The Lincoln National Life Insurance Company

A Stock Company   Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

EXEC-U-CARE PARTICIPATION AGREEMENT

The undersigned Employer hereby requests to be approved as a Participant in The Lincoln National Life Insurance Company's Medical Expense Reimbursement Insurance Trust, and to be insured under a group insurance policy issued to the Trust. The Employer accepts the provisions of the Trust and group policy, and agrees to be bound by their terms.

1. Employer's legal name:______________________________

2. Type of organization: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other

3. Employer's Address:______________________________

   City______________________ State__________ ZIP__________

4. Type of Business:______________________ EIN__________

5. Proposed Plan Entry Date (Effective Date): First Day of ______________________
   (month) (year)

6. Associated companies to be included under this application:______________________

   ____

7. Individual at Employer's firm responsible for Plan administration:

   Name/Title______________________ Phone (____)__________

Exec-U-Care Benefits will be administered as if each claimant is also covered by a Base Medical Plan, which provides at least the following benefits:

When the underlying Base Medical Plan is a major medical plan, it must provide at least:

(a) a $250,000 lifetime maximum per person; subject to:
   (i) an annual deductible not to exceed $1,000 per person; and
   (ii) copayments not to exceed 20% of the first $10,000 of covered expenses beyond deductible incurred by each person each plan year;

   If a PPO (preferred provider organization) option is included, copayments may not exceed 20% of that amount for covered expenses incurred within the PPO network, or 40% of that amount for covered expenses incurred outside the PPO network;
(b) coverage of the full cost of semi-private hospital room and board, intensive care and extended care;
(c) coverage of the usual, customary and reasonable charges for professional services and supplies, including (but not limited to):
   (i) physician's or surgeon's services, nursing care and physiotherapy;
   (ii) prescription drugs and medicines; and
   (iii) x-ray, laboratory and ambulance services; and
(d) any other coverage required by federal law and by the state laws, which apply where the Participating Employer's Certificates are delivered.

For persons who are eligible for Medicare, the Base Medical Plan may also consist of coverage under Medicare Parts A, B and D, which meets the minimum state requirements for such plans.

When the underlying Base Medical Plan is a High Deductible Health Plan, (HDHP), it must qualify as a High Deductible Health Plan under section 223(c)(2) of the Internal Revenue Code of 1986, as amended, and must provide:

(a) an annual deductible not to exceed $5,000 per person. (In no event may the annual deductible be less than the minimum required under the Internal Revenue Code for a qualified High Deductible Health Plan);

(b) the Maximum Annual Deductible and Other Out-of-Pocket Expense limit required under the Internal Revenue Code for a qualified High Deductible Health Plan. Out-of-pocket expense includes the annual deductible, any copayments and coinsurance, including for prescription drugs. This limit does not apply to expenses for out-of-network providers if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure the limit; and

(c) any other coverage required by federal law and by the state laws, which apply where the Participating Employer's Certificates are delivered.

For persons who are eligible for Medicare, the Base Medical Plan may also consist of coverage under Medicare Parts A, B and D, which meets the minimum state requirements for such plans.

NOTE: The issuance of Exec-U-Care coverage may violate various IRS statutes if the High Deductible Health Plan used as the Base Medical Plan incorporates a Health Savings Account (HSA). An individual covered under a High Deductible Health Plan and a Health Savings Account is ineligible for Exec-U-Care coverage.

8. The Employer understands that all Insured Employees and Dependents must also be covered under a Base Medical Plan, during the entire period their Exec-U-Care coverage is in effect. Only these exceptions are requested, for individuals or benefits not meeting the above requirements:

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____

____

9. Carrier underwriting Base Medical Plan:______________________________________

10. Eligible classes of employees (and any outside directors, retired employees or surviving spouses) to be included:

	Base Medical Plan Type			
	Major Medical	Medicare Supplement	HDHP	Other
1)______________________	☐	☐	☐	☐
2)______________________	☐	☐	☐	☐
3)______________________	☐	☐	☐	☐
4)______________________	☐	☐	☐	☐

If a HDHP is elected as the Base Medical Plan Type, please indicate the dollar amount of the Deductible in use for the Employer's HDHP: ________________
If more than one HDHP Deductible applies, please provide details on a separate page.

