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 Health Plan which provides at least the following benefits.

(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 each person's first $10,000 of covered expenses incurred beyond the deductible each plan year, under a plan without a PPO option; or
   (iii) copayments not to exceed 20% for PPO services or 40% for Non-PPO services, for each person's first $10,000 of covered expenses incurred beyond the deductible each plan year, under a plan with a PPO option.

(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) physician's or surgeon's services, nursing care and physiotherapy; prescription drugs and medicines; and x-ray, laboratory and ambulance services.

(d) Any other coverage required by the state laws where the Employer is located.

For persons eligible for Medicare, the Base Health Plan may also consist of coverage under Medicare Parts A and B; plus a Medicare Supplement Insurance Policy which meets the minimum state requirements for such plans.

8. The Employer understands that all Insured Persons and Dependents must also be covered under a Base Health 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:
   ____
   ____
   ____
9. Carrier underwriting Base Health Plan:______________________________

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

	Base Health Plan Type		
	Major Medical	Medicare Supplement	Other
1)________________________	☐	☐	☐
2)________________________	☐	☐	☐
3)________________________	☐	☐	☐
4)________________________	☐	☐	☐

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 Persons during the plan year (or times 3, if greater). The Cost Factor is based upon group size.

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

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
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: ___________________________