeteria) Plan refers to the regulations defined in Section 125 of the U.S. tax code, and is used to meet the IRS regulations pertaining to the pre-tax payroll deductions of certain qualifying healthcare premiums for which the employee is responsible for. The Health Plan offers this product to its participating employer groups as a protective service, as in the past, a large number of participating employer groups were found not to be in compliance with these IRS regulations when using other programs available. The Section 125 (Cafeteria) Plan offered through the Health Plan is a Premium-Only-Plan (POP), this should **not** be confused with similar programs offered in the insurance market, such as Flexible-Spending-Accounts (FSA's) which in addition to the Premium-Only-Plan offer debit cards and re-imbursement service for certain out-of-pocket healthcare costs, the Health Plan **does not** offer such product. If your employer group has a Flexible-Savings-Account program, you do not also need a Section 125 (Cafeteria) Plan. The Section 125 (Cafeteria) Plan must be administered by an employer group's human resources/payroll department, the Health Plan will provide guidance, an administrative manual and regular on-time updates to ensure that an employer group does compliant. The Health Plan is held harmless, and cannot be held responsible for the employer group failing to complete the simple administrative tasks required for a Section 125 (Cafeteria) Plan. Participation in the Health Plan's Section 125 (Cafeteria) Plan is completely voluntary, and has no baring on any aspect on an employer group's participation in the Health Plan. An employer is free to participate in or leave the Health Plan's Section 125 (Cafeteria) Plan at any time, and need not notify the Health Plan of the discontinuing use of it.

Do you want to use the Health Plan's Section 125 (Cafeteria) Plan? ◯ **No** ◯ **Yes**

Check-Mark Here to Acknowledge Understanding:* ◯

Administrative Responsibilities for Current or Future Federal Regulations

The administrative office of the Health Plan is a full service unit, to that end, complete administration of federal regulations such as COBRA & HIPAA are provided at no additional charge. The administrative office staff of the Health Plan are continually trained and educated in the many complex functions of these regulations, and all associated materials and mailings are continually updated and legally reviewed to ensure maximum compliance is maintained. However, it is ultimately the responsibility of the employer group itself to communicate to the administration office in a timely manner all enrollments and terminations. With the strict time-lines required in these federal regulations, failure to do so might result in unfavorable legal opinions and/or severe fines. Proper training will be given to your staff responsible for human resource operations to ensure strict adherence to these rules.

Checking here acknowledges your understanding*: ◯

Continued Full Disclosure

The participating entity will communicate in writing to the Health Plan Administrator immediately any and all information on enrolled individuals who experience one of the following events:

- Become eligible for COBRA Coverage
- Become eligible for Retiree Coverage
- Die
- Become Disabled
- Start and End a Leave of Absence
- Are Laid-off

Checking here acknowledges your understanding:* ◯

Money

Monies paid into the Health Plan are the property of the Health Plan Participants and cannot be used for the benefit of any non-Health Plan Employer Group. If your Employer Group, elects to leave the Health Plan, you represent that your Employer Group shall be responsible for the payment of all claims and associated administrative expenses not paid for with the terminating Employer Group's fair share of available funds (Health Plan Reserves) at the time of termination. You also understand that only the Health Plan Trustees have the authority to award any entity a portion of any surplus and that the Trustees can only do so after all claims have been paid for by the terminating Employer Group under guidelines established by the Trustees. You also accept that if any monies are refunded, they can only be used for the Health & Welfare coverage of the employees (and their dependents) at the terminating Employer Group.

Checking here acknowledges your understanding:* ◯

Premium Payments

The Health Plan invoices for premiums at the end of each month. You will have **15-days** from the receipt of your monthly billing invoice to remit payment.

Checking here acknowledges your understanding:* ◯

Eligibility

If an effort to administer your employer group effectively we need to determine when and which employees are eligible for healthcare benefits with you. Therefore, please answer the following questions with as much clarity as possible, and if any of your business rules should change in the future, please notify the Health Plan Administrators Office prior to new stipulations becoming effective.

