SPECIAL MEETING OF CITY COUNCIL

TO: THE HONORABLE PRESIDENT AND MEMBERS OF MASSILLON CITY COUNCIL

Ladies and Gentlemen:

A Special Meeting of the City Council of the City of Massillon, Ohio, is hereby called. This Meeting shall be held in the Massillon City Council Chambers at City Hall on **MONDAY, NOVEMBER 30, 2015, AT 6:00 p.m.** for the purpose of:

SEE ATTACHED AGENDA

On this **19th** Day of **NOVEMBER 2015**

CC:

MAYOR
AUDITOR
SAFETY SERVICE DIRECTOR
INCOME TAX ADMINISTATOR/BUDGET DIRECTOR
CHIEF ENGINEER

Section 731.46 Ohio Revised Code

"The Council of a municipal corporation shall not be required to hold more than one regular meeting in each week; and the meetings may be held at such time and place as may be prescribed by ordinance and shall at all time be open to the public; and the Mayor or any three members may call special meetings upon at least twelve hour notice to each member, served personally or left at his usual place of residence."

MASSILLON CITY COUNCIL
CITY OF MASSILLON, OHIO
TONY M. TOWNSEND, PRESIDENT

AGENDA FOR SPECIAL MEETING
HELD MONDAY, NOVEMBER 30, 2015 AT 6:00 P.M.

1. ROLL CALL

2. ACTION TAKEN WITH POSSIBLE PASSAGE ON THE FOLLOWING:

ORDINANCE NO. 184 – 2015 **BY: ENVIRONMENTAL COMMITTEE**

AN ORDINANCE authorizing the Mayor of the City of Massillon, Ohio, to submit an application for financial assistance to the Muskingum Watershed Conservancy District for a Hydraulic Feasibility Study for water quality improvements to the Tuscarawas River and to execute all necessary documentation needed to secure the funding, and declaring an emergency.

ORDINANCE NO. 185 – 2015 **BY: FINANCE COMMITTEE**

AN ORDINANCE authorizing the Director of Public Service and Safety of the City of Massillon, Ohio, to enter into a contract with The Health Plan for health insurance coverage for City employees for the 2016 calendar year, and declaring an emergency.

3. ADJOURNMENT

DIANE ROLLAND – CLERK OF COUNCIL

DATE: NOVEMBER 30, 2015 CLERK: DIANE ROLLAND

MASSILLON CITY COUNCIL
CITY OF MASSILLON, OHIO
TONY M. TOWNSEND, PRESIDENT

COUNCIL CHAMBERS LEGISLATIVE DEPARTMENT

ORDINANCE NO. 184 – 2015

BY: ENVIRONMENTAL COMMITTEE

TITLE: AN ORDINANCE authorizing the Mayor of the City of Massillon, Ohio, to submit an application for financial assistance to the Muskingum Watershed Conservancy District for a Hydraulic Feasibility Study for water quality improvements to the Tuscarawas River and to execute all necessary documentation needed to secure the funding, and declaring an emergency.

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF MASSILLON, STATE OF OHIO, THAT:

Section 1:

The Council of the City of Massillon, Ohio, hereby determines it to be necessary for the Mayor of the City of Massillon, Ohio, to submit an application for financial assistance to the Muskingum Watershed Conservancy District for a Hydraulic Feasibility Study for water quality improvements to the Tuscarawas River and to execute all necessary documentation needed to secure the funding.

Section 2:

The Mayor of the City of Massillon, Ohio, is hereby authorized and directed to submit an application for financial assistance to the Muskingum Watershed Conservancy District and execute all necessary documentation needed to secure funding for a Hydraulic Feasibility Study for water quality improvements to the Tuscarawas River.

Section 3:

The Clerk of Council is authorized to correct any typographical errors discovered herein during or after the pendency or passage of this ordinance. The Clerk of Council is further authorized, in conjunction with the Law Department and the Council President to correct any ministerial or de minimis errors that do not substantially alter the intended results or numerical total sums of this ordinance, during or after the pendency or passage of this ordinance. Corrected copies are to be sent to all official recipients.

Section 4:

This Ordinance is hereby declared to be an emergency measure for the efficient operation of the City of Massillon and for the preservation of the health, safety and welfare of the community. Provided it receives the affirmative vote of two-thirds of the elected members to Council, it shall take effect and be in force immediately upon its passage and approval by the Mayor. Otherwise, it shall take effect and be in force from and after the earliest period allowed by law.

