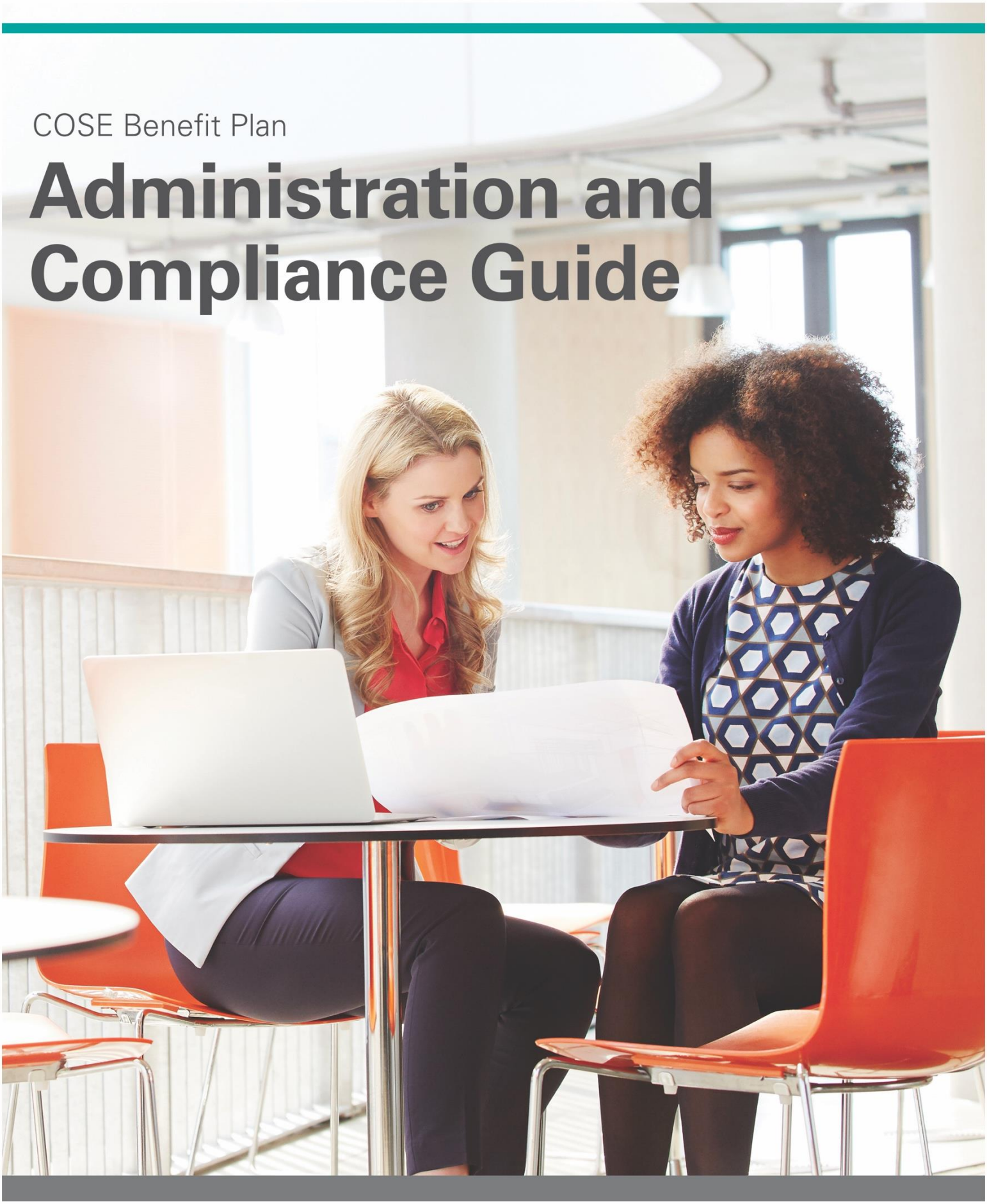
COSE Benefit Plan

Administration and Compliance Guide



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MEDICAL MUTUAL®

cose BENEFIT PLAN

CONTACT INFORMATION AND RESOURCES

TYPE OF QUESTION	CONTACT INFORMATION
Medical Mutual Billing and Enrollment EmployerLink.com: • View invoices • Make enrollment changes • Pay your bill	Please contact your assigned Medical Mutual billing representative Fax: (419) 473 7285 (Also shown on employer's invoice) Send enrollment changes to: Medical Mutual Attn: Membership Dept., cc:6200 2060 East Ninth Street Cleveland, Ohio 44115-1355 Email: MemApps@medmutual.com
For questions regarding governance of the COSE Benefit Plan	COSE Benefit Plan 1240 Huron Road, Ste. 300 Cleveland, Ohio 44115-1717 Phone: (216) 592-2404 Email: chwt@gcpartnership.com cosebenefitplan.com
COSE Membership Benefits (other than COSE Benefit Plan benefits)	COSE Customer Service Phone: (216) 592-2222 Toll-free: (866) 553-5427 Email: memberservices@COSE.org
General questions about your renewal or Benefit Plans	Your broker, or if no broker: COSE Medical Mutual Benefits Group Phone: (440) 878-5930 Toll free: (888) 310-6262 Fax: (440) 878-5946 Email: cosebenefits@medmutual.com
COBRA Eligibility and Regulations: COBRA Options – Brought to you by Medical Mutual: • Standard General Notice distribution • Annual Qualifying Event Notification • Qualifying Event Election Notification • Billing • Collection of Funding Rate	Phone: (833) 232-4680 Fax: (855) 778-9836 Email: COBRAOptionsEmployer@healthaccountservices.com
Questions about covered services or assistance with claim information, identification cards, and benefit books MedMutual.com • *MyHealthPlan* • Search for a provider • Cost compare tool	Medical Mutual Customer Care Center Phone: (216) 687-7444 or Toll-free: (800) 362-7100

TYPE OF QUESTION	CONTACT INFORMATION
• View claims and real-time deductible and coinsurance information	
Prescription Drug Benefits	For prescription drug benefits and pricing information, contact Express Scripts Phone: (800) 206-4005 MedMutual.com
Life and Disability Benefits	For information about life insurance and disability coverage, contact your Broker or Sales Representative or MedMutual Life Sales Phone: (440) 878-5930 MedMutual Life Claims Inquiries Phone: (866) 925-2542 MedMutualLife.com
VSP Vision Benefits	For information about Vision coverage, contact your Broker or Sales Representative VSP Claims Inquiries Phone: (800) 877-7195 To search for a provider: VSP.com
Dental Benefits	For information about Dental coverage, contact your Broker or Sales Representative Dental Claims Inquiries: (866) 336-8251 To search for a provider: MedMutual.com/SDCNetwork
Medical Mutual Extend Indemnity Products	For information about Indemnity coverage, contact your Broker or Sales Representative. Indemnity Claims Inquiries: (877) 271-4094 MedMutual.com/Indemnity
ID Resolution	(877) 308-9167 admin@idresolution.net
EAP (Life Only)	(877) 240-6863 healthadvocate.com

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COSE Benefit Plan

ADMINISTRATION & COMPLIANCE GUIDE

The Council of Smaller Enterprises ("COSE") is dedicated to providing comprehensive health and wellness options to its members. This Administration & Compliance Guide (the "Guide") explains information you need to know before participating in the COSE Benefit Plan. COSE Health and Wellness Trust is the technical name of this arrangement, referred to in this document and in marketing materials as the "COSE Benefit Plan". This guide also contains information to help you administer your plan and provides summary guidance on compliance with State and Federal laws that may apply. Our goal is to enable you to successfully deliver and manage the highest quality benefit programs for your employees, and to support you in that process.

This Guide is incorporated into the Application and Participation Agreement and is intended to be an integral part of the agreement between the Participating Employer and the COSE Benefit Plan, along with the Benefit Book. The COSE Benefit Plan is maintained pursuant to the COSE Benefit Plan. The Participating Employer acknowledges receipt of these documents and agrees to be bound by these documents. Except as expressly provided herein, these documents and any attachments or exhibits contain the entire agreement among the parties and supersedes any prior discussions, negotiations, representations, or agreements among them regarding this matter. No additions or other changes to this agreement will be made or be binding unless made in writing.

The Participating Employer's combined "plan document" and "summary plan description" are intended to consist of the Benefit Book, the "wrap" document, which should be customized by the employer with their specific plan details, and any policies for any fully-insured coverage purchased through Medical Mutual or other carriers and treated as part of the Employer's plan. A Summary Plan description wrap template for the "wrap" document is at www.cosebenefitplan.com. The Employer is required to provide the set of plan documents (as outlined above) to plan participants and beneficiaries upon initial enrollment, upon demand, and at certain intervals, as applicable.

Medical Mutual will assist the Participating Employer by preparing and distributing the "Benefit Books" (Plan Document and Summary Plan Description) that describe the Covered Services, benefits, eligibility requirements and other features and limitations of the plan with respect to the Covered Persons, as tailored for each Participating Employer. "Covered Services" are services, supplied by a provider or accommodation described in the Benefit Books, schedules of benefits, riders, addenda or Amendments. The Benefit Book sets forth a number of Employer requirements, in addition to what is discussed in this Guide. For example, the Employer is responsible for establishing and complying with Qualified Medical Child Support Order procedures.

The Participating Employer must comply with the terms and conditions of the Application and Participation Agreement, the Administration and Compliance Guide (Guide), and all the plan documentation.

PART I – ADMINISTRATION

ARTICLE I DEFINITIONS

1. *Benefit Book:*
   The documents that describe the Covered Services, benefits, eligibility requirements and other features and limitations of the plan with respect to the Covered Persons, as tailored for each Participating Employer

2. *Benefits:*
   Benefits mean medical and prescription drug benefits provided by the Participating Employer to Covered Persons under the COSE Benefit Plan.

3. *Claims Administrator:*
   The entity employed by Group Services, Inc., the COSE Benefit Plan Administrator, to pay claims for Covered Services under the plan for Covered Persons. The Claims Administrator is Medical Mutual.

4. *Covered Person:*
   A "Covered Person" is the Participant or the Participant's Eligible Dependent(s) or other related person (e.g., spouse or domestic partner), as defined in the Benefit Book(s) and other documentation.