Pre-Existing Condition Exclusion Periods

For covered individuals aged **18-years old or younger** (either a member, spouse or dependent), there is **NO** prior continuous coverage requirement, and therefore, no possibility of a Pre-Existing Conditions Exclusion Period to meet.

For covered individuals aged **19-years old or older** (whether a member, spouse or dependent), **with** continuous health insurance coverage during the previous **12-months** without a gap in coverage of more than **63-days**, there is **NO** Pre-Existing Conditions Exclusion Period to meet.

For covered individuals aged **19-years old or older** (whether a member, spouse or dependent), **without** continuous health insurance coverage during the previous **12-months** or with a gap in coverage of more than **63-days**, there **WILL BE** a Pre-Existing Conditions Exclusion Period of **12-months** to meet for any condition which the individual has sought treatment or advice from a medical professional in the last **6-months** (certain conditions such as pregnancy are not considered).

If an individual aged **19-years old or older** was working through (or drawing down) an Exclusion Period with their previous carrier, they will continue to draw it down from that point, with no loss of credit (i.e. if they only had **3-months** of an exclusion period left with their previous carrier, they would continue to have only **3-months** left upon joining the Health Plan, drawing it down from that point).

Please Note: As of **7/1/2014** Pre-Existing Conditions Exclusion Period will **NO LONGER** exist.

Checking here acknowledges your understanding:* ◯

The Health Plan's Eligibility Guidelines

The Health Plan's standard definition of an employee is as follows (taken directly from the Health Plan's Benefit Book): All Employees are eligible for coverage under the Health Plan if they are a full-time employee of an employer which is a participating governmental agency of the inter-local government agreement.

A full-time employee is an employee who, at a location established by the employer, is actively working a full scheduled work week of not less than **20-hours** in the conduct of the business of the employer and not classified as a part-time, temporary or seasonal employee, except that a person elected by popular vote, including elected officials and board members of a participating governmental agency, will be considered an eligible employee during the persons tenure in office. Education employees must be actively working a full scheduled workweek of not less than **20-hours** or equivalent of **20-hours**.

Checking here acknowledges your understanding:* ◯

Actively At Work

The Health Plan has an actively at work provision which means that coverage of employees who are not actively at work on their effective date (hospital confined or not performing functions of a person of the same sex and age, with respect to dependents) will have a delayed effective date for being covered under this Health Plan. The effective date of coverage shall be the day following the second consecutive day following their return to work (or normal activity for dependents) on a full-time basis, unless exempted in writing, by the stop-loss carrier from this provision wherein they are covered as though not disabled.

Checking here acknowledges your understanding:* ◯

Hour's per Week Required for Eligibility

If your requirement for eligibility of benefits is greater than the Health Plan's minimum of 20-hours, enter it here. By Federal regulation you cannot exceed 30-hours: ☐☐

It is your responsibility to police this to ensure that this rule is adhered to. Failure to do so may create legal issues from disenfranchised employees. Furthermore, the Health Plan reserves the right to deny payment of claims for employees not meeting this minimum requirement, including the right to recover Health Plan expenses from the employee and/ or provider.

Checking here acknowledges your understanding:* ◯

When Can Eligible Employees Enroll & Under What Rules?

Conceivably, there are sections of your workforce whom may become eligible at different times, have probationary periods to meet before they are eligible, or be eligible for different cost/premium sharing rules. Therefore, in order to provide excellence in the Health Plan's administration practices, please complete multiple versions of the last page of this form to demonstrate these. There exist serious legal considerations to ensure that these are followed precisely, primarily to avoid COBRA malpractice issues. Please help us, help you by providing accurate information, and keep the Health Plan's administration offices informed of any changes which may occur.

Explanation of a 'New Hire Waiting Periods'

The length of time after someone is hired before their benefits become effective. Typically this is 'Date of Hire' which is the 1st of the month following their hire date, or the same day if they commence their employment on the 1st day of a month. Other options are 30- days or 60-days. However, effective dates will always be the next occurring 1st day of the month following the end of their waiting period, or the 1st day of a month if it so falls.

Checking here acknowledges your understanding:* ◯

Enrollment

The administration office of the Health Plan will **NOT** conduct an onsite enrollment of your employees, instead your employees will use the Health Plan's secure online enrollment platform (HEART) available at **www.opehwheart.com**.