PASSED IN COUNCIL THIS_____DAY OF_____, 2015

ATTEST:_____ _____
DIANE ROLLAND, CLERK OF COUNCIL TONY TOWNSEND, PRESIDENT

APPROVED:_____ _____
KATHY CATAZARO-PERRY, MAYOR

DATE: NOVEMBER 30, 2015 CLERK: DIANE ROLLAND

MASSILLON CITY COUNCIL
CITY OF MASSILLON, OHIO
TONY M. TOWNSEND, PRESIDENT

COUNCIL CHAMBERS LEGISLATIVE DEPARTMENT

ORDINANCE NO. 185 – 2015

BY: FINANCE COMMITTEE

TITLE: AN ORDINANCE authorizing the Director of Public Service and Safety of the City of Massillon, Ohio, to enter into a contract with The Health Plan for health insurance coverage for City employees for the 2016 calendar year, and declaring an emergency.

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF MASSILLON, STATE OF OHIO, THAT:

Section 1:

The Council of the City of Massillon, Ohio, hereby determines it to be necessary and in the public health, safety and welfare to enter into a contract with The Health Plan for health insurance coverage for City employees for the 2016 calendar year.

Section 2:

The Director of Public Service and Safety of the City of Massillon, Ohio, is hereby authorized to enter into a contract with The Health Plan for health insurance coverage for City employees for the 2016 calendar year.

Section 3:

The Clerk of Council is authorized to correct any typographical errors discovered herein during or after the pendency or passage of this ordinance. The Clerk of Council is further authorized, in conjunction with the Law Department and the Council President to correct any ministerial or de minimis errors that do not substantially alter the intended results or numerical total sums of this ordinance, during or after the pendency or passage of this ordinance. Corrected copies are to be sent to all official recipients.

Section 4:

This Ordinance is hereby declared to be an emergency measure necessary for the immediate preservation of the health, safety, and welfare of the community, and for the additional reason that it is necessary to enter into a contract with The Health Plan for health insurance coverage for City employees for the 2016 calendar year. Provided it receives the affirmative vote of two-thirds of the elected members to Council, it shall take effect and be in force immediately upon its passage and approval by the Mayor. Otherwise, it shall take effect and be in force from and after the earliest period allowed by law.

PASSED IN COUNCIL THIS 30th DAY OF November, 2015

ATTEST: Diane Rolland
DIANE ROLLAND, CLERK OF COUNCIL

Tony Townsend
TONY TOWNSEND, PRESIDENT

APPROVED: November 30, 2015

KATHY CATAZARO-PERRY, MAYOR

I hereby certify that the foregoing ordinance is a true copy of the original, as passed by the Council of the City of Massillon, Ohio, and approved as noted thereon:

Diane Rolland
Clerk of Council

Date 11/30/15

The HealthPlan

Employer Master Application, 51+ Eligible Lives

Corporate Office:

The Health Plan
52160 National Rd. East
St. Clairsville, OH 43950-9365
Toll Free 1.800.624.6961

The Employer named below applies to become an Employer Group under the policy(ies) issued by The Health Plan (the Plan). Before signing this application, read carefully and complete all areas. **Please type.**

Renewal Date: 1-1-16

Name of Business	Nature of Business (be specific)		Federal Tax I.D. #
City of Massillon	Municipality		34-6001829
Street Address	**City**	**State**	**Zip Code**
151 Lincoln Way E	Massillon	OH	44646
Mailing Address (if different)		**Contact Person**	
same		Joel Smith	
Phone #	**Fax #**	**Email Address**	
330-830-1702	330-830-1764		
Billing Information (if different) Address		**Contact Person**	
Phone #	**Fax #**	**Email Address**	

Employer's Contribution for:

Employee ____% Dependent(s) ____% Other ____

List Medical & Rx. Plan(s) Selected:	List Rider(s) Selected:
HMO Value $10/20/0	15/25/40

Is this a multi-Employer group health plan?[1] Yes ☐ No ☒ If yes, does any participating Employer employ (including part-time) **less** than **20** employees Yes ☐ No ☐ or **more** than **100** Yes ☐ No ☐

Has the Employer filed a Small Employer Exception (SEE) with CMS/Medicare on behalf of any employee(s)?[2] Yes ☐ No ☐ If yes, please list the name of the employee(s)

Sponsor Type: Employer ☐ Union ☐ Trustee of a Fund ☐ Other ☐

Organization Type: State Government ☐ Local Government ☐ Publicly Traded ☐ Privately Held ☐ Non-Profit ☐ Church Group ☐ Other ☐

[1]Multi-Employer group health plan is any trust, plan association or any other arrangement made by one or more Employers to contribute, sponsor, directly provide health benefits, or facilitate directly or indirectly the acquisition of health insurance by an Employer. If such facilitation exists, the Employer is considered to be a participant in a multi-Employer GHP even if it has a separate contract with an insurer.

