7500 Rialto Boulevard, Building 1, Suite 250 ♦ Austin, TX 78735
www.membershealthplan.com

HEALTH PLAN PARTICIPATION REQUEST/CONTRACT

AABN #: _____ **Account #:** _____

SECTION 1 - EMPLOYER DATA

1. Full Legal Business Name: _____
2. Street Address: _____ City: _____ State: _____ Zip Code: _____
3. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
4. Group Phone: _____
5. Federal Tax ID No: _____ Type of Business: ☐ Sole Prop ☐ C-Corp ☐ S-Corp ☐ Partnership
6. Industry: _____
7. Administration Contact Person: _____ Email Address: _____
8. Executive Contact Person: _____ Email Address: _____
9. List prior insurance carrier or Third Party Administrator (TPA):_____

MEDICAL Current group health plan (check one): ☐ Fully Insured ☐ Self Funded ☐ Partially Self Funded

If this plan is replacing current group coverage, please provide your most recent copy of your invoice.

10. Name of Worker's Compensation carrier: _____

11. ☐ Yes ☐ No Are any persons to be covered NOT also covered by worker's compensation?
If Yes, please attach the names and reason for each.

12. ☒ Yes ☐ No Are you subject to COBRA? (You are subject to COBRA if you employed at least 20 full-time employees on at least 50% of the working days during the previous calendar year. PT employees are partially credited.)

SECTION 2 - EMPLOYEE DATA

1. Employee Probationary Period: ☐ 30 Days ☐ 60 Days
2. Coverage Effective Date: ☒ First day of the month after completion of probationary period
3. Waive Waiting Period: ☐ Select if you wish to waive the waiting period for employees in their probationary period during initial enrollment of the group.
4. Coverage Termination Date: ☒ First day of the month after termination

SECTION 3 - INITIAL PLAN SELECTION

MHP Medical Plan Options: Choose your plan options (based on Participation Requirements from Assumption page)

☐ Plan 1 - PLATINUM 500 90
☐ Rx1 ☐ Rx2 ☐ Rx4

☐ Plan 2 - GOLD 1500 80
☐ Rx1 ☐ Rx2 ☐ Rx4

☐ Plan 3 - SILVER 2500 70
☐ Rx1 ☐ Rx2 ☐ Rx4

☐ Plan 4 - SILVER 3000 80
☐ Rx1 ☐ Rx2 ☐ Rx4

☐ Plan 7 - SILVER 5000 80
☐ Rx1 ☐ Rx2 ☐ Rx4

☐ Plan 10 - SILVER HSA 2700 80
☐ Rx5

☐ Plan 11 - BRONZE HSA 6500 100
☐ Rx5

☐ Plan 13 - BRONZE 6550 80
☐ Rx1 ☐ Rx2 ☐ Rx4

Plans 14 and 15 are available to Texas Residents Only

☐ Plan 14 - APCN+ SILVER 2500 70
☐ Rx1 ☐ Rx2 ☐ Rx4

☐ Plan 15 - APCN+ SILVER 5000 80
☐ Rx1 ☐ Rx2 ☐ Rx4

Plans 16 and 17 are available to Texas Residents Only with Infertility Benefits

☐ Plan 16 - SILVER 5000 80 - Infertility
☐ Rx5

☐ Plan 17 - BRONZE 6550 80 - Infertility
☐ Rx5

Rx Drug Plan Descriptions:

- ♦ Rx Plan 1 - $10 / $40 / $100 / 30%
- ♦ Rx Plan 2 - $20 / $60 / $150 / 30%
- ♦ Rx Plan 4 - $20 Generic Only
- ♦ Rx Plan 5 - 0% / 20% / 50% / 20%

SECTION 4 - MANDATED BENEFIT OFFERS (to be completed by Texas Employers only)

The following mandated benefit offers are made by MHP in compliance with Texas regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment.

In Vitro Fertilization Services - (must choose one)

☐ Accept – Outpatient benefits are paid same as any other pregnancy-related expense (Note: If selected an additional charge will be added to your rates.)

☐ Decline – If declined, no benefits are available

The following Mandated Benefit Offers are already included in the MHP Plans:

- Treatment of mental or emotional illness
- Treatment of loss or impairment of speech or hearing
- Treatment of serious mental illness

SECTION 5 - DISCLOSURE OF GUARANTY FUND NONPARTICIPATION

In the event the MEWA is unable to fulfill its contractual obligation under this contract, the contract holder is not protected by an insurance guaranty fund or other solvency protection arrangement. If you have any complaints and/or issues regarding this plan, please contact the Texas Department of Insurance consumer services division at (800) 252-3439 (from 8 am to 5 pm Central time) or send an email to: ConsumerProtection@tdi.texas.gov or Arkansas Insurance Department Consumer Services Division at (800) 852-5494 or (501) 371-2640 (from 8am to 5pm Central time) or send an email to: Insurance.Consumers@Arkansas.gov.