5. *Covered Service(s):*
   A provider's service, supply or accommodation described in the Benefit Book – including but not limited to, any schedules of benefits, riders, addenda or amendments to the Benefit Book.

6. *Funding Rate:*
   The monthly amount (premium equivalent) due to the COSE Benefit Plan from Participating Employers required to keep coverage in force.

7. *Participant:*
   A person, employed by or retired from, a Participating Employer of the COSE Benefit Plan who is eligible for and has elected to enroll in the COSE Benefit Plan. Participant also includes Covered Persons who have lost eligibility under the plan and are continuing coverage pursuant to COBRA or state continuation.

8. *Participating Employer:*
   A self-employed individual or small employer who is a member of the Greater Cleveland Partnership (GCP) and/or the Council of Smaller Enterprises (COSE), or affiliate Chamber Partner, and who:

   - Has established a health plan for itself or its employees and their dependents; and
   - Has enrolled for coverage for its health plan through the COSE Benefit Plan

9. Trustees:

The elected Trustees of the COSE Benefit Plan which has responsibility and oversight for the operations of the COSE Benefit Plan and control of the funds related to the COSE Benefit Plan.

ARTICLE II DESCRIPTION OF ARRANGEMENT

General Description

This Guide is designed to support you in meeting responsibilities as a Participating Employer and provide guidance to help you do so. It is important that you stay up to date with the variety of compliance responsibilities for your Plan.

Medical Mutual Services, L.L.C. ("Medical Mutual") is the entity responsible for handling COSE Benefit Plan claims (the "Claims Administrator") and has certain administrative responsibilities. Medical Mutual has agreed to be the named fiduciary for the purposes of administering claims and hearing appeals of adverse benefit determinations only. Medical Mutual of Ohio provides stop loss insurance for the COSE Benefit Plan, which means that Medical Mutual of Ohio provides funding to the COSE Benefit Plan when claims for a specific Covered Person exceed a threshold, and when aggregate claims exceed a threshold.

The COSE Benefit Plan does not offer coverage to plans that are seeking to rely on "grandfathered" or "grandmothered," status for purposes of the Patient Protection and Affordable Care Act ("PPACA"), and Participating Employers should not be relying on any exceptions for such plans.

1. ERISA Obligations

The COSE Benefit Plan is a "non-plan multiple employer welfare arrangement," which means that each Participating Employer subject to the Employee Retirement Income Security Act ("ERISA") sponsors its own employee benefit plan. ERISA applies to a Participating Employer, that Participating Employer is considered the Plan Sponsor and Plan Administrator for its own plan. This means that each participating employer is responsible for complying with all duties of a Plan Sponsor and Plan Administrator under ERISA and as stated in this Guide. Group Services Inc. ("GSI"), is considered the COSE Benefit Plan's Administrator. GSI, Medical Mutual Services, L.L.C. and Medical Mutual of Ohio are not Plan Sponsors or Plan Administrators.

Participating Employer acknowledges that the parties mentioned above are providing services for which they may be compensated, and approves such compensation as reasonable.

The COSE Benefit Plan filed an initial Form M-1 with the U.S. Department of Labor to indicate the COSE Benefit Plan's status, and will file a Form M-1 annually.

2. Eligibility for Participation in the COSE Benefit Plan under Ohio Law

In general, the Ohio Department of Insurance ("ODI") requires a multiple employer welfare arrangement to maintain minimum enrollment of 300 employees of self-employed individuals, and to file various reports. ODI defines an employee as self-employed individuals and/or employees of employer groups.

An employer must be a member of the Greater Cleveland Partnership ("GCP") and/or the Council of Smaller Enterprises ("COSE") or member of an affiliate Chamber Partner that has established a health plan. Each Participating Employer must be a member in good standing with COSE or GCP either directly or through its affiliate membership program with its Chamber Partners.

3. Financial Structure of a Multiple Employer Welfare Arrangement

The COSE Benefit Plan is an "assessable plan" under Ohio law. The COSE Benefit Plan is a multiple employer welfare arrangement that is operated under a certificate of authority issued by the Ohio Department of Insurance. For purposes of ERISA, the COSE Benefit Plan is intended to be an insurance service or insurance organization qualified to do business in the State of Ohio, which issues "guaranteed benefit policies." A guaranteed benefit policy may be an asset of the Participating Employer's benefit plan, **but the assets of the COSE Benefit Plan are not assets of the Participating Employer's benefit plan. The COSE Benefit Plan is a self-insured benefit plan, licensed pursuant to Ohio law. The COSE Benefit Plan is not covered by the Ohio Life and Health Guaranty Association. This is a fully assessable benefit plan**.

Funds to support the claims costs and operating expenses of the benefits provided by the COSE Benefit Plan arrangement are held in the COSE Benefit Plan on behalf of Participating Employers. Trustees elected by Participating Employers are empowered to determine the contributions necessary from Participating Employers to provide an adequate reserve of funds, as determined by the Trustees with the advice of actuarial advisors, for payment of the benefits in the COSE Benefit Plan. The Trustees are also responsible to ensure compliance with applicable federal and state laws and regulations for the multiple employer welfare arrangement. Certain other major protections offered to Ohio residents under the Ohio Insurance Code and Rules and Regulations, such as certain mandated or required benefits, may not be available through the COSE Benefit Plan.

Ohio Revised Code Section 1739.15(A) provides that a member (Participating Employer) of a multiple employer welfare arrangement operating a group self-insurance program is liable for all legal obligations of the arrangement, including any obligations of the arrangement to pay claims against it arising out of any occurrence, incident or accident covered under Sections 1739.01 to 1739.22 of the Ohio Revised Code, in proportion to the ratio of the total number of covered employees employed by the member on the first day of the month that the obligation arose to the total number of covered employees employed by all members of the arrangement at the time the obligation arose.

This requirement applies only to the extent that the total legal obligations of the multiple employer welfare arrangement exceed the amount of any separate reserve fund that is established by the arrangement for payment of the legal obligations of the arrangement, provided the fund consists only of amounts in excess of the minimum reserves required under Ohio Revised Code Section 1739.11(A).

If the COSE Benefit Plan or Ohio Department of Insurance determines that reserves are not sufficient and that adjustment of premiums for the following year is not sufficient to resolve this issue, the COSE Benefit Plan may levy "assessments."

If a Participating Employer elects to terminate its participation in the COSE Benefit Plan and in accordance with Ohio law, the Participating Employer is liable for any liabilities or obligations of the COSE Benefit Plan through the date of the employer withdrawals from the COSE Benefit Plan. This would include any funding deficits determined by the COSE Benefit Plan. The Participating Employer's liability will be limited to the funding deficit or obligations that were incurred prior to the Participating Employer's withdrawal from the COSE Benefit Plan and is pro-rated based on the Participating Employer's plan participants in the COSE Benefit Plan at the time of the withdrawal or termination.

The COSE Benefit Plan does have a Participating Employer protection of withdraw liability provision for funding deficiency. This provision would permit a Participating Employer to withdraw from the COSE Benefit Plan without incurring any liability that would result from this withdrawal. If the COSE Benefit Plan decides to eliminate this provision it will inform all Participating Employers 60 days prior to the elimination of this provision. During these 60 days, a Participating Employer can elect to withdraw without incurring any withdrawal liability.

4. *Termination or Withdrawal Insurance*

The COSE Benefit Plan will indemnify the Participating Employer from any funding deficiency described in the Financial Structure of the COSE Benefit Plan. The Plan must provide the Participating Employer at least a sixty (60) day prior written notice if this withdrawal or termination insurance is ever cancelled and the Participating Employer will be able to terminate its participation in the Plan before the insurance is cancelled in which case the Participating Employer will not be liable for any funding deficiency.

If a Participating Employer joins the Plan with insurance in force, the Plan will provide the Participating Employer with a sixty (60) day notice of cancellation of insurance and the Participating Employer will be able to terminate their participation without being liable for their share of its funding deficiency. A Participating Employer will be deemed to have approved the change in insurance if they fail to respond to the notice and to terminate their participation in the COSE Benefit Plan during the thirty (30) day notice period.

5. *Employer Payments to the COSE Benefit Plan*

The COSE Benefit Plan will establish the monthly amounts due to the COSE Benefit Plan to keep coverage in force (the "Funding Rate"). The Funding Rate is your share of the COSE Benefit Plan's projected obligations for health benefit liabilities, administrative expenses, taxes and fees and other costs incurred by the COSE Benefit Plan. Your monthly Funding Rates support the costs of providing benefits to Covered Persons in the COSE Benefit Plan. This amount is typically adjusted upon the COSE Benefit Plan renewal, based on the claims experience of Participating Employers. The Board will provide written notice to you of any changes in the Funding Rate via the annual renewal provided by Medical Mutual on behalf of the COSE Benefit Plan. Certain other benefits (such as dental and vision) may be funded through fully-insured policies.

ARTICLE III IMPORTANT DOCUMENTS

1. Enrollment Procedure and Documents

The Participating Employer must comply with the terms and conditions of the Participation Agreement, the plan document, summary plan description, Benefit Book, and any amendments to each as may occur.

The following will be provided to you at the time of enrollment. Any document that you are bound to and is not listed here is available to you at www.cosebenefitplan.com. The Participating Employer may request a copy of any of the documents referred to in Article III from GSI, the COSE Benefit Plan Administrator, at any time.