Pre-Enrollment Data Requirements

To ensure as smooth a transition as possible, we would like to have the following data no later than **6-weeks** prior to your employer group's Health Plan start date:

A listing of current retirees and later in a Microsoft Excel spreadsheet file:
If your employer group is an OPERS participant, and you are leaving the State Insurance Pool to join the Health Plan, the this should only include those retirees with retirement dates of 1/1/2002 onwards. Retirees with retirement dates prior to 1/1/2002 will remain on the State Insurance Pool. This is an OPERS rule, and is necessary to secure the continuation of any OPERS premium subsidy.

- Name
- Address
- Phone Number
- Retirement Date

A current listing of COBRA participants in a Microsoft Excel spreadsheet file:

- Name
- Address
- Phone Number
- Qualifying Events Dates & Details
- Original COBRA coverage effective date

Checking here acknowledges your understanding*: ◯

How Many Employees Do You Have?

Using the above stipulated rules, how many current employees do you have whom are eligible for healthcare benefits. This is not the number whom are currently participating. Furthermore, we understand that due to regular turnover of employees that this number is likely to fluctuate considerably on a monthly basis.

Number of Eligible Employees:* ☐☐☐

Number of COBRA Participants:* ☐☐☐

Number of Retirees:* ☐☐☐

Checking here acknowledges your understanding:* ◯

Deductible Credit Program

Does your current plan year start on a date other than July? ◯ **No** ◯ **Yes**

If you answered 'Yes', then, in an effort to prevent undue hardship on your employees as a result of a change in their healthcare benefits and given that if there is a difference in plan year start dates between the Health Plan and your current carrier; the Health Plan will offer a Deductible Credit Program to all of your employees enrolled at the time of transition. For this to be done, you must provide the Health Plan Administrator's office with a deductible credit report from your current healthcare benefits provider.

Checking here acknowledges your understanding*: ◯

Acknowledgement & Disclosure of Full Understanding

To ensure that all due consideration has been given to the communication of the various components of the Health Plan, please state your acknowledgement and full understanding of the following points, all of which you have been fully disclosed of and satisfactorily educated in, additionally, that you have been given every opportunity to question and seek a thorough understanding.

Finally, your acknowledgement equates to an understanding of these terms in respect to your employer group and to ensure you have a full understanding of all these points before final execution of this document and the Health Plan's Inter-Local Government and Participation Agreements.

Please acknowledge your complete understanding of each of the following by check-marking each oval*:

- ◯ The **Twelve (12)** Month Minimum Entity Participation Period
- ◯ The Inter-Local Government Agreement
  - ◯ Ownership % Methodology
  - ◯ What Happens if you leave the Health Plan
    - ◯ Run-off Claims
  - ◯ Catastrophic Fundraising Mechanism
  - ◯ The Plan's Concept, Construction & Control Mechanisms
- ◯ Retirees
  - ◯ Over-65 – Medical Coverage - Medicare Supplements
  - ◯ Over-65 – Rx Coverage - Medicare Part D
  - ◯ Which Retirees Must Move & Enroll
    (only applicable to employer groups which are joining from State Insurance Pool)
  - ◯ OPERS Entitlements
    (only applicable to employer groups who participate in the Oklahoma Public Employees Retirement (OPERS) program)
- ◯ COBRA Administration
  - ◯ Current COBRA Participants
- ◯ Enrollment, Transition & Post- Enrollment Actions
  - ◯ Certificates of Creditable Coverage
- ◯ The Health Plan's Coverage Lines & Benefits
  - ◯ Health (Medical & Rx)
  - ◯ Dental
  - ◯ Orthodontic Dental
  - ◯ Vision
    - ◯ Employer Group Options
  - ◯ Group Life
    - ◯ Employer Group Options
  - ◯ Additional Life
    - ◯ Employer Group Options

Employer Group - Decision Maker's Final Approval

(if applying entity is a county, then all three (3) commissioners are required to sign)

As a Governmental Entity subscribing to the Inter-Local Governmental Agreement sponsoring the Oklahoma Public Employees Health & Welfare Plan, the undersigned hereby applies to participate in the Oklahoma Public Employees Health & Welfare Plan and agrees to be bound by the terms and conditions of the Health Plan's Documents, as amended, under Titles 51 & 74 of the Oklahoma Code.

The undersigned represent that the Governmental Entity has read and fully understands the Health Plan's legal documents, the eligibility requirements, limitations of coverage, summary of benefits available, and exclusion from benefits, as contained in the Oklahoma Public Employees Health & Welfare Benefit Book.

12 Month Minimum Term

The undersigned represent that they understand that their Employer Group is committing to a **one** year term only, with no additional actions required to maintain participation for subsequent years; and that after the first year of membership the Employer Group may choose to leave at anytime.

Termination of Participation

The undersigned represent that they will communicate in writing to the Board of Trustees, intent to terminate coverage under the Oklahoma Public Employees Health & Welfare Plan at least **60** days prior to actual termination. (Intent does not imply a definite termination but only an effort to do so.)

Decision Maker #1

Name*

Title*

Signature*

Date* / /

Decision Maker #2

Name*

Title*

Signature*

Date* / /

Decision Maker #3

Name*

Title*

Signature*

Date* / /

Employee Class Definitions & Rules

Please complete a copy of this page for each type of employee listed in your Employee Handbook who are eligible for Health Insurance Benefits. If all employee's are treated the same, then please enter **ALL** in the Employee Class field. For example: A management employee may have different health benefit coverage options and employer contribution amounts compared to that of a regular employee.

Employee Class* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please use the same terminology as your employee handbook lists.

Benefit Start Date* (Waiting Period)

- ◯ Date of Hire / First 1st Day of the Month
- ◯ 30 Days
- ◯ 60 Days

Contribution Model*

Please explain how and what you contribute towards the cost of an employee's health benefits. For example: Do you pay a percentage of the cost? Do you pay up to a certain dollar amount, and if so, is the dollar amount a combined value for the employee to choose where to apply it, or is a certain amount per coverage? Or, do you require an employee to pay an amount towards their coverage, after which, you pay the rest, and again, is this a combined amount for the employee, or a does it differ by coverage type (medical, dental, vision, life)? If necessary, list the contribution next to each coverage line below.

Coverage Lines to be Offered

Which coverage lines should we make available to your employees?

Health (Medical/Rx) ◯ **No** ◯ **Yes**

Dental ◯ **No** ◯ **Yes**

Orthodontic Dental ◯ **No** ◯ **Yes**

This is a full dental plan through MetLife, additionally, it offers coverage for Orthodontia, for adults as well as children. It can be taken with or without the Health Plan's core dental coverage. This coverage line is a voluntary benefit option, i.e. paid for by the Employee through pay-roll deduction.

Vision ◯ **No** ◯ **High** (frames every **12**-months) ◯ **Low** (frames every **24**-months)

Group Life ◯ **No** ◯ **$20k** ◯ **$30k** ◯ **$40k** ◯ **$50k**

The Group Life product is guaranteed issue (i.e. enrollment in it is not dependent upon health status) and the premium is not age rated. Typically, this coverage line is paid for by the employer group, but can sometimes be the employees responsibility.

If selected above, will Group Life be paid for by the employer group, or, the employee?

◯ **Employer Group Paid** ◯ **Employee Paid**

Additional Life ◯ **No** ◯ **Yes**

The Additional Life product is sometimes called 'Voluntary Life', this is additional life coverage available to the employee, and is age priced. The employee is able to select a coverage level based upon there annual pay. Initial enrollments are guaranteed issue for amounts up to $150,000, after which health status is considered before coverage is approved. Additional Life is a voluntary coverage line and so the paid for by the employee through pay-roll deduction. Sometimes, an employer group may pay for a small amount of Additional Life Coverage for each employee in addition to their Group Life coverage.

If selected, will your employer group be paying for any Additional Life for your employees? ◯ **No** ◯ **Yes**

If Yes, what amount of coverage will the employer group be paying for (in thousands)? ☐☐☐