SECTION 6 - BILLING INFORMATION

1 Billing Address: _____
Street Address Suite City State Zip

2 Billing Contact Name: _____ Billing Contact Phone: _____

3 Direct Debit from Bank Account: Bank Name: _____

ABA Routing #: _____ Account #: _____

SECTION 7 - BILLING & COLLECTIONS GUIDELINES

Although the contract period is one year, payment of the Health Care Fee will be required monthly. Member Benefits is the billing administrator for the Members Health Plan and handles the collection of health care fees. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. Bills will be generated on the 1st of the month prior to the billing month.
2. Payments will be deducted on the 9th business day of every month.
3. If payment is not received, or moneys are not available for debit from a bank account by the end of the 31-day grace period, all coverage for a Participating Member/Group's covered employees may be terminated retroactive back to the 1st of the month for which payment was due and the Participating Member/Group will be responsible for Health Care Fees due until the earlier of the end of the contract period or by providing the Trust with the proper termination notice as provided for in Section 11. Reinstatement will not be permissible for a Participating Member/Group for 12 months from the Termination Date.
4. If the Plan receives payment within 2 weeks after the Final Termination letters is sent and the account is paid through the current month, the group will be considered for reinstatement if this is the first instance the group is terminated for non-payment. Subsequent instances of termination for non-payment will not be considered for reinstatement.
5. The Plan will enforce a fee of $100.00 to any group that is reinstated after termination for non-payment.
6. As a condition of reinstatement, the group must enroll into the ACH Direct Debit process by e-mailing a copy of a voided check and authorizing us in the email to debit their account on a monthly basis.
7. A $35.00 NSF Fee will be posted to the next invoice if there are unavailable funds in the given account.
8. Employee and/or dependent terminations must be sent to the Plan Administrator prior to the termination date. If a termination request is received more than 15 days after the termination date, the employee and/or dependent will not be terminated until the end of the month in which the termination is received and the employer will be responsible for any applicable Health Care Fees. Employers are ultimately responsible for confirming terminations are received by the Plan and should review their bills each month.
9. Billing will be based on the current census of employees enrolled in our system. Upon enrollment if quoted membership changes more than 10% from the original quote or if the group's membership changes more than 10% during the year, the Plan reserves the right to requote. The rate structure is subject to change at any time.

By signing this contract, the applicant understands that failure to pay Health Care Fees in accordance with the "Billing and Collections Guidelines" will result in the termination of this contract and that it will be responsible for Health Care Fees due.

SECTION 8 - EFFECTIVE DATE/DEPOSIT

Deposit must include the first month's estimated health care fees.

Requested Effective Date: _____ **Deposit with Application: $**_____

IMPORTANT: Coverage is not in effect until the undersigned receives written approval from Member Benefits. (MB). No action is taken on the Application until after all required information is submitted. No person other than an officer of MB has the authority to bind this contract and the undersigned agrees that any such attempt by the agent is void and not effective.

SECTION 9 - PLAN TYPE & EMPLOYEE COVERAGE

The applicant requests participation for _____employees (enter approximate number of employees, including owners enrolling for coverage). Enrollment material will be provided to the applicant for distribution to eligible employees upon approval of this Participation Request/Contract.

SECTION 10 - HEALTH CARE FEES

Exhibit A: Health Care Fees (rates) are effective from the Effective Date of Coverage above (Section 7) through the Initial Contract Period. However, rates may be adjusted at any time during the contract period should the claim expense and/or plan utilization exceed projections.

SECTION 11 - CONTRACT TERMS & TERMINATION OF CONTRACT

Contract Terms*:* The Renewal Date for this Plan is every 12 months. Renewal Rates will be provided at least 30 days prior to the Renewal Date. Coverage will be automatically renewed for additional one-year (1) contract periods (Renewal Contract Periods) by payment of the applicable Health Care Fee due every month, provided the group continues to meet eligibility requirements. Renewals will be on the same terms and conditions as those in effect for the Initial Contract Period, unless notified otherwise by the Plan.