Please note: if the Deductible amount changes, the Employer must notify Exec-U-Care of the change within 31 days of the effective date of its change.

Individuals become eligible on the Employer's Effective Date, or on the first of the month after becoming a member of an eligible class, if later.

11. Total Number of employees (including those ineligible for coverage):____________
Total Number of eligible employees:________
Total Number of eligible outside directors, if any:__________
Total Number of eligible retired employees and surviving spouses, if any:________
(Individual enrollment cards must be completed and signed by all eligible persons.)

12. Plan requested: ☐ Plan A - $100,000 Plan ☐ Plan B - $50,000 Plan

Annual Cost: The annual cost is $250 per Insured Person, plus 111% of the group's total eligible medical reimbursement claims. The maximum annual cost equals the applicable Cost Factor times the number of Insured Employees during the plan year. The Cost Factor is based upon the type of underlying Base Medical Plan, group size, and deductible when the underlying Base Medical Plan is a High Deductible Health Plan.

When the underlying Base Medical Plan is a major medical plan:

No. of Insured Employees	Cost Factor For Plan A - $100,000	Cost Factor For Plan B - $50,000
1 – 2	$14,060	NA
3 - 4	$11,920	$11,560
5 - 7	$10,805	$10,510
8 - 10	$10,165	$9,865
11 - 15	$9,735	$9,430
16 - 20	$9,280	$8,970
21 - 25	$8,920	$8,610
26 - 49	$8,435	$8,120
50 - 74	$7,980	$7,675
75 - 99	$7,480	$7,175
100 - 149	$7,015	$6,745
150 or More	$6,550	$6,310

When the underlying Base Medical Plan is a High Deductible Health Plan:

Group Size	$1,100-$2,750 deductible, Plan A $100,000	$1,100-$2,750 deductible, Plan B $50,000	$2,751-$4,250 deductible, Plan A $100,000	$2,751-$4,250 deductible, Plan B $50,000	$4,251+ deductible, Plan A $100,000	$4,251+ deductible, Plan B $50,000
1 - 2	$21,005	NA	$26,170	NA	$29,940	NA
3 - 4	$17,700	$17,290	$21,930	$21,695	$25,090	$24,820
5 – 7	$16,315	$15,995	$20,255	$19,765	$23,170	$22,610
8 – 10	$15,315	$15,030	$18,990	$18,485	$21,725	$21,145
11 – 15	$14,650	$14,435	$18,145	$17,690	$20,760	$20,235
16 – 20	$13,950	$13,625	$17,260	$16,860	$19,745	$19,290
21 – 25	$13,390	$13,055	$16,555	$16,195	$18,940	$18,525
26 – 49	$12,645	$12,275	$15,615	$15,320	$17,865	$17,525
50 – 74	$11,955	$11,550	$14,755	$14,540	$16,880	$16,635
75 – 99	$11,195	$10,760	$13,795	$13,655	$15,780	$15,620
100 – 149	$10,510	$10,170	$12,950	$12,760	$14,815	$14,600
150 or More	$9,830	$9,580	$12,105	$11,865	$13,850	$13,575

Rates are subject to change, upon prior written notice to Participants. An initial premium of $62.50 per Insured Person must accompany this Participation Agreement. All subsequent premiums are due upon receipt of each billing statement, subject to a 31-day Grace Period.

The undersigned Employer has read this entire Participation Agreement, and certifies that all information supplied above is true and complete. The requested insurance will not take effect until this Participation Agreement has been accepted in writing by The Lincoln National Life Insurance Company.

Date:____________________ Employer's Name:____

By:____

Authorized Signature   Typed/Printed Name   Title

Agent's Name:____ License No.______________________

Agent's Firm:____ EIN____________________________

Firm Address:____ Phone (____)____________________

NOTE: A person is guilty of insurance fraud, if he submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he is helping defraud an insurance company).