The following are provided by either the COSE Benefit Plan, your broker or Medical Mutual representative to you, the COSE Benefit Plan Member:

a. COSE Application/Participation Agreement (Life Insurance, Basic Accident and Dismemberment and Short-Term Disability)

b. Medicare Primary Registration Documentation

c. COSE Benefit Plan Administration and Compliance Guide (this document)

d. COSE Benefit Plan Electronic Funds Transfer (EFT) Form

e. SuperMed HRA COSE Benefit Plan Product Selection Form Checklist

f. Medical Mutual Health Savings Account (HSA) Set-Up Form, HSA EFT Authorization Form, and Administrative Services Contract

g. COSE Benefit Plan Employer Group Enrollment Application and Participation Agreement

h. Employee Application/Change Form for Groups with 1-50 Employees (or self-employed)

i. Trust Agreement for the COSE Benefit Plan

2. Documents produced by Medical Mutual and the COSE Benefit Plan

The Following are provided by Medical Mutual and/or the COSE Benefit Plan to you the COSE Benefit Plan Participating Employer:

a. **Benefit Book(s)**

Medical Mutual will assist the Participating Employer by preparing and distributing "Benefit Books" that describe the Covered Services, benefits, eligibility requirements and other features and limitations of the plan with respect to the Covered Persons, as tailored for each Participating Employer. "Covered Services" are a Provider's service, supply or accommodation described in the Benefit Books, schedules of benefits, riders, addenda or

Amendments. “Benefits” means medical and prescription drug benefits provided by the Participating Employer to Covered Persons under the COSE Benefit Plan.

b. **Summary Plan Description**

COSE GSI and Medical Mutual will work together to develop a template for a wraparound document for use by Participating Employers to support their requirement to complete the combined plan document and summary plan description. The Participating Employer may seek outside services to develop a custom summary plan description. The provided resource is a template that can be used by those Participating Employers that determine it is an adequate description for use. It is the Participating Employer’s obligation to notify Participants of any changes and the effective dates thereof and provide any required Summary of Material Modifications. Any change in the nature of the services provided by Medical Mutual must be approved in writing by Medical Mutual.

c. **Summary of Material Modifications**

Medical Mutual will assist Participating Employers by providing Summaries of Material Modification, if required. Medical Mutual can also assist Participating Employers in providing appropriate notices of annual benefit changes at the time the plan renews.

To help Participating Employers understand the above, please see the following checklist of what is required and when.

Prior to the Group Electing Coverage, the following forms and information needs to be provided to the Employee

- Employee Application- This will be submitted as part of the enrollment process with Medical Mutual
- Summary of Benefits and Coverage (SBC) – This will be provided to the group official at the initial enrollment by Medical Mutual. It is the Employers responsibility to distribute the SBC to each employee.
- Notice of Special Enrollment Rights, Woman’s Health and Cancer Rights Notice, Employer CHIPRA Notice (Children’s Health Insurance Program Reauthorization Act). Samples of which are at: https://www.dol.gov/agencies/ebsa/workers-and-families

After the Group has Elected Coverage, the following needs to be provided to your employees who have selected coverage:

- HIPAA Notice of Privacy. For more information see page 32 of this guide or the website from HHS. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/
- General Notice of COBRA Rights (if applicable to company). This is provided by Medical Mutual directly to your employees as part of the Benefit Certificate.

- Plan Document and Summary Plan Description. This is provided directly to your employees by Medical Mutual as part of the Benefit Book.
- Summary Plan Description ("SPD"). This is to be completed by the employer either by using the template for the "SPD Wrap Document" available at www.cosebenefitplan.com or by using other means available to the employer.
- Notice of Patient Protection (included in SPD). This is part of the SPD Wrap Document template available on the COSE Benefit Plan website.

For New employees that join your company who are offered coverage (even if they do not elect coverage), the following should be given to them by the employer:

- Marketplace Exchange Availability Notice. For more information see the COSE website www.cosebenefitplan.com
- Employee Application. This is available via FormFire.
- Summary of Benefits and Coverage.
- Notice of Special Enrollment Rights. This is provided with the benefit book from Medical Mutual
- Woman's Health and Cancer Rights Notice. More information is at: https://www.dol.gov/general/topic/health-plans/womens.
- Employer CHIPRA Notice (Children's Health Insurance Program Reauthorization Act) (CHIPRA More information is at: http://www.ahrq.gov/policymakers/chipra/index.html

For a new hire who elects coverage, the following should be given to them by the Participating Employer:

- HIPAA Notice of Privacy. For more information see Article XIII or this website: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/
- General Notice of COBRA Rights (if applicable to the Participating Employer). This is provided by Medical Mutual directly to your employees as part of the Benefit Book. For more information see Article XIII.
- Plan Document and Summary Plan Description. This is provided by Medical Mutual. (SPD). This is part of the Wrap documented available on the COSE Benefit Plan website: cosebenefitplan.com
- Notice of Patient Protection (included in SPD). This is part of the SPD Wrap Document template available on the COSE Benefit Plan website: cosebenefitplan.com

ARTICLE IV UNDERWRITING GUIDELINES

Please read this section carefully. You must satisfy these requirements to participate in the COSE Benefit Plan. If these requirements are not met, your participation in the COSE Benefit Plan can be cancelled by the COSE Benefit Plan after 31 days' notice. Any changes to these guidelines will

be noted in your renewal notice and can be accessed at cosebenefitplan.com. You must promptly provide any documentation requested by Medical Mutual or the COSE Benefit Plan that ensures your compliance with all COSE Benefit Plan enrollment or underwriting requirements.

1. Eligible Employers

Participating Employer may participate in the COSE Benefit Plan, provided that:

a. the Employer employed an average of 50 or fewer "total employees" on business days during the preceding calendar year, and

b. the employer is a business (or other legal entity) that is actively engaged in a FULL-TIME enterprise that has the legal capacity to sponsor a group health plan on behalf of one or more employees whereby an employer and employee relationship exists, and

c. Business is headquartered in Ohio

d. A self-employed individual may establish a group plan whether or not the business has employees. Medical Mutual generally requires quarterly wage reports. If an employer is not required to file a quarterly wage report, alternate tax documentation will be required as follows:

- Sole Proprietor - Schedule C
- Partner of Partnership - Form 1065 with Schedule K-1
- Owner of C Corporation - Form 1120
- Owner of S Corporation - Form 1120S with Schedule K-1
- Church Group - Forms W-3 and W-2 or Payroll Register

2. Enrollees

Any elections the Participating Employer makes regarding eligibility for participation or benefits should be documented as a part of the Summary Plan Description Wrap Document, to the extent such provisions are not set forth in the Benefit Book.

a. Minimum Enrollment Requirements

At least 75 percent of "net eligible enrollees" must be covered under this arrangement. An individual is excluded from the computation of net eligible enrollees if he or she would have been an eligible enrollee, but waives coverage because the individual is:

i. In a spouse's employer-sponsored health plan
ii. An active eligible or retiree in another health plan sponsored by a second employer
iii. Covered under a parent's plan
iv. Covered by Medicare and/or a Medicare supplement plan
v. In a government-sponsored plan, such as TRICARE, Medicaid or Veteran's Administration (VA) coverage

vi. Enrolled in an individual plan that was purchased through a public exchange and was approved for federal subsidy

The Participating Employer may set requirements for eligible enrollees in its "SPD Wrap Document" and application, as applicable.

b. Minimum Residency Requirement

A minimum of 50 percent of the Participants must reside in Ohio.

c. Probationary (Waiting) Period

Employers must clearly state any probationary (waiting) period for new hires and rehires on the Group Application and Participation Agreement. Employers may not assign effective dates on a case-by-case basis or waive the probationary period for any specific Participant.

If an employer wants to change the probationary period, the effective date for that change must be a future effective date. The new probationary period will not apply to anyone hired prior to that effective date but will apply to all new hires hired on or after that date. Your probationary period may only be changed once per calendar year. Your probationary period may not be longer than 90 calendar days.

d. Hours Requirement

The Employer must define the number of hours per week the employee must work to be treated as an "eligible employee." The Employer may set this requirement as low as 20 hours per week, or as high as 30 hours per week. Employees working less than the minimum hours per week are not eligible.

The Employer's wrap document should address provisions regarding coverage during absence from work, such as during paid or unpaid short-term disability, including coordination with any COBRA requirements, to the extent applicable.

e. Independent Contractors

A person who provides services to an Employer, the compensation for which is reported on Form 1099, may be covered if ALL the following criteria are met:

i. The person provides at least as many hours of service to the Employer as would be required to be an eligible employee if employed by the Employer;
ii. Your contribution toward to the person's Funding Rate is equal to that for all other eligible Participants.
iii. You make coverage available to all current and future persons meeting the same criteria;
iv. A minimum of 50 percent of your enrollees are employees (receiving Form W-2).

f. Retirees

If you provide retiree coverage, please note this on the employer application. Retired employees under 65 years of age who meet all the following criteria may be considered eligible:

- Length of service with you plus his or her age must be 60 or more years;
- Continuous service of the minimum number of hours or more per week for five or more conse11cutive years prior to retirement;
- Continuous enrollment in your group health plan for five or more consecutive years prior to retirement.

g. Domestic Partners

Same and opposite sex domestic partners are eligible to enroll if the Participant and domestic partner meet ALL of the following criteria:

- Cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely;
- Are engaged in an exclusive and committed relationship and are financially interdependent;
- Are both at least 18 years of age and are each other's sole domestic partner;
- Are not married to or separated from anyone else;
- Have not had another domestic partner within six months of establishing the current domestic partnership;
- Are not related by blood; and
- Are not in this relationship solely for the purpose of obtaining coverage under the COSE Benefit Plan.

An eligible employee or retiree may enroll a domestic partner by completing a Medical Mutual form for Declaration of Domestic Partnership, to be submitted to Medical Mutual for approval. Employees are required to promptly provide an updated Declaration of Domestic Partnership form to Medical Mutual in the event of: termination of a domestic partnership, change of residence, marriage to another person, death of domestic partner, or no longer jointly responsible for each other's common welfare and living expenses. Various COSE Benefit Plan provisions (e.g., COBRA) do not apply to domestic partners. Employers are responsible for determining proper withholding and reporting regarding coverage of domestic partners.

3. Renewal Date

Your coverage will renew 12-months from the effective date of your coverage under the COSE Benefit Plan, and every 12-months thereafter. Renewal rates will be provided at least 30 days prior to your renewal date.

4. Funding Rate – Contributions by Employees

As a Participating Employer, you may pay the entire Funding Rate yourself, or require certain contributions by your employees. In order to participate in the COSE Benefit Plan, the COSE Benefit Plan requires that the Participating Employer contribute at least the lesser of:

a. Approximately 50 percent of the average single Funding Rate or

b. 50 percent of the Funding Rate for each Participant, including retiree, but excluding any Participant continuing coverage under the plan, as allowed by state or federal law (example: state continuation or COBRA).