[2]Small (fewer than 20 full-time and/or part-time employees) Employer exception is a request by a multi-Employer GHP to CMS for an exception(s) to the Working-Aged MSP rules.

How many full-time employees did firm have in the preceding calendar year? ____

Note: Contract renewals are subject to mandatory requirements as outlined in Federal and State laws.

The HealthPlan

EXHIBIT G
EMPLOYER GROUP ELIGIBILITY RULES

The Plan will permit changes to these eligibility rules only at the renewal date of the Medical and Hospital Group Service Agreement (GSA). The administrative procedures for group member enrollments/terminations for the duration of this GSA are based on the following:

New Hire Waiting Period:	☐ Date of Hire ☒ 30 days ☐ 60 days ☐ Effective following day ☒ 1st of following month ☐ 90 days, Effective 91st Day
Eligibility for Benefits:	☒ 30 Hours (per PPACA requirement) See "Agreement" section letter "b" for additional eligibility information.
Terminations:	☐ Date of Event ☒ End of Month ☐ Other (explain): **Note:** The Plan will retroactively terminate a member (at the request of an Employer) only if there were no claims paid after the requested termination date, and in any case no greater than 60 days. If claims were paid after the requested termination date, termination will occur on the last paid claim date or the above termination policy date, whichever is later.
Marriage:	☒ Date of Event ☐ 1st of following month
Divorces:	☒ Date of Event ☐ End of Month
Dependent Age Cut-off:	☒ to 26
New Born/Adoptions:	Date of Event
Layoffs/Recalls:	Layoffs: Term date of event ☒ Term end of month Recalls: ☒ Reinstate date of event ☐ Reinstate first of following month
HIPAA Loss of Coverage:	First of the following month, upon the Plan's receipt of the completed enrollment information.
HIPAA Family Status Change:	Date of event, upon the Plan's receipt of the completed enrollment information.
Federal COBRA Continuation Coverage (20 or more employees, see "Agreement" section letter "m" for more information):	☒ Yes ☐ No Administrator: ☒ In-House ☐ Other, Name: ____
Sick Leave Event:	☒ Yes ☐ No **Note:** If you have a specific written policy in place please attach. If you do not, see "Agreement" section letter "n" will prevail.
Section 125:	☒ Yes ☐ No
FMLA Qualified 50+ Employees:	☒ Yes ☐ No **Note:** If you have a specific written policy in place please attach. If you do not, see "Agreement" section letter "n" will prevail.
Workers' Comp Event:	**Unless otherwise required by law or by Plan terms, if an employee is absent from work for more than 30 days, the employee's coverage under the plan will terminate unless the employee is eligible for and properly elects continuation coverage.**
Total # of Full-Time Employees: ____ **Total # of Part-Time Employees:** ____	**Total # of Eligible Employees:** ____ **Total # of Covered Employees:** ____ **(as defined by Medicare Secondary Payer (MSP) specifications, see "Agreement" section letter "l" for additional information).**
Employer Name: City of Massillon	**Group #:** 201100025
Group Administrator (signature):	**Date:**
Title:	**Contract Dates:** 1-1-16 to 12-31-16

AGREEMENT:

a. **Administration.** The Employer agrees to provide the Plan with a list of all employees and retirees who are eligible for coverage under this Employer Master Application (Application) and the effective date of coverage for each employee and his/her dependents. Employer also agrees to provide the Plan with the effective date of any change in each employee's coverage including the effective date of any termination in coverage of an employee or dependent. Employer agrees to provide any other information that may be reasonably required by the Plan to administer this Agreement in a timely manner.

