WELLNESS TRUST
ODA MEMBER BENEFIT

Health Plan Participation Contract

Administered by: MEDICAL MUTUAL

Send forms to:
Ohio Dental Association Services Corporation
1370 Dublin Road
Columbus, OH 43215-1098
Phone: 614-486-2700
Fax: 614-340-9444

This contract is entered into between:

Employer Name: _____ Federal Tax Identification #: _____

And the **Ohio Dental Association Wellness Trust (ODAWT).**

This Contract is made in consideration of the Group application and individual applications which are incorporated in and made a part of this Contract by reference.

Contract Terms & Termination of Contract

Contract Terms: The Renewal Date for this Plan is January 1st of each year. Renewal Rates will be provided at least 30 days prior to the Renewal Date. If accepted upon renewal, coverage will be renewed for additional one-year (1) contract periods (Renewal Contract Periods) by payment of the applicable Renewal Health Care Fees due at the Renewal Date. 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 Members 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 Members may also terminate this Contract at any time by giving the Plan Administrator written notice at least 30 days in advance of termination date. Posted dated terminations are never allowed.

By signing this contract, the applicant agrees to pay the Health Care Fees as outlined in the attached proposal, based on the census maintained by the Plan Administrator 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.

Summary of Benefits and Coverage (SBC)

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 SBCs by visiting www.odawt.org. Copies of the SBC are available at www.odawt.org or upon request. Please call the Plan at (800) 282-1526 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.

Participation Guidelines

Participation Guidelines are in force from the Effective Date of this contract and remain in effect for each subsequent Renewal Contract Period unless written notification is provided by the Trust. By signing this contract, the applicant agrees to the participation guidelines and proposal qualifications, and understands that should it provide false information or fail to meet the requirements for eligibility, it will result in the termination of this contract for all covered persons.

Statement of Contingent Liability

The Plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer. The Plan is not covered by the Ohio Life and Health Guaranty Association. This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations. Certain other major protections offered to Ohio residents under the Ohio Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through the multiple employer self-insured plan. The applicant requests participation for its employees in the Trust.

Billing & Collections Guidelines

Although the contract period is one year, payment of Health Care Fees will be required monthly. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. *Bills will be mailed on or about the 15th of the month prior to the billing month.*
2. *Remittance will be due on the 1st 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 Group's covered employees will be terminated retroactive back to the 1st of the month for which payment was due, and the Participating 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 under Contract Terms.*
4. *Reinstatement will not be permissible for a Participating Group until one year from the date of termination.*
5. *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(s) 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 for that month.*
6. *Billing will be based on the current census of employees enrolled in the system as of the date bills are run. Rates may change based on the individual age of each employee at the time of renewal.*

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 the Group will be responsible for Health Care Fees due.

Section 2: Effective Date of Coverage

Effective Date of Coverage: _____

Acceptance of this request is subject to all of the Trusts' requirements, including the provisions of any Administrative Services Agreement between the Trust and any third party administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participating Employers in the Trust, and the terms of the applicable benefit plan. The Trust 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 Employer, 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 the Trust's terms and conditions as well as the terms and conditions of the Administrative Services Agreement mentioned in the prior paragraph (to the extent they apply to Participating Employers).

Name of Applicant (Please Print): _____

Signed: _____ **Date**:_____

FRAUD STATEMENT – Any person with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

ODA Wellness Trust

Administered by: Medical Mutual

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1370 Dublin Road; Columbus, OH 43215-1098
Phone: 614-486-2700
Fax: 614-340-9444

ODA Wellness Trust Plan Participation Details

Employer Information:

Group Name:	ODA Member Name:
Federal Tax Identification #:	

Participation Criteria

What is the minimum # of hours to be worked per week for employees to be considered eligible for health benefits*

_____ **minimum 25 hours, maximum 30 hours*

Waiting period for newly hired eligible employees:
(Per ACA guidelines, may not exceed 90 calendar days. Eligible employees electing coverage shall be enrolled within the 60 day administrative period following their eligibility date.)

- ☐ First of month following Date of Hire
- ☐ First of month following 30 calendar days
- ☐ First of month following 60 calendar days
- ☐ 90 calendar days following Date of Hire

Employer Contributions (Check box and specify amount*)	Single	2-Person	Family	None
	☐ _____	☐ _____	☐ _____	☐ _____

* Please state in % or $ amount. **No employer contribution is required.**

	Table 1: Calculating Participation Requirements (Information to complete this table is found in Table 2 on Page 2)		
1	Total number of current Employees (*part-time & full-time*) including Doctors:		
2	Total number of Eligible Full-time Employees (Tables 2 & 3, Column A):		
3	Number of Eligible Employees currently enrolled or requesting a quote (Table 2):		
4	Total number of Eligible Employees with **Qualified Waivers**: Covered through Parent, Spouse's Employer, Subsidy, Medicaid, or Medicare (Table 3, Column B)		
5	Total number of Eligible Employees waiving due to Individual Coverage or No Coverage: (Table 3, Column B)		
	Participation Requirement: 65% of net Eligible Employees, Minimum of 2 Subscribers per Group. (Line **2** –Line **4**) = Total Eligible Employees **x 65%** ≥ 2 *Please contact ODAWT at 1-800-282-1526 with questions regarding final Participation Calculation.*		

Table 2: ODA Wellness Trust Participation

Please list below **ALL** Doctors and Employees in your office that are:

(use additional sheets if necessary)

1. **Currently** enrolled in ODAWT
2. Requesting an ODAWT **Quote**
3. Part-Time or **Not** Eligible*:

Group Name:					**Column A**	
Title: **Dr, Mr, Ms**	First Name	MI	Last Name	Date of Hire	Total Hours Per Week	Indicate: **C-** Current ODAWT **Q** – Eligible **N** – Not Eligible*

*Ineligible employees include: part time employees that work less than 25 hours per week, temporary employees, or employees that have not completed the group probationary period.

Table 3: ODA Wellness Trust -- Waivers
Please list ALL Doctors and Employees in your office on the below census that are ***waiving coverage***: (use additional sheets if necessary)

Group Name:

Employer Signature: **Date:**

				Column A	**Column B**	**Column C**	
Title **Dr, Mr, Ms**	First Name	Last Name	Date of Hire	Total Hours Per Week	If Waiving Coverage, indicate why: **S** = Spouse' Employer **P**= Parent **Sub**= Subsidy **M**= Medicare or Medicaid **No**=No coverage **IND** = Individual coverage	**Waiver **** Please complete information below and sign. If no other coverage, indicate N/A and sign.	
						Plan Name **And** Company/Group Sponsor	Signature

**This benefit waiver is available to employees who are regularly scheduled to work the minimum number of hours per week as specified in the Employer Health Plan Participation Request/Contract on file with the ODA Wellness Trust. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period, or at any time upon a qualifying event as defined in the Plan's Summary Plan Description.

I voluntarily agree to waive coverage under the health benefits offered by my Employer.
I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered. I understand that if I purchase individual health insurance, it must not be paid for with pre-tax dollars, and any contribution from my employer toward individual health insurance will be considered part of my salary and taxed as such.