•Please make check payable to Exec-U-Care and mail to: Exec-U-Care, P. O. Box 4540, Iowa City, Iowa 52244•

Exec-U-Care is NOT available to groups sitused in the following states: Alabama, Connecticut, Kansas, Maine, North Dakota, New Hampshire, New York, South Dakota, Vermont, Washington and West Virginia.

EXEC-U-CARE
PRIVACY LETTER OF UNDERSTANDING

Introduction. Exec-U-Care is made available through an employer's health benefits program ("Program") to reimburse certain medical expenses incurred by employees, their spouses, and dependents, defined by the employer as eligible for coverage. In the course of administering this coverage, it is necessary for the employer who sponsors Exec-U-Care coverage ("Sponsor"), or its authorized representative, to receive, and disclose health information that is protected by federal, state, or other privacy laws ("Protected Health Information"). These laws may include, but are not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For instance, a Sponsor will likely receive Protected Health Information in the claims verification and submission process, and when administering coverage in those instances where premium payments exceed Exec-U-Care's maximum premium factor.

Through this Letter of Understanding, Exec-U-Care is offering the Sponsor certain options regarding how Exec-U-Care may disclose Protected Health Information to the Sponsor when administering the coverage. **Please provide the names of ALL individuals who are authorized to receive protected health information (PHI). Check the corresponding box with the information that each individual is authorized to receive.**

Name	***Phone Number***	***Fax Number***	***Email Address***	***Information to be released to individual***
				☐ Billing ☐ Eligibility ☐ Claims ☐ Funding
				☐ Billing ☐ Eligibility ☐ Claims ☐ Funding
				☐ Billing ☐ Eligibility ☐ Claims ☐ Funding
				☐ Billing ☐ Eligibility ☐ Claims ☐ Funding

Coverage Administration Disclosure Procedures. Exec-U-Care may disclose Protected Health Information for certain coverage administration functions to a Sponsor who executes this Privacy Letter of Understanding, or its authorized representative. Exec-U-Care may not require any other disclosure documentation in these instances.

In the absence of a signed Privacy Letter of Understanding, Exec-U-Care may disclose Protected Health Information to a Sponsor, or its authorized representative, as agreed by, and in the presence of, the individual who is the subject of the Protected Health Information to be disclosed, or his/her recognized personal representative. Alternatively, disclosure to a Sponsor, or its authorized representative, may occur in the absence of a signed Privacy Letter of Understanding if pursuant to a controlling disclosure authorization. Disclosure authorizations must be secured by the Sponsor as necessary, timely provided to Exec-U-Care, and signed by the individual who is the subject of the Protected Health Information to be disclosed, or his/her recognized personal representative.

Conclusion. Through its undersigned authorized representative, the Sponsor hereby acknowledges its, and its Program's compliance with governing privacy laws. This compliance includes, without limitation, HIPAA requirements to amend controlling group health plan documents, and certification of such, to enable the plan's disclosure of Protected Health Information to its plan sponsor.

Exec-U-Care advises the Sponsor to consult with its legal counsel regarding any questions of privacy compliance.

EMPLOYER / SPONSOR

Employer Name / Sponsor:____

Employer Address: ____

Company # ____________________

EMPLOYER/ SPONSOR AUTHORIZING SIGNATURE

Signature: ____

Print Name: ____

Date: _________________________

EXEC-U-CARE®
PO Box 4540, Iowa City, IA 52244

COMPANY CONTACT PIN DESIGNATION FORM

Company Number: ______________________________

Company Name: ______________________________

Authorized Contact Name: ______________________________

Authorized Contact PIN: ______________________________
4 Characters Only. The PIN will be used for caller verification purposes.

Due to privacy regulations, Exec-U-Care now requires a PIN for each authorized individual listed on your Privacy Letter of Understanding. Upon receipt of this form, you will be asked to verify your PIN each time you call Exec-U-Care.

If you would like to change your PIN at any time, please contact us to obtain a new form.

Please sign, date and return this form to Exec-U-Care at the address shown above or via fax to (319) 354-5204.

Authorized Contact Signature: ___________________________

Date: ___________________________