5. Enrollment Changes

Medical Mutual reserves the right to adjust the Funding Rates for the Contract Period if the group's monthly enrollment changes, either in aggregate or for a specific line of business, by 10% or more from the average monthly enrollment used in the group's renewal rate development. Any adjustment in Funding Rates will be effective after 30 days' notice from Medical Mutual. Changes in Funding Rates will be conclusively determined to have been approved by the group if the group pays the required Funding Rate.

Generally, Employers may not offer "opt out" payments to participants who decline coverage, because such payments would be taxable, even to the participants who do not receive the payments but instead take the coverage. However, the COSE Benefit Plan allows a Participating Employer to set forth an opt-out provision in its Code Section 125 cafeteria plan, provided that the payment is the same for all similarly situated participants, and provided that the provision is communicated to all participants in the "wrap" document. The manner in which opt-out payments may be properly structured is limited, e.g., opt-outs may not be targeted at participants with high claims. Opt-out payments are taxable to the participants.

6. Nondiscrimination

There are numerous Federal and state law provisions that prohibit employers from "discriminating" against individuals or treating them differently from other individuals. The following is not an exhaustive list but is intended to provide some guidance. If you want to treat individuals differently, you will need to consult with an attorney regarding the requirements. Examples of these rules include:

- Internal Revenue Code Section 105(h) self-insured health care plan discrimination as to eligibility and benefits, with respect to "highly compensated" individuals.
- If you want to charge employees different funding rates based on health factors, such as a smoker premium, you can only do this if you first establish a "wellness program" that complies with all applicable legal requirements, including all documentation requirements.

The Participating Employer is responsible for any Section 105(h), Section 125, and other nondiscrimination testing to demonstrate compliance with the rules. You are also responsible for determining the tax treatment of any contributions and benefits under this

arrangement. If you need assistance on these issues, please consult with a benefits adviser, accountant and/or a benefits attorney.

7. *Failure to Timely Pay the Funding Rate*

If you have not paid the full Funding Rate due, the COSE Benefit Plan, in accordance with its policies, may elect to cancel your coverage. Benefits will terminate on the last day of the month in which you became ineligible, or the last day of the month in which you have paid Funding Rates to the COSE Benefit Plan, whichever comes first. When terminating group healthcare coverage, you must provide written notification to Medical Mutual at least 31 days prior to the requested termination date. Failure to provide written notice will result in termination of coverage due to lack of payment.

8. *Medicare Primary Registration (For groups with fewer than 20 employees)*

In general, if at least one Participating Employer in a multiple employer welfare arrangement has at least 20 full and/or part time employees, the group health plan is the primary payor of health care claims even for Participating Employers having fewer than 20 employees. The COSE Benefit Plan has a number of employers that exceed the twenty-employee threshold, making it the primary payor for claims.

However, there is an exception process for certain individuals entitled to Medicare on the basis of age for a Participating Employer with fewer than 20 employees (the Small Employer Exception or "SEE"). SEE allows Medicare to be the primary payer for covered persons over the age of 65 for employers with fewer than 20 employees in a multiple employer plan. This helps reduce the overall costs of the COSE Benefit Plan and the Funding Rates. The COSE Benefit Plan has developed an arrangement to help the Participating Employer file for access to SEE. During the enrollment process, the COSE Benefit Plan will provide a form that the Participating Employer may complete and submit to Medical Mutual. A Participating Employer that timely completes and returns the form with enrollment materials will initially be charged the "Medicare as Secondary" funding rate, until the form has been approved by the Centers for Medicare Services ("CMS"), at which time the Covered Person will be placed in the "Medicare as Primary" funding rate. If the Participating Employer does not complete this form as part of the enrollment process, the Participating Employer will be charged the plan primary rate. The Participating Employer can submit the form at a later date, but no retroactive credit will be applied.

In order to apply for SEE (and receive the lower Funding Rate associated with Medicare being primary) you must provide a written notice to Medical Mutual whenever a covered person is about to turn 65. Written notice must also be provided to the individual prior to turning 65. Each Participating Employer must also send to Medical Mutual any required census data or application form requested by Medical Mutual. The COSE Benefit Plan will submit a written request to CMS with all required supporting documents to elect Medicare as the primary payer. **Please be aware that when Medicare is primary, it is very important that any employee electing Medicare Part A must also purchase and elect Medicare Part B in order for the individual to receive the maximum benefit possible. Failure to purchase and enroll in Part B will cause the employee to have a much higher cost-share for Part B claims because the COSE Benefit Plan will only pay what it would have paid as a secondary plan.**

The COSE Benefit Plan will report each member's Medicare approval or denial to Medical Mutual to ensure the appropriate monthly rate is billed. Additionally, the COSE Benefit Plan will send the notification of Medicare approval or denial to the Employer directly. Approved members will be notified in writing by the COSE Benefit Plan of the date that Medicare will become the primary payer and the COSE Benefit Plan the secondary payer. This letter will notify the approved Participating Employers that if their employees desire to obtain Medicare Part B coverage, and do not currently have it, they should contact the local Social Security office. Currently there is not a fee associated with the submission to Medicare, but this is subject to change and any costs for this support will be communicated if they apply prior to applications being submitted.

A Participating Employer is responsible for determining whether it is initially qualified for SEE. The worksheet that was provided as part of the enrollment process in helping determine if you are eligible for SEE. A Participating Employer is also responsible, as the plan administrator of their own plan, for advising Medicare (and Medical Mutual and the COSE Benefit Plan) of a change in status or the need to withdraw a previously submitted SEE request or approval. Notification of status changes are required when 1) the eligible employee no longer works for the employer; 2) an eligible spouse no longer is covered by the plan; 3) the employer no longer qualifies because the number of employees goes above 20; or 4) an error was made in a filing for exception that needs to be withdrawn. These are listed on Page 5 of 5 of the SEE Package form. Failure to notify Medicare when required may result in fines and penalties in addition to Medicare seeking reimbursement for any incorrectly paid claims. The SEE Package form is at cosebenefitplan.com.

9. Medicare Secondary Payer – Disabled Beneficiary

Medicare is primary under the Medical Secondary Payer rules for those who are Medicare eligible due to disability, when enrolled in the COSE Benefit Plan. Medicare Primary Registration is not applicable.

NOTE: Medicare fraud is a federal offense. Additional information on Medicare as a secondary payer is at this website: Medicare.gov.

ARTICLE V ENROLLMENT AND CHANGING / TERMINATING COVERAGE

1. Adding New Hires and their Dependents

New hires and employees adding dependents as a result of a qualifying event (e.g., marriage, birth, adoption, etc.) should complete the Employee Application/Change Form or go to the Manage Employees tab on EmployerLink. (See Resources for additional information on EmployerLink).

The effective date for a new hire is determined by considering the employee's date of hire and the group's probationary period. For example, if the employee's date of hire is June 15 and the group probationary period is 60 days, then the first date of coverage would be August 14. The date of hire is required on all applications for new hires, including late entrants. Applications for newly eligible individuals that are not received within 31 days of their eligibility date are considered late entrants. The maximum probationary period is 90 days from date of hire, set at time of group enrollment for new hires.

Other than an event that qualifies for special enrollment, late entrants must wait until the Participating Employer's next open enrollment date to apply for coverage. The Benefit Book contains more information on special enrollment.

If there is a concern that an application may not be received on time through standard mail, applications and other documents may be faxed to Medical Mutual' s Membership and Billing Department at (419) 473-7285, or they can be emailed to MemApps@MedMutual.com. The application should be clearly marked with the group number and section or plan election to ensure timely delivery and processing. Please do not mail the originals if the forms have been faxed or emailed.

2. *Rehires*

a. Rehired employees must reapply for coverage, even if they have active coverage due to Consolidated Omnibus Budget Reconciliation Act continuation law (COBRA). Failure to reapply may cause the COBRA qualified beneficiary to have a lapse in coverage or to make additional COBRA payments.

b. The rehired or recalled employee's application must be received within 31 days from the date of rehire, or within 31 days from the coverage effective date. The maximum probationary period is 90 days from date of hire, set at time of group enrollment for new hires and rehires. Your probationary period may be changed once per year upon written request.

If the rehire probationary period is different from their new hire probationary period:

a. The rehire probationary period applies to those who are rehired within one year of terminating their employment.

b. If the employee is rehired after one year from leaving the company, the new hire probationary period applies.

3. *Changing Covered Person's Coverage / Mid-Year Changes in Coverage*

The COSE Benefit Plan only allows mid-year changes in coverage to be made in accordance with new hires, rehires, "special enrollment rights," (see Benefit Book), coverage termination provisions (see Benefit Book), and to the extent the changes would be permitted under the Code Section 125 cafeteria plan rules. These provisions should be set forth in the Employer's Code Section 125 cafeteria plan (premium conversion plan). Other changes may be made during the Participating Employer's next open enrollment period.

You are responsible for notifying Medical Mutual of a Covered Person's change in eligibility under the Plan in a prompt and timely manner, but no later than thirty (31) days following the change in eligibility. Failure to do so will cause you, as a Participating Employer, to be responsible for funding claims incurred by Covered Persons and paid by the Claims Administrator prior to receipt from you of the termination of the Covered Person's enrollment in the Plan. Changing coverage can be made via Employerlink or by submitting an employee application/change form to Medical Mutual's Membership department MemApps@MedMutual.com.

You are responsible for timely notifying Medical Mutual when a Participant terminates employment, or when a Covered Person's coverage should otherwise terminate for whatever reason. Terminations of coverage can only occur to the extent permitted by law and plan provisions.

Notify Medical Mutual right away when you need to terminate a Covered Person's coverage under the COSE Benefit Plan. Coverage terminations will only be allowed as permitted by applicable law. Be specific as to the Covered Person whose coverage is being terminated. If a termination request is received more than 31 days after the termination date, the Covered Person's coverage will not be terminated until the end of the month in which the termination is received, and you will be responsible for any applicable Funding Rates.