b. **Eligibility.** Employer agrees to make the Plan group coverage available to all present and future eligible employees. Each employee must satisfy all eligibility requirements stated in this Application and in the Evidence of Coverage (Member Handbook) before coverage becomes effective. Only full-time employees and their dependents are eligible for coverage under this Application. any variation to this must be agreed to by the Plan.. Rehires and employees changing from part-time to full-time status must complete the new hire waiting period, if any, unless otherwise agreed to by the Plan. If the Employer has a probation or waiting period during which a new employee may not enroll, or the subscriber is adding a newly acquired dependent, the Plan must receive a properly completed enrollment form on or before the coverage effective date. Enrollment requests received after the tenth (10th) of the month, in which coverage is to become effective, will have an effective date of the first (1st) of the following month (unless specified differently by the Employer and agreed to by the Plan).

c. **Waiver of Coverage.** Any employee who waives coverage at the time of the initial Plan offering (or upon initial eligibility) for him/herself or dependents must complete a Waiver of Coverage stating the reason for declining coverage.

d. **Special Enrollment.** If eligible for Special Enrollment, employees or dependents may enroll immediately without waiting until the Employer's next open enrollment period or satisfying the Employer's waiting period requirements, if any. If the employee completed a Waiver of Coverage declining coverage at the time of initial eligibility because of coverage under another group health plan or other health insurance coverage, and the employee or dependent subsequently lost this coverage for the reasons stated in the Plan Evidence of Coverage, the employee or dependent may be eligible for Special Enrollment.

e. **Participation.** Employer must have at least ten (10) employees enrolled with the Plan if a dual choice with another carrier. For Plan participation requirements see the Plan Large Group underwriting rules. The Plan, at any time, may require a group to submit support documentation to assure minimum participation requirements are met and to verify eligibility.

f. **Late Enrollment.** Employees or dependents who do not enroll in the Plan at their initial eligibility, will only be allowed to enroll during

g. **Contribution.** Employer agrees to contribute at least 75% of the cost of the single premium, or 50% of the cost for all tiers, for all employees covered by the Plan. Employer also agrees to contribute the same percentage toward the cost of employee healthcare provided by the Plan that Employer contributes towards the cost of employee healthcare provided by other carriers, up to the amount of the entire Plan premium.

h. **Waiting Period.** The Plan will follow Employer's service waiting period if any. A properly completed enrollment form must be received by the Plan on or before the effective date of coverage. Enrollment requests received after the tenth (10th) of the month in which coverage is to become effective will have an effective date of the first (1st) of the following month (unless specified differently by the Employer and agreed to by the Plan). Service waiting periods shall not be greater than 90 days.

i. **Premium Payments.** Employer agrees to pay premiums when due to the Plan. Employer acknowledges and agrees that failure to pay premiums **may** result in termination of coverage.

j. **Type of Coverage.** Employer agrees to promptly furnish the Plan the name of each employee to be covered and all the information necessary to determine the employee's type of coverage.

k. **Agreement.** This Application and Agreement shall be made a part of the Master Group Policy between the Plan and the Employer. Coverage under this Application shall not be effective until it is approved by the Plan.

l. **Medicare Secondary Payer (MSP).** The working aged MSP provision applies only to GHPs (Group Health Plans) of Employers with 20 or more employees and to multi-Employer and multiple Employer GHPs in which at least one Employer employs 20 or more employees. This requirement is met if an Employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An Employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the Employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if the employee does not work on a particular day. An Employer may not have different employment rolls for different days reflecting those scheduled.

Where an Employer does not have 20 or more employees in the preceding year, it is required to offer its employees and spouses age 65 or over primary coverage beginning with the point in time at which the Employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The Employer is then required to offer primary coverage for the remainder of that year and throughout the following year even if the number of employees drops below 20 after the Employer has met the requirement.

q. **ERISA.** It is expressly agreed by the parties that Employer will be the Plan Administrator and named fiduciary of the Plan (unless it validly delegates that position to another person or entity), as those terms are defined by ERISA or any similar or successor law (collectively referred to as ERISA) with the exclusive authority to control and manage the operation of the group plan and that the Plan will be a fiduciary with respect to the group plan solely for purposes of, and to the extent that, its services relating to claims processing and review of appeals are considered fiduciary functions under ERISA and the Plan will have no other fiduciary obligations under the group on account of this Application, the GSA or the Evidence of Coverage (Member Handbook). In reviewing and making decisions on claims for benefits, the Plan will have the discretionary authority to interpret the terms of the group and to make factual determinations, including determining eligibility for benefits and validity of charges submitted for reimbursement, subject to Employer's responsibility as Plan Administrator as set forth above.