Termination of Contract: Participating Member's may terminate this Contract upon renewal by providing the Plan Administrator written notice within 15 days from the end of a Renewal Contract Period. Participating Member's may also terminate this Contract at any time by giving the Plan Administrator written notice at least 60 days in advance of termination date. If written notice is not provided 60 days in advance, the Participating Member will be responsible for Health Care Fees that would be due as if proper notice been provided, i.e., for the 60 day period.

By signing this contract, the applicant agrees to pay the Health Care Fees (Exhibit A) as provided in Section 10, based on the census maintained by the Trustees for employees that are eligible for coverage under the benefit plan applied for through the end of the Initial Contract Period and, upon payment of revised Health Care Fees, any Renewal Contract Period. The applicant understands that each Renewal Contract Period will be for additional periods of twelve (12) months and at the Health Care Fees provided by the Trust 30 days prior to the end of each contract period, subject to change as described above.

SECTION 12 - SUMMARY OF BENEFITS AND COVERAGE (SBC)/SUMMARY PLAN DESCRIPTION

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting www.membershealthplan.com. A hard copy of the SBC can also be provided upon request, please call the Plan at 800-282-8626 for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit www.healthcare.gov.

ERISA requires that Summary Plan Descriptions (SPD's) are distributed to all plan participants. Employers and plan participants can access the Plan's SPDs by visiting www.membershealthplan.com. A hard copy of the SPD can also be provided upon request, please call the Plan at 800-282-8626 for a copy or if you have any questions about the SPDs. Employers are responsible to ensure the distribution of SPD's to their participants or beneficiaries.

SECTION 13 - STATEMENT OF CONTINGENT LIABILITY

This is a fully assessable self-funded multiple employer welfare arrangement (MEWA) benefit plan. In the event that the Trust is unable to pay its obligations, participating members in the Trust shall be required to contribute on a pro rata earned contribution basis the funds necessary to meet any unfilled obligations. The MEWA shall assess all members enrolled during the assessment period (whether or not they are currently enrolled with the Trust) if the arrangement's reserve or cash requirement at the end of any accounting period is less than the amount required by law. The minimum assessment shall be the amount necessary to comply with the requirements of the Law plus any costs to collect the assessment, including legal fees. Each member's assessment shall be computed by applying the earned healthcare fees for each participating employer's coverage during the assessment period as a percent of the amount of the total of all employers' healthcare fees for the same period. Each member's assessment shall be that member's percent times the total assessment levied. In the event a member fails to pay an assessment, the other members shall be liable on a proportionate basis for an additional assessment. The MEWA, acting on behalf of all members who paid the additional assessment, shall take appropriate action to recover the assessment from any member who fails to pay an assessment.

SECTION 14 - PARTICIPATION REQUEST

The applicant requests participation for its employees in the Trust. The applicant also agrees to be bound by all the conditions of participation and further agrees that:

1. Neither this request to participate, nor the payment of any moneys to be applied towards contributions for coverage, shall cause coverage to become effective on any of the applicant's employees. In order for coverage to go into effect on the date specified by this Contract, the applicant must be accepted as a Participating Member and the applicant's employees must satisfy the applicable eligibility requirements.
2. If applicable, the applicant must be a member in good standing with its association when applying for participation in this Trust, must meet membership requirements established by the by-laws of its association and must remain a member in good standing with its association for coverage to stay in effect.
3. The applicant has seen a copy of the benefits proposed and agrees to pay the required contributions (Health Care Fees) to the Trustees when due and in accordance with the Billing & Collections Guidelines. The Applicant further agrees to give all eligible employees an opportunity to enroll for coverage, if contributions from employees are required.
4. The coverage is subject at all times to the benefit plan applied for, which alone constitutes the contract under which benefits become payable.

Acceptance of this request is subject to all of the Trustees' requirements, including the provisions of any Administrative Services Agreement between the Trustees and any third party administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participating Members in the Trust, and the terms of the applicable benefit plan. The Trustees will notify the applicant of the approval or disapproval of this request. A notice of approval will specify the effective date of the applicant's participation in the Trust. If the applicant is accepted as a Participating Member, it will receive the appropriate benefit plan descriptions and material for enrolling its employees.

The applicant hereby requests participation in the Trust and agrees to be bound by its terms and conditions and the terms and conditions of the Administrative Services Agreement mentioned in the prior paragraph (to the extent they apply to Participating Members).

Name of Applicant (Please Print): _____

Signed: _____ **Date**: _____

SECTION 15 - To be filled out by the Trust

☐ Applicant has been Accepted and has met all participation requirements. Coverage will become effective as to applicant's eligible employees on _____, 20_____.

☐ Applicant has been declined and has not met one or all of the participation requirements.

Signed: _____ **Date**: _____