If claims were incurred and paid after coverage should have ended, regardless of when the termination request was received, you will remain responsible for Funding Rates for the month in which claims were incurred.

Coverage terminations can be submitted using one of the following:

- Complete an application/change form and send to Medical Mutual Membership and Billing: MemApps@MedMutual.com
- Submit through EmployerLink
- Write the change on the billing invoice and send to Medical Mutual Membership MemApps@MedMutual.com
- Fax: (419) 473-7285

Coverage ends on the earliest of the following dates:

- The date the plan is terminated
- The date on which employment is terminated for any reason, including disability, death, retirement, lay-off, leave of absence or termination of employment
- The date the Covered Person no longer meets eligibility requirements

PPACA provides that a group's health plan or a health insurance issuer offering group or individual insurance coverage may not rescind coverage of an enrolled individual unless the individual (or a person seeking coverage on behalf of the individual) commits fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan coverage. A rescission is any retroactive cancellation or discontinuance of coverage; except for a cancellation or discontinuance that is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage. If coverage is rescinded, at least 30 days' written notice must be provided.

4. Changes to Your Plan and the COSE Benefit Plan

It is the Participating Employer's obligation to timely notify Participants of any changes in the plan, including any provisions that affect eligibility, and the effective dates thereof.

Medical Mutual will update the Benefit Book when changes are made in the annual renewal process (e.g., in preparation for the annual enrollment process).

If you are making changes to enrollment or the benefits of the plan, contact your broker or Medical Mutual representative as applicable. Please be aware that group-level changes may not be made on the invoice.

ARTICLE VI HOW TO PAY FOR COVERAGE

While you may require your employees to contribute toward the cost of coverage, the Participating Employer is solely responsible for the payment of the Funding Rate due to the COSE Benefit Plan, and any other charges or expenses assessed under the terms of the COSE Benefit Plan.

You may authorize the COSE Benefit Plan to initiate debit entries to your group's checking or savings account by completing the Electronic Funds Transfer (EFT) Form. Each month the amount of the COSE Benefit Plan invoice will be debited from your account (recommended). Or you may pay electronically through Medical Mutual's on-line enrollment administration tool Employerlink.

If you have elected the EFT deduction and wish to view your monthly invoice, you must log on to Employerlink. You should receive a billing statement for the Funding Rate for a month and all other amounts due approximately 15 days prior to the first day of the month.

1. Please pay as billed. If you arrange for your Funding Rates and all other amounts due to be automatically deducted from your bank account (via direct debit), no billing fee applies. The amount billed, will be deducted from your account on the first business day of every month. If you wish to pay by check, your payment must be received by Medical Mutual on or before the first day of the billing month in the full amount as billed, and you will be charged a monthly billing fee of $25.

2. If a Participant's coverage is being canceled, the cancellation should be entered through EmployerLink, or by sending an email with the health ID#, member name, group# and effective date of the requested cancellation to MemApps@medmutual.com. This information is required to properly balance your account and issue the appropriate credit. (Please note that change in the age of a Covered Person in an age-rated group may affect the Funding Rate due.)

3. You have until the end of a 31-day grace period to make payment in full (less any deduction for participant cancellations discussed above). If payment is not received, or if monies are not available for debit from your bank account, your group coverage may be terminated retroactively back to the first of the month for which payment was due. Medical Mutual will pursue late payments from you as follows:

   If, after the 31-day grace period has expired, you are actively working out a payment plan with Medical Mutual to make payment, your Covered Persons' coverage will be placed on hold or in terminated status until payment is received. A late fee of $39 may be assessed. Coverage may only be reinstated once payment in full is received.

a) If, after the 31-day grace period has expired, you are not working with Medical Mutual to make payment, coverage for you and your Participants will be terminated retroactively back to the first of the month for which payment was due, or, if claims have been paid during the grace period, coverage will be terminated at the end of the month for which claims have been paid. Medical Mutual's collection firm will be notified of your payment delinquency for recoupment of payment due.

b) If coverage has been terminated due to nonpayment of the Funding Rate, you will need to wait one year to apply for reinstatement, unless you agree to pay a one-month funding rate retainer and agree to a direct debit payment for future payments.

c) Medical Mutual is not responsible for hospital and provider discounts (if any), loss of reinsurance coverage or reimbursements, or delays in claims processing that result from your untimely payment of the Funding Rate.

d) In the event you do not pay the full Funding Rate when due, the COSE Benefit Plan may terminate your participation in the COSE Benefit Plan. If medical and prescription benefits are both offered, your failure to pay any portion of the Funding Rate charged, in accordance with the COSE Benefit Plan's billing and collections guidelines will result in the termination of both medical and prescription coverage as of the last date for which the Funding Rate was paid.

ARTICLE VII WITHDRAWAL FROM THE COSE BENEFIT PLAN

You may terminate your participation in the COSE Benefit Plan and coverage voluntarily, or you may be terminated involuntarily. If your coverage under the COSE Benefit Plan is cancelled or terminated or the COSE Benefit Plan itself ends, Medical Mutual will terminate eligibility of Covered Persons from its system and all identification cards will be deactivated. **You are responsible for providing timely written notice to Covered Persons regarding the change or termination of their coverage**.

Ohio Revised Code Section 1739.07 provides that a voluntarily or involuntarily terminating member remains liable for all obligations of the arrangement incurred during its membership in proportion to the ratio of the total number of covered employees employed by the member at the time of termination to the total number of covered employees employed by all members of the arrangement at the time of termination. (See Article II regarding liability.)

1. Voluntary Termination

a. **Upon Renewal**

You may elect to withdraw from participation in the COSE Benefit Plan at the time of your annual renewal, by providing Medical Mutual written notice at least 31 days prior to your renewal date. If you do not provide 31 days' written notice, you will still be responsible for the following month's premium. If your Covered Employees total 5% or more of the total COSE Benefit Plan Covered Employees, your termination is not effective until approved by the Board that you are member in good standing, that all the requirements of Ohio Revised Code Sections 1739.01 to 1739.22 have been met.

b. **Outside Renewal**

Outside of your annual renewal, you may also elect to withdraw from participation in the COSE Benefit Plan only as of the end of a calendar month by giving written notice to Medical Mutual at least 60 days prior to the end of such month. Such withdrawal and termination will be effective at the end of the said month upon ratification and approval by the Claims Administrator. The COSE Benefit Plan will approve the withdrawal if it determines you are in good standing under the COSE Benefit Plan, and that both you and the COSE Benefit Plan have met all requirements of applicable Ohio Revised Code. If written notice is not provided 60 days in advance, you will be responsible for the Funding Rates that would be due as if proper notice had been provided, (i.e., for the 60-day period).

2. Involuntary Termination

The COSE Benefit Plan may terminate your participation in the COSE Benefit Plan upon a determination that you have:

- Failed to comply with State or Federal law or regulations governing the COSE Benefit Plan or your plan and failed to take timely action to correct;
- Failed to comply with benefit plan provisions, the COSE Benefit Plan, or other documents under which the COSE Benefit Plan is operated;
- Failed to pay, in a timely manner, any Funding Rates or installments thereof due; or
- Failed to discharge your obligations to the COSE Benefit Plan when due.

Benefits will terminate on the last day of the month in which you became ineligible, or the last day of the month in which you have paid Funding Rates to the COSE Benefit Plan, whichever comes first. Other than termination for failure to timely pay, an involuntary termination will be effective at a time stated in a written notice from the COSE Benefit Plan or Medical Mutual to you, which time will not be less than 15 days after the date of the notice, or any longer period required by applicable law or regulations. You are responsible for providing any notice regarding a Participant's right to other coverage. Medical Mutual will not provide benefits coverage for services rendered after the effective date of termination, except as otherwise provided by the COSE Benefit Plan or required by law.

ARTICLE VIII ADDITIONAL ARRANGEMENTS

You may elect to provide additional arrangements to your employees, either through Medical Mutual, or through other vendors. These arrangements, except for fully-insured options provided through Medical Mutual, will be treated as separate from your health care plan.

To add any of the optional features described below or to receive the necessary forms, please contact your broker, your Medical Mutual sales representative, or go to www.cosebenefitplan.com.

1. *Premium Conversion Plan*
   Internal Revenue Code Section 125 allows employees to make their contributions toward the cost of coverage on a pre-tax basis, but only after the employer establishes a premium conversion plan (also called a cafeteria plan or 125 plan). The employer must comply with the Code provisions and plan provisions. For example, coverage for domestic partners cannot be paid for on a pre-tax basis, and the cost of coverage paid for by the employer for a domestic partner is taxable to the employee. Further, participants may not make election changes during the plan year unless the change is due to an event set forth in the premium conversion plan. You, the Employer, are responsible for adopting a premium conversion plan if payments are made on a pre-tax basis or if you want to provide opt-payment, for ensuring that any mid-year election changes are in accordance with Code provisions and plan terms, and for any tax withholding and reporting.

2. *Flexible Spending Accounts*
   A cafeteria plan may also provide for flexible spending accounts ("FSAs"). An FSA is a pre-tax account an employee funds and uses to pay for out-of-pocket healthcare costs. The employee's pre-tax contribution to the FSA lowers the employer's FICA tax liability and may help save on other taxes. Depending on the FSA, employees can be reimbursed for expenses related to healthcare, vision and dental expenses; work-related transportation; and dependent daycare. Medical Mutual offers several FSA options to meet the needs of your employees:

   - Health care FSA: For expenses related to certain out-of-pocket healthcare costs, including deductibles, copays, prescription medications and medical equipment
   - Limited purpose FSA: For dental and vision expenses only, and can be paired with
   - an HSA
   - Dependent care FSA: To pay for the care of dependent children under age 13 or dependent adults who cannot care for themselves
   - Commuter benefit accounts: For parking or public transportation expenses related to commuting to and from work

3. *Health Savings Account*
   If you sponsor a high-deductible health care plan, you may be eligible to offer a health savings account ("HSA"). An HSA is a savings account your employees can use to pay for certain medical costs. The many benefits of having an HSA include tax deductible contributions, the funds grow tax-free and there are no taxes on withdrawals when paying for qualified medical expenses. An employee's HSA balance can be carried over year after year and the funds may be eligible to invest, similar to a 401(k) or IRA. After turning 65, funds can be withdrawn for any reason without penalty. You may choose your own administrator for the HSA. One of your choices is the Medical Mutual HSA, which gives your group members multiple tax benefits and a single location to access insurance and account information.