The Plan shall process claims for covered benefits under the group plan for members. Claims for plan benefits must be submitted in a form that is satisfactory to the Plan. The Plan will use claim procedures and standards that the Plan develops for benefit claim determination. Employer delegates to the Plan the discretion and authority to use such procedures and standards.

Employer expressly delegates to the Plan the discretionary authority to determine the validity of claims under the group plan. The Plan has the discretionary authority to administer, construe and interpret the terms of the group plan and to make final, binding determinations concerning the availability of group plan benefits, including appeals concerning denial of the same.

r. **Choice of Law.** This Agreement will be construed under applicable state law, to the extent the same is not preempted in whole or in part by federal law.

I hereby certify that I have reviewed the above information and it is true and accurate to the best of my knowledge. I understand and agree that the information on this Application and any other information I have provided, or will provide, shall serve as the basis for the policy to be issued and that I have a duty to notify the Plan of any changes. I further agree to be bound by the terms of this Application.

Employer Name

Employer Representative's Name (Please print) Title

Employer Representative's Signature Date

BROKER INFORMATION AND STATEMENT

I understand that I have no right to bind this coverage, to alter terms of the Agreement or Application in any manner, or to adjust any claim for benefits under the Agreement.

Writing Broker's Name: Charles L. Clark (Please print) License #:

By (Writing Broker's Signature): Charles L Clark Date:

The HealthPlan

Employer Master Application,
51+ Eligible Lives

Corporate Office:

The Health Plan
52160 National Rd. East
St. Clairsville, OH 43950-9365
Toll Free 1.800.624.6961

The Employer named below applies to become an Employer Group under the policy(ies) issued by The Health Plan (the Plan). Before signing this application, read carefully and complete all areas. **Please type.**

Renewal Date: 1-1-16

Name of Business	Nature of Business (be specific)		Federal Tax I.D. #
City of Massillon	Municipality		34-6001829
Street Address	**City**	**State**	**Zip Code**
151 Lincoln Way E	Massillon	OH	44646
Mailing Address (if different)		**Contact Person**	
Same		Joel Smith	
Phone #	**Fax #**	**Email Address**	
330-830-1702	330-830-1764		
Billing Information (if different) Address		**Contact Person**	
Same		Joel Smith	
Phone #	**Fax #**	**Email Address**	
330-830-1702	330-830-1764		

Employer's Contribution for:

Employee ____% Dependent(s) ____% Other ____

List Medical & Rx. Plan(s) Selected:	List Rider(s) Selected:
PPO 80/15/250	15/25/40

Is this a multi-Employer group health plan?[1] Yes ☐ No ☒ If yes, does any participating Employer employ (including part-time) **less** than **20** employees Yes ☐ No ☐ or **more** than **100** Yes ☐ No ☐

Has the Employer filed a Small Employer Exception (SEE) with CMS/Medicare on behalf of any employee(s)?[2] Yes ☐ No ☒ If yes, please list the name of the employee(s) .

Sponsor Type: Employer ☐ Union ☐ Trustee of a Fund ☐ Other ☐

Organization Type: State Government ☐ Local Government ☐ Publicly Traded ☐ Privately Held ☐ Non-Profit ☐ Church Group ☐ Other ☐

How many full-time employees did firm have in the preceding calendar year? ____

Note: Contract renewals are subject to mandatory requirements as outlined in Federal and State laws.

[1]Multi-Employer group health plan is any trust, plan association or any other arrangement made by one or more Employers to contribute, sponsor, directly provide health benefits, or facilitate directly or indirectly the acquisition of health insurance by an Employer. If such facilitation exists, the Employer is considered to be a participant in a multi-Employer GHP even if it has a separate contract with an insurer.

[2]Small (fewer than 20 full-time and/or part-time employees) Employer exception is a request by a multi-Employer GHP to CMS for an exception(s) to the Working-Aged MSP rules.

The HealthPlan

EXHIBIT G
EMPLOYER GROUP ELIGIBILITY RULES

The Plan will permit changes to those eligibility rules only at the renewal date of the Medical and Hospital Group Service Agreement (GSA). The administrative procedures for group member enrollments/terminations for the duration of this GSA are based on the following:

New Hire Waiting Period:	☐ Date of Hire ☒ 30 days ☐ 60 days ☐ Effective following day ☒ 1st of following month ☐ 90 days, Effective 91st Day
Eligibility for Benefits:	☒ 30 Hours (per PPACA requirement) See "Agreement" section letter "b" for additional eligibility information.
Terminations:	☐ Date of Event ☒ End of Month ☐ Other (explain): **Note:** The Plan will retroactively terminate a member (at the request of an Employer) only if there were no claims paid after the requested termination date, and in any case no greater than 60 days. If claims were paid after the requested termination date, termination will occur on the last paid claim date **or** the above termination policy date, whichever is later.
Marriage:	☒ Date of Event ☐ 1st of following month
Divorces:	☒ Date of Event ☐ End of Month
Dependent Age Cut-off:	☒ to 26
New Born/Adoptions:	Date of Event
Layoffs/Recalls:	Layoffs: ☐ Term date of event ☒ Term end of month Recalls: ☒ Reinstate date of event ☐ Reinstate first of following month
HIPAA Loss of Coverage:	First of the following month, upon the Plan's receipt of the completed enrollment information.
HIPAA Family Status Change:	Date of event, upon the Plan's receipt of the completed enrollment information.
Federal COBRA Continuation Coverage (20 or more employees, see "Agreement" section letter "m" for more information):	☒ Yes ☐ No Administrator: ☒ In-House ☐ Other, Name: ____
Sick Leave Event:	☒ Yes ☐ No **Note:** If you have a specific written policy in place please attach. If you do not, see "Agreement" section letter "n" will prevail.
Section 125:	☒ Yes ☐ No
FMLA Qualified 50+ Employees:	☒ Yes ☐ No **Note:** If you have a specific written policy in place please attach. If you do not, see "Agreement" section letter "n" will prevail.
Workers' Comp Event:	**Unless otherwise required by law or by Plan terms, if an employee is absent from work for more than 30 days, the employee's coverage under the plan will terminate unless the employee is eligible for and properly elects continuation coverage.**

Total # of Full-Time Employees: ____ **Total # of Eligible Employees:** ____ **Total # of Covered Employees:** ____

Total # of Part-Time Employees: ____ (as defined by Medicare Secondary Payer (MSP) specifications, see "Agreement" section letter "l" for additional information).

Employer Name: City of Massillon	**Group #:** 224150103
Group Administrator (signature):	**Date:**
Title:	**Contract Dates:** 1-1-16 - 12-31-16

AGREEMENT:

a. **Administration.** The Employer agrees to provide the Plan with a list of all employees and retirees who are eligible for coverage under this Employer Master Application (Application) and the effective date of coverage for each employee and his/her dependents. Employer also agrees to provide the Plan with the effective date of any change in each employee's coverage including the effective date of any termination in coverage of an employee or dependent. Employer agrees to provide any other information that may be reasonably required by the Plan to administer this Agreement in a timely manner.

b. **Eligibility.** Employer agrees to make the Plan group coverage available to all present and future eligible employees. Each employee must satisfy all eligibility requirements stated in this Application and in the Evidence of Coverage (Member Handbook) before coverage becomes effective. Only full-time employees and their dependents are eligible for coverage under this Application, any variation to this must be agreed to by the Plan.. Rehires and employees changing from part-time to full-time status must complete the new hire waiting period, if any, unless otherwise agreed to by the Plan. If the Employer has a probation or waiting period during which a new employee may not enroll, or the subscriber is adding a newly acquired dependent, the Plan must receive a properly completed enrollment form on or before the coverage effective date. Enrollment requests received after the tenth (10th) of the month, in which coverage is to become effective, will have an effective date of the first (1st) of the following month (unless specified differently by the Employer and agreed to by the Plan).

c. **Waiver of Coverage.** Any employee who waives coverage at the time of the initial Plan offering (or upon initial eligibility) for him/herself or dependents must complete a Waiver of Coverage stating the reason for declining coverage.

d. **Special Enrollment.** If eligible for Special Enrollment, employees or dependents may enroll immediately without waiting until the Employer's next open enrollment period or satisfying the Employer's waiting period requirements, if any. If the employee completed a Waiver of Coverage declining coverage at the time of initial eligibility because of coverage under another group health plan or other health insurance coverage, and the employee or dependent subsequently lost this coverage for the reasons stated in the Plan Evidence of Coverage, the employee or dependent may be eligible for Special Enrollment.