4. *Health Reimbursement Account*
A Health Reimbursement Account ("HRA") is an employer-funded payment plan that offers comprehensive and flexible cost coverage. Medical Mutual offers the SuperMed Health Reimbursement Account. If you are setting up an HRA, you must first complete the two required contract amendments, Product Selection Sheet and the HIPAA Privacy Certification form.

5. *Fully-insured Coverage Options*
Medical Mutual offers fully-insured vision, dental, and life & accidental death and dismemberment ("AD&D") options for small businesses. These options will be treated as part of your COSE Benefit Plan, but billing enrollment and ID cards will be separate from your coverage with the COSE Benefit Plan. For more information, please contact your sales representative or broker. Insurance obtained elsewhere will not be treated as part of your COSE Benefit Plan.

To add any of the above optional features or to receive the necessary forms, please contact your broker, Medical Mutual sales representative, or go to cosebenefitplan.com.

ARTICLE IX GENERAL PROVISIONS

1. *Applicable Law, Venue and Jurisdiction, and Limitation of Action*
To the extent not preempted by ERISA, the Code, or any other laws of the United States, this Agreement and all related documents are governed by, and construed in accordance with, the laws of the State of Ohio, without regard to the conflict of law provisions thereof to the extent such principles or rules would require or permit the application of the laws of any jurisdiction other than those of the State of Ohio. The parties agree that exclusive venue for any litigation arising under this Agreement lies with the Courts of Cuyahoga County, Ohio and further, agree to submit jointly and individually to the personal jurisdiction of such courts. Parties may not file suit involving a dispute arising under his Agreement more than three calendar years from the date the cause of action arises.

2. *Severability*
If any term or provision of this Agreement and related documents is invalid, illegal or unenforceable, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision. Upon a determination that any term or provision is invalid, illegal or unenforceable, the parties shall negotiate in good faith to modify this Agreement to affect the original intent of the parties as closely as possible in order that the transactions contemplated hereby be consummated as originally contemplated to the greatest extent possible.

3. *Assignment, No Third-Party Benefit and Non-Alienation*
This Agreement will not be assigned by either party without the prior written consent of the other party. This Agreement is made solely for the benefit of the parties hereto, their respective successors, heirs, personal and legal representatives, and permitted assigns; and no other person will acquire or have any right by virtue of this Agreement. None of the benefits, payments, proceeds or claims of any Participating Employer or Covered Person

will be subject to any claim, attachment, or garnishment of any creditor, nor will any Participating Employer or Covered Person have any right to alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or payments that are expected to be received under the COSE Benefit Plan, and any attempt to accomplish the same will be void.

4. Gender, Number and Headings

Whenever in this Agreement the masculine gender is used, it will be deemed to include the feminine and neuter genders as well, and singular usage will include plural usage, and vice versa, as the context will require. Headings and numbers in this Administration and Compliance Guide and related documents are included for convenience of reference only. If there is any conflict between any of the numbers and headings and the text of this Agreement, the text will control.

5. Liability

Participating Employer acknowledges that Greater Cleveland Partnership and COSE offer the COSE Benefit Plan for the benefit of the Participating Employers and has no obligation or liability to provide or fund benefits.

Participating Employer acknowledges that the terms and conditions of the COSE Benefit Plan may change from time to time. Any such change shall be subject to notice provisions. Accordingly, Participating Employer agrees that it will make no claim against Greater Cleveland Partnership or COSE or other members of Greater Cleveland Partnership or COSE, their directors, officers, employees and agents, from any and all liability, loss, damage, claims, penalties, excise taxes or assessments, and all costs, such as legal fees, associated with PPACA, HIPAA, and any other applicable law and regulations or other guidance under such laws, which may arise with respect to the Participating Employer's health care plan, or participation in the COSE Benefit Plan.

6. Notice and Waiver

Any notice required under this Agreement must be in writing. Notice must be hand-delivered or mailed by first class mail with proper postage, to the respective party's address. Notice shall be deemed effectively received on the date of delivery or three (3) days after the date of post mark, whichever is earlier. Any party to this Agreement may, by written notice, indicate a new notice address. Current addresses are as follows:

Group Services, Inc.
Attn: Vice President, Membership Development & Service
1240 Huron Road East, Suite 200
Cleveland, OH 44115
Phone (216) 592-2436

Notices to Participating Employers are to be provided to the address indicated in the Application, unless written notice of a new address has been provided. No waiver of satisfaction of a condition or nonperformance of an obligation under this agreement will be effective unless it is in writing and signed by the party granting the waiver.

ARTICLE X ADDITIONAL ONLINE RESOURCES

1. *EmployerLink*
   Medical Mutual offers Participating Employer groups access to its enrollment administration tool, EmployerLink. On EmployerLink, users can order ID cards, pay monthly invoices, view benefit books and change personal and dependent information online. And the best part? EmployerLink is completely free. To register, visit MedMutual.com and go to the Employers tab. For EmployerLink technical support, email employerlink@MedMutual.com or call (800) 218-2205.

2. *MedMutual.com*
   Medical Mutual's website, MedMutual.com, was developed to help bring members the information they need when they need it. Our goal is to provide as many features as possible to members via the Internet.

   Some of the available features include using the Provider Locator function to easily search for providers by location, specialty or hospital affiliation. This feature also identifies providers who are board certified and accepting new patients. Healthy living information is also available online, including Medical Mutual's wellness and disease prevention programs and links to other sites.

3. *My Health Plan*
   From MedMutual.com registered participants can log in to MyHealthPlan, Medical Mutual's secure member website. On MyHealthPlan, members can view their benefits and claims information, update personal information, request a new ID card or benefit booklet, email a Medical Mutual Customer Care Specialist, change or choose a primary care provider (PCP), locate a network hospital or physician's office and much more. With ***Medical Mutual's cost estimator tool*** members can get cost estimates for services, compare costs at different locations, view quality ratings of doctors and hospitals and watch videos that describe what you can expect with various treatments.

   All of these functions are available 24 hours a day, seven days a week. Participant with an in-force policy, along with any of their adult dependents who are 18 years old and up, are permitted to register. To protect the privacy of our participant, potential users of MyHealthPlan must register for the service and specify a password.

   This COSE Benefit Plan Compliance Guide may be amended from time to time. For the most current version, please go to cosebenefitplan.com.

4. *U.S. Department of Labor*
   The U.S. Department of Labor has provided a Reporting and Disclosure Guide for Employee Benefit Plans for plans subject to ERISA and has provided a guide for Cybersecurity Program Best Practices. Additional information is at the Employee Benefits Security Administration website.

The following Part II has been put together to help COSE Benefit Plan members in understanding their compliance obligations. This section is not intended to be exhaustive but is intended to provide merely a summary of compliance obligations, as of the time of

publication, to raise awareness of potential obligations. We understand that each member's situation is unique and if there are questions, we strongly suggest that you contact your accountant, attorney or your benefit consultant for help and guidance.

PART II -ADDITIONAL COMPLIANCE INFORMATION

Participating Employers are potentially subject to various state laws (e.g., Chapter 1739 of the Ohio Revised Code) and federal laws, including, but not limited to, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Internal Revenue Code of 1986, as amended ("Code"), the Patient Protection and Affordable Care Act ("PPACA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and each of their associated regulations. Each Participating Employer is responsible for complying with the duties under such laws, regulations and guidance.

ARTICLE XI STATUTES THAT REQUIRE IDENTIFYING THE EMPLOYER AND EMPLOYEES

1. *Identifying the Employer: Controlled Groups and Affiliated Service Groups*

Various federal and state health care laws distinguish between "small" and "large" employers. Unfortunately, those definitions, and the ways employees are counted, vary considerably. Virtually all of the rules require first considering whether any legal entities must be combined to be treated as a "single employer" for counting purposes.

If any member of the COSE Benefit Plan believes it may be part of a controlled group or affiliated service group, it is critical that this determination is made at the outset. When counting employees, the employer will generally be required to count all of the controlled group and affiliated service group companies' employees. In addition, the status as a COSE Benefit Plan may change the rules (e.g., count all employees in the COSE Benefit Plan, not just employees of the employer). The following summary is intended to provide Employers with some guidance on how these rules may apply. However, it is strongly recommended that COSE Benefit Plan members seek the advice of their own accountants, benefit consultants or ERISA attorneys for more information.

Code Sections 414(b) and (c), and Section 1563, set forth the controlled group rules. The analysis is similar to the analysis done for consolidated tax return purposes but differs in some ways. For example, foreign companies are taken into consideration. So, if a German company owns 100% of Company A and Company B, whose operations are completely separate, they nonetheless form a controlled group. A controlled group may exist where entities have one of the following relationships:

- Parent-subsidiary,
- Brother-sister, and
- Combination parent-subsidiary and brother-sister.

Entities include corporation, partnership, sole proprietorship, trust, and estates. Attribution rules may apply to attribute ownership or voting control to related parties (e.g., husband to wife).

In a corporation, ownership interests include the combined voting power of all classes of outstanding stock, and the total value of all shares of all classes of outstanding stock. If more than one class of stock is held by an organization, the higher percentage of ownership interest is used for controlled group purposes. "Stock" does not include Treasury stock or nonvoting preferred stock.

The affiliated service group rules set forth in Code Section 414(m) apply to certain other organizations based on their structure and operation.

An IRS summary of the controlled group and affiliated service group rules is at https://www.irs.gov/pub/irs-tege/epchd704.pdf.

2. *Misclassified Employees*

The IRS, Department of Labor and many states are collaborating to target perceived misclassification of employees as independent contractors in a variety of ways, such as employers mislabeling employees as independent contractors (with Forms 1099 rather than Forms W-2) to reduce payroll and benefits costs. They are reviewing the use of subcontractors, temporary agencies, labor brokers, franchising, licensing, and third-party management. A finding of misclassification can pose significant issues for an Employer, so Employers relying on these types of arrangements should seek counsel as needed.

3. *Leased Employees / Staffing Agencies*

Employers that rely on leased employees or staffing agencies need to be familiar with rules that apply in various contexts. Essentially, the workers may be treated as employees of the Employer, either while providing services or for purposes of providing prior service credit, for various benefits purposes.

4. *Counting Employees*

When a private sector Employer is determining whether it is exempt from a particular legal requirement applicable to health care plans, it needs to start by considering the controlled group and affiliated service group rules. The explanations set forth below simply provide a summary. Employers should review the statute or regulatory guidance and seek counsel, as necessary.

a. **PPACA shared responsibility provisions and employer information reporting of minimum essential coverage**

An employer with **50 or more** employees is an "applicable large employer" for purposes of PPACA. These rules treat employees who work an average of 30 hours per week as "full-time," and require employers to add up hours of employees who work fewer hours to count "full-time equivalents." Employers who think they have many fewer than 50 "full-time" employees can be surprised to learn they have 50 or more under this counting method. The IRS summarizes the rule here, with links to the applicable Treasury Regulations on their website. https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer

There are different methods for counting employees for pay-or-play penalty purposes. This Guide presumes that Participating Employers are not applicable large employers and does not discuss the responsibilities of applicable large employers.

b. **Ohio small employer health plan**

Under the Ohio small employer health plan law, "small employer" means, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Eligible employee" means an employee who works a normal work week of 20-30 or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances. Coverage must be offered to all Eligible employees. After initial group enrollment, the employer may impose a waiting period of up to 90 days. The COSE Benefit Plan health benefit design presumes that the Ohio small employer health benefit plan requirements apply.

http://codes.ohio.gov/orc/3924

c. **"Eligible Employee" for COSE Benefit Plan purposes**

Article IV of this guide addresses employee eligibility for COSE Benefit Plan purposes. Whether and when an individual is an Eligible Employee for COSE Benefit Plan purposes are separate questions from whether an applicable large employer may be subject to penalties with respect to a particular employee. An Employer that is an applicable large employer needs to consider these issues in adopting a plan.

d. **ERISA**

A health care plan that covers 1 employee is covered by ERISA, absent an exception (e.g., church plans and governmental plans). A plan that covers only owners is not a "group health care plan" for ERISA purposes and is not an ERISA plan.

https://www.dol.gov/agencies/ebsa

https://www.law.cornell.edu/uscode/text/29/1002

e. **Consolidated Omnibus Budget Reconciliation Act (COBRA) or State health care continuation**

Employers with 20 or more employees may be subject to federal COBRA requirements. COBRA generally applies to all private-sector group health plans

maintained by employers that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time. An employer may use its own definition of full-time based on its employment practices, provided that the definition does not exceed eight hours per day or 40 hours per week.

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf

and

https://www.law.cornell.edu/cfr/text/26/54.4980B-2

Smaller employers may be subject to state health care continuation requirements.

Ohio: http://codes.ohio.gov/orc/3923.38

f. **Americans with Disability Act (ADA)**

The ADA applies to an employer that has **15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.**

https://www.law.cornell.edu/uscode/text/42/12111

g. **Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act (PDA)**

Title VII, as amended by the PDA, generally applies to employers with 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

https://www.law.cornell.edu/uscode/text/42/2000e

h. **Age Discrimination in Employment Act (ADEA)**

The ADEA generally applies to all governmental employers and to all private employers with 20 or more employees for each working day in at least 20 calendar weeks in the current or preceding calendar year.

https://www.law.cornell.edu/uscode/text/29/630

i. **HIPAA**

Some HIPAA provisions do not apply to group health care plans covering fewer than two current employees.

https://www.law.cornell.edu/cfr/text/26/54.9831-1

j. **Genetic Information Nondisclosure Act (GINA) 20**

An ERISA group health care plan (e.g., covers one employee) is subject to GINA.

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/gina.pdf

k. **Medicare Secondary Payer (MSP) rules based on age**

The MSP set forth an exception for employers with less than 20 employees, but because this is a multiple employer welfare plan, special rules apply. See Article IV, Section 7 "Medicare Primary Registration" of this guide for more information about the Medicare Secondary Payer Exception Process for COSE Benefit Plan participants with less than 20 employees.

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

l. **Family and Medical Leave Act (FMLA)**

FMLA generally applies to public agencies, including State, local and Federal employers, and local education agencies (schools); and, private sector employers who employ **50 or more employees for at least 20 workweeks in the current or preceding calendar year** - including joint employers and successors of covered employers.

https://www.dol.gov/whd/fmla/finalrule/nonmilitaryfaqs.pdf

m. **Mental Health Parity and Addiction Equity Act (MHPAEA)**

The MHPAEA applies to non-Federal governmental plans with more than 50 employees, and to group health plans of private employers with **more than 50** employees.

https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html

There are some additional counting rules that apply to larger employers, including Medicare Secondary Payer based on disability (100), Form 5500 exception for certain welfare plans with fewer than 100 participants, and PPACA Form W-2 reporting (250 employees). There are also rules for counting participants for fee purposes, such as the

Transitional Reinsurance Program Fee and Patient-Centered Outcomes Research Institute fee.

ARTICLE XII HIPAA AND HEALTHCARE CONTINUATION COVERAGE

1. Health Insurance Portability and Accountability Act ("HIPAA")

HIPAA requires that "Covered Entities" (including group health plans) protect individuals' Protected Health Information ("PHI") by complying with the Privacy and Security Rules. Pursuant to the HIPAA rules, each respective member of the COSE Benefit Plan, as a sponsor of the self-funded group health plan, will be responsible for complying with the Privacy and Security rules on behalf of the Plan. A Summary of the HIPAA Privacy and Security requirements, as well as options for compliance, are listed below. As an employer, you are responsible to Comply with HIPAA.

a. **HIPAA Notice of Privacy Practices**

i. Notice must include specific information per the HIPAA regulations about the uses and disclosures of PHI that may be made by the Plan, the rights of individuals regarding HIPAA Privacy, the Plan's legal duties with respect to protected health information (PHI), certain contact information, etc.
ii. Generally, this notice must be posted on the employer's website or intranet (if such site displays benefits information), if applicable, and must also be individually delivered in accordance with the timing rules set forth in HIPAA.

b. **HIPAA Privacy Policies and Procedures**

i. HIPAA requires that all Covered Entities maintain HIPAA Privacy Policies and Procedures. These Policies must include all of the required elements from the HIPAA Privacy regulations.
ii. HIPAA Privacy Policies and Procedures contents, generally:

1. Information on the Responsibility of the Plan as Covered Entity
2. Details on the Plan's Policies and Procedures on certain uses and disclosures of PHI
3. Details on the Plan's Policies and Procedures for complying with individual rights
4. Forms/Agreements that Accompany the Policies and Procedures to be completed or used by Workforce members

c. **Other Privacy Documents**

i. HIPAA "Plan Amendment"
ii. HIPAA "Plan Certification"

d. **HIPAA Training** of all staff designated to access PHI (and certification that such training was performed) on the Plan's Policies and Procedures

e. **Updated Business Associate Agreements** with all BAs of the Plan

f. **HIPAA Security** – must follow the HIPAA rules and have the following:

i. Security Policies and Procedures and Implementation "guide"
ii. Risk Analysis (risks to integrity, confidentiality, and availability)
iii. Designation/Job Description of Security Official
iv. Emergency Mode Operation Plan
v. Disaster Recovery Plan
vi. Device and Media Controls Policy
vii. Data Back-up Plan

2. COBRA

Generally, an employer is responsible for providing coverage if it maintains a group health care plan and has 20 or more employees (on at least 50% of its working days during the preceding calendar year). Certain entities may be required to be combined together to identify the "employer", and the law and regulations set forth methods for determining number of employees. If an employer is subject to COBRA, it is the employer's responsibility to inform Covered Persons of their COBRA-mandated rights, and to comply with all COBRA requirements. COBRA Options – Brought to you by Medical Mutual provides employers with certain COBRA administrative services. Each Participating Employer may arrange for such services by contacting Medical Mutual. (See Contact Information and Resources.) Please note: the employer is responsible for notifying all continuants of any plan changes made at the time of renewal or at other times of the year, and for updating COBRA rates upon renewal. More information is at www.dol.gov. Information on how to count is at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf

3. Ohio State Continuation

The Ohio state continuation law applies to small group policies, where the employer is not subject to COBRA (fewer than 20 employees). The law provides for 12 months of continuation of group hospital, surgical and medical coverage.

Terminated employees are eligible if they: a) have been continuously covered under group coverage for the entire three-month period preceding termination of employment; b) have not terminated employment voluntarily or have not been terminated as a result of gross misconduct; d) were not or have not become covered or eligible for Medicare; and d) were not or have not become eligible for other coverage that provides hospital, surgical or medical coverage.

The Ohio law is set forth at: http://codes.ohio.gov/orc/3923.38.

ARTICLE XIII REPORTING, NOTICE AND DISCLOSURE REQUIREMENTS

1. Reporting

IRS Reporting of Minimum Essential Coverage

PPACA requires employers that provide health care coverage to report coverage. Employers that are not "applicable large employers" are required to report health care coverage on Forms 1094-B (to employees) and 1095-B (to the IRS with Forms 1094-B). Failure to file could result in IRS penalties for the Participating Employer and/or its Participants.

Medical Mutual, as the Claims Administrator, will provide each employee a Form 1095-B each year, as well as submit Form 1094-B information to the IRS. This information will provide monthly coverage detail. Each Participant should verify the Form 1094-B and promptly notify Medical Mutual of any discrepancies, at the toll-free number that will be provided by Medical Mutual.

Medical Mutual members may download their 1095-B tax forms directly from My Health Plan, our secure member portal. Hard copies will only be mailed to members who call our Customer Care team to request one.

IRS Reporting by Applicable Large Employers

An employer that is an "applicable large employer" is required to report using Forms 1095-C and 1094-C, rather than Forms 1095-B and 1094-B. If you have determined that you are an "applicable large employer," please notify Medical Mutual so that it does not provide Forms 1095-B and 1094-B.

An applicable large employer will be required to report whether it offered "affordable" coverage. Medical Mutual will provide the employer with enrollment data necessary to complete the coverage portion of the form; however, the Participating Employer is responsible for performing affordability testing. Participating Employers who are applicable large employers will need to work with their financial or tax advisors to complete the Forms 1094-C and 1095-C

More explanation of these requirements is at www.IRS.gov.

Form 5500

An annual Form 5500 is required for an ERISA plan participating in a non-plan multiple employer welfare arrangement, absent an exemption. An Employer that is subject to Form 5500 reporting requirement is also required to provide a "summary annual report" to Participants. An Employer that is relying on an exemption, such as 29 CFR 2520.104-20(b) is responsible for any compliance requirements, *e.g.*, notifying new participants about any provisions regarding allocation of refunds, and timely forwarding contributions. Employers should also forward employee contributions as soon as they can reasonably be

segregated from employer assets to prevent an argument that amounts are plan assets required to be held in trust.

2. Notices and Disclosures

The Participating Employer (in its capacity as plan sponsor or plan administrator) is responsible for providing notices to Plan Participants required by ERISA and any other applicable state or federal law. Please establish procedures for ensuring compliance with the requirements. The table set forth below will help Participating Employers determine who is responsible and how notices will be distributed. A summary of requirements (excluding HIPAA and COBRA), and steps Medical Mutual and the COSE Benefit Plan are taking to help you comply, follows. Three disclosure requirements, in particular, are brought to your attention below.

a. **Summary of Benefits and Coverage**

The Summary of Benefits and Coverage (SBC) will be produced by Medical Mutual and distributed to the Participating Employer at the time of initial group enrollment and will be available electronically through cosebenefitplan.com. Participating Employers must agree to access the appropriate SBC online and to distribute the SBC to its employees and their dependents in accordance with the SBC requirements of the Patient Protection and Affordable Care Act (PPACA), as follows:

- Upon eligibility for enrollment or enrollment in the COSE Benefit Plan
- By the first day of the plan's open enrollment period
- If there is no open enrollment period, at least 30 days prior to the next plan or policy year
- By the first day coverage starts, if the SBC changed from the version provided during open enrollment
- After a request for special enrollment, as defined by the Health Insurance Portability and Accountability Act (HIPAA)
- If there is a mid-year change to the plan that affects the information in the SBC
- Upon request

b. **Summary of Material Modification**

It is the Participating Employer's obligation to notify Participants of any changes and the effective dates thereof and provide any required summary of material modification. Medical Mutual will update the Benefit Book with any plan changes that are timely communicated.

To the extent that the Ohio Department of Insurance mandates benefit changes applicable to multiple employer welfare arrangements, Medical Mutual will assist Participating Employers in providing summaries of material modification, if required. Medical Mutual will also assist Participating Employers in providing appropriate notices of annual benefit changes at renewal.

The material modification rule states that a notice of modification should be provided when:

- Changes to the health plan occur at a time other than renewal of coverage
- A change to the health benefits affects the content of the SBC
- Information is not reflected in the most recent SBC

In the situations above, the notice is required to be provided to Participants at least 60 days prior to the date that the health plan change will become effective.

c. Transparency in Coverage

The Transparency in Coverage mandate requires insurers and group health plans to make rate information publicly accessible in machine reasonable files to members and non-members starting in July of 2022. The sponsor of a self-insured healthcare plan must include a link on its own website that directs users to the location of the publicly available machine readable files. An explanation regarding how this requirement is satisfied, including a link for the sponsor to include on its own website, is here:

https://www.cosebenefitplan.com/Compliance-Resources.aspx

d. Consolidated Appropriations Act

Section 204 of the Consolidated Appropriations Act (CAA) requires health plans and insurers in individual and group markets to report certain information about prescription drug and healthcare spending to the Departments of Health & Human Services, Labor, and the Treasury on an annual basis. This is also known as Prescription Drug and Health Care Spending Data Collection, or RxDc. Medical Mutual will assist the Plan to comply and submit any reporting requirements under the Consolidated Appropriations Act, including Prescription Drug Data Collection under Section 204. Medical Mutual Services will report the data for the claims it administers for the Plan.

Section 201 of the Consolidated Appropriations Act (CAA) requires health plans and insurers in individual and group markets to attest to the Departments of Health & Human Services, Labor, and the Treasury on an annual basis. This is also known as Prohibition on Gag Clauses. Medical Mutual will assist the Plan to comply and submit any attestation requirements under the Consolidated Appropriations Act, under Section 201. Medical Mutual will attest for claims it administers for the Plan.

Document	Timing Requirement	Purpose	Who is Responsible
Summary Plan Description (SPD) And Plan Document.	This must be provided within 90 days of becoming a Plan Participant. A Plan has 120 days after first becoming subject to ERISA to provide an SPD. Any amended SPD must be provided every 5 years if material changes are made; otherwise, every 10 years. Employers must also provide this documentation to participants within 30 days of request, to avoid penalties.	This describes the benefits and terms of coverage.	It is the Participating Employer's responsibility for the content and distribution of the plan document and SPD; COSE Benefit Plan will create the wrap and SPD template that describes the COSE Benefit Plan. The Plan Document and Benefit Book will be created by Medical Mutual to create the SPD which should be distributed to employees. **Participating Employers must distribute the SPDs to their Participants.**
Summary of Material Modification (SMM)	This must be provided within 210 days after the end of the plan year in which the modification is adopted. If the change results in a material reduction of benefits, the SMM must be provided within 60 days after the change	This describes any modifications to the Plan or changes in information that affects the Summary of Benefits and Coverage (SBC).	The Employer is responsible for the content and distribution of any SMM, which describes any modifications to the Plan or changes in information that affects the SPD. Medical Mutual will offer assistance with creating an SMM. **Participating Employers must distribute the SMMs to their Participants**
Summary of Benefits and Coverage (SBC)	See previous section.	This highlights some of the cost-sharing components of the Plan, as well as certain exclusions. This standard format	The Employer is responsible for the content and distribution of the SBC, which is set forth in a required format. Medical Mutual will prepare the initial SBC and subsequent SBCs for the Participating Employer, and post the SBC on cosebenefitplan.com

		is part of the ACA requirements and must be distributed at the time of renewal.	• Upon eligibility for enrollment or enrollment in the COSE Benefit Plan; • By the first day of the plan's open enrollment period; • If there is no open enrollment period, at least 30 days prior to the next plan or policy year; • By the first day coverage starts, if the SBC changed from the version provided during enrollment; • Upon "special enrollment," as defined by HIPAA – within 90 days from enrollment; • If there is a mid-year change to the plan that affects the information in the SBC, *60 days in advance of the change;* and • Upon request - as soon as practical, not later than seven business days following request
HIPAA Special Enrollment Notice	At or before the time an employee is initially offered the opportunity to enroll in a group health plan.	Make Participants aware that special enrollment opportunities exist for certain situations.	Information about special enrollment is included on the employee application, as well as in the Participant's Benefit Book.
Women's Health and Cancer Rights Act	Upon enrollment and annually.	To make Participants aware of coverage for breast reconstruction following a	Initial notice for Participant is included in the Benefit Book provided by Medical Mutual. Annual notice will be included in a newsletter provided by Medical Mutual.

		mastectomy for cancer.	
COBRA	Initially and at time of each qualifying event.	Employers with over 20 employees for more than half of the prior year are required to provide continuation of benefits to terminated employees.	Notification provided by COBRA Options – Brought to you by Medical Mutual. **Each eligible Participating Employer must be set-up with Medical Mutual** (see Contacts and Resources page).
State assistance with premiums under Medicaid or Children's Health Insurance Program Reauthorization (CHIPRA)	Annually. May be provided with enrollment materials, open enrollment materials, or the SPD.	The Employer CHIPRA notice must be provided to all employees who reside in any of the 40 states that provide funding rate assistance through employer-based plans. Ohio is not currently one of these states.	The COSE Benefit Plan will have a copy of the standard notice on their website at cosebenefitplan.com. **If you have employees in other states, you need to determine whether you need to distribute any notices.** https://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf
Marketplace Exchange availability	**The Employer is required to provide this notice to a new employee within 14 days of his or her date of hire.**	Information on Exchanges and consequences if an employee purchases a Qualified Health Plan through the Exchange in lieu of employer-sponsored coverage.	Sample notices are at Healthcare.gov. A link to these notices is at cosebenefitplan.com. **You, the employer, need to provide these notices.**

Medicare Part D creditable coverage	Annually.	Employer groups are required by law to send an annual notification to certain members regarding their prescription Drug plans' Creditable ("at least as good as" the base Medicare Part D plan design) status related to Medicare Part D coverage.	**Medical Mutual will send the annual notifications to participants and Participating Employers.**

Please work with your own consultant, human resources, or benefits attorney. If you determine that an error is made with respect to these requirements, please take prompt action to correct. Failure to comply with Participating Employers' responsibilities will result in potential penalties, assessments and fees.

3. Other Notices

Although many notices are provided in the SPD or summary annual notice provided by Medical Mutual, listed below are some of the other notices that you may be required to provide. If you have questions, please your Broker, Medical Mutual representative or your attorney.

- Uniformed Services Employment and Reemployment Rights Act. More information is at https://www.dol.gov/vets/programs/userra/userra_fs.htm
- Newborns and Mothers' Health Protection Act. More information is at https://www.dol.gov/general/topic/health-plans/newborns
- Qualified Medical Child Support Order. More information is at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf
- Michelle's Law. Moreinformation is at http://webapps.dol.gov/elaws/ebsa/health/employe r/657.asp
- Genetic Information Nondiscrimination Act (GINA). More information is at https://www.eeoc.gov/laws/statutes/gina.cfm
- Women's Health and Cancer Rights Act (WHCRA). More information is at https://www.dol.gov/general/topic/health-plans/womens
- Children's Health Insurance Program Reauthorization Act (CHIPRA). More information is at http://www.ahrq.gov/policymakers/chipra/index.html
- PPACA Section 1557 nondiscrimination. More information is at https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html