e. **Participation.** Employer must have at least ten (10) employees enrolled with the Plan if a dual choice with another carrier. For Plan participation requirements see the Plan Large Group underwriting rules. The Plan, at any time, may require a group to submit support documentation to assure minimum participation requirements are met and to verify eligibility.

f. **Late Enrollment.** Employees or dependents who do not enroll in the Plan at their initial eligibility, will only be allowed to enroll during

g. **Contribution.** Employer agrees to contribute at least 75% of the cost of the single premium, or 50% of the cost for all tiers, for all employees covered by the Plan. Employer also agrees to contribute the same percentage toward the cost of employee healthcare provided by the Plan that Employer contributes towards the cost of employee healthcare provided by other carriers, up to the amount of the entire Plan premium.

h. **Waiting Period.** The Plan will follow Employer's service waiting period if any. A properly completed enrollment form must be received by the Plan on or before the effective date of coverage. Enrollment requests received after the tenth (10th) of the month in which coverage is to become effective will have an effective date of the first (1st) of the following month (unless specified differently by the Employer and agreed to by the Plan). Service waiting periods shall not be greater than 90 days.

i. **Premium Payments.** Employer agrees to pay premiums when due to the Plan. Employer acknowledges and agrees that failure to pay premiums **may** result in termination of coverage.

j. **Type of Coverage.** Employer agrees to promptly furnish the Plan the name of each employee to be covered and all the information necessary to determine the employee's type of coverage.

k. **Agreement.** This Application and Agreement shall be made a part of the Master Group Policy between the Plan and the Employer. Coverage under this Application shall not be effective until it is approved by the Plan.

l. **Medicare Secondary Payer (MSP).** The working aged MSP provision applies only to GHPs (Group Health Plans) of Employers with 20 or more employees and to multi-Employer and multiple Employer GHPs in which at least one Employer employs 20 or more employees. This requirement is met if an Employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An Employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the Employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if the employee does not work on a particular day. An Employer may not have different employment rolls for different days reflecting those scheduled.

Where an Employer does not have 20 or more employees in the preceding year, it is required to offer its employees and spouses age 65 or over primary coverage beginning with the point in time at which the Employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The Employer is then required to offer primary coverage for the remainder of that year and throughout the following year even if the number of employees drops below 20 after the Employer has met the requirement.

q. **ERISA.** It is expressly agreed by the parties that Employer will be the Plan Administrator and named fiduciary of the Plan (unless it validly delegates that position to another person or entity), as those terms are defined by ERISA or any similar or successor law (collectively referred to as ERISA) with the exclusive authority to control and manage the operation of the group plan and that the Plan will be a fiduciary with respect to the group plan solely for purposes of, and to the extent that, its services relating to claims processing and review of appeals are considered fiduciary functions under ERISA and the Plan will have no other fiduciary obligations under the group on account of this Application, the GSA or the Evidence of Coverage (Member Handbook). In reviewing and making decisions on claims for benefits, the Plan will have the discretionary authority to interpret the terms of the group and to make factual determinations, including determining eligibility for benefits and validity of charges submitted for reimbursement, subject to Employer's responsibility as Plan Administrator as set forth above.

The Plan shall process claims for covered benefits under the group plan for members. Claims for plan benefits must be submitted in a form that is satisfactory to the Plan. The Plan will use claim procedures and standards that the Plan develops for benefit claim determination. Employer delegates to the Plan the discretion and authority to use such procedures and standards.

Employer expressly delegates to the Plan the discretionary authority to determine the validity of claims under the group plan. The Plan has the discretionary authority to administer, construe and interpret the terms of the group plan and to make final, binding determinations concerning the availability of group plan benefits, including appeals concerning denial of the same.

r. **Choice of Law.** This Agreement will be construed under applicable state law, to the extent the same is not preempted in whole or in part by federal law.

I hereby certify that I have reviewed the above information and it is true and accurate to the best of my knowledge. I understand and agree that the information on this Application and any other information I have provided, or will provide, shall serve as the basis for the policy to be issued and that I have a duty to notify the Plan of any changes. I further agree to be bound by the terms of this Application.

Employer Name

Employer Representative's Name (Please print) Title

Employer Representative's Signature Date

BROKER INFORMATION AND STATEMENT

I understand that I have no right to bind this coverage, to alter terms of the Agreement or Application in any manner, or to adjust any claim for benefits under the Agreement.

Writing Broker's Name: Charles L. Clark (Please print) License #:

By (Writing Broker's Signature): Charles L Clark Date: