WESTERN HEALTHCARE INSURANCE TRUST

2020 MASTER PARTICIPATION AGREEMENT

WHIT Benefits for Healthcare Employers in the Northwest

This is an application for (check one): ☐ **Annual Renewal** ☐ **Existing Employer Change** ☐ **New Participating Employer**	**Effective Date:**	Vimly Account Number (Internal Use Only):

SECTION I: GROUP INFORMATION

EMPLOYER INFORMATION

Legal Name of Business				
Doing Business As (DBA)				
Business Physical Address		City:	State:	Zip:
Mailing PO Box		City:	State:	Zip:
Federal Tax ID Number		State of Legal Domicile		
Type of Legal Entity		Tax Exempt: ☐ YES ☐ NO	Governmental Entity: ☐ YES ☐ NO	

Does your group cover Non-Registered Domestic Partners? ☐ YES ☐ NO	We allow the following Domestic Partnerships. ☐ Same Sex ☐ Opposite Sex ☐ Both

Group Benefits Administrator (This contact will be the primary contact for benefit updates and administration)

Name & Title	Phone:	Email:

Group Billing Administrator (This contact will be the primary contact for billing updates)

Name & Title	Phone:	Email:

Insurance Producer (as applicable)

Does your organization use an insurance producer for WHIT plans? ☐ YES (if YES, complete the following) ☐ NO

Agency Name:	Producer Name:	Phone:

Agency Address:	City:	State:	Zip:

PRODUCER SIGNATURE:	DATE:

COBRA

An employer is subject to Cobra during the current calendar year if the company employed 20 or more employees on 50% of its typical business days in the preceding calendar year.	Subject to COBRA? ☐ YES ☐ NO

Does your group currently have any COBRA participants? ☐ YES (if YES, how many) _____ ☐ NO

If your organization uses an outside COBRA administrator, please complete the following:

Agency Name:	How should COBRA premiums be billed: ☐ Employer Bill ☐ TPA Direct

Contact Name:	Phone:	Email:	

Agency Address:	City:	State:	Zip:

SIMON

Will the group process enrollment via the WHIT/Vimly Benefit Solutions Web Enrollment System? ☐ YES ☐ NO

If YES, for access to the online enrollment system and billing services, indicate the individual(s) whom should be authorized. An email invitation will be sent out to the designated individual(s) to register for Web Enrollment System functionality. *
IMPORTANT: Email addresses are mandatory for Web Enrollment System access.

Name & Title	Phone:	Email:
Name & Title	Phone:	Email:

VERIFY

FOR RENEWING GROUPS ONLY:

☐ **Please check this box to acknowledge that the group will be renewing with no changes for the 2020 plan year and proceed to page 4.** (*If the group will be changing plans or eligibility requirements in 2020, proceed to page 2.)*

CLASS

Classes (affiliates, subsidiaries, or office locations within the same employer) have the same BSI Account Number as the main group, and are included on the same bill, but are assigned class codes and will have separate class premium totals on the bill. If you have more than 3 classes, please indicate in the Notes section at the end of this document.

Class 1	Class Name *("Admin," "Physicians")*:	Class Code *(to appear on bill)*:
Class 2	Class Name:	Class Code:
Class 3	Class Name:	Class Code:

A current census must accompany each new class designation. For additional classes, attach a separate sheet of paper.

SECTION II: BENEFIT ELIGIBILITY

PROBATIONARY PERIODS / CONTRIBUTION

This organization defines an active (benefit-eligible) employee as one who works a minimum of _____ hours per _____.

WHIT EFFECTIVE DATE DEFINITION

WHIT defines an employee's coverage effective date as follows. Employees hired:

- **On the first** of the month may count the full month towards their probationary period. If the employer has a 0 day probationary period, the employee will come onto coverage on the date of hire.
- **On the 2nd to the 31st** of the month are eligible for coverage effective on the first day of the month following the date of hire.

How does the employer administer benefit coverage effective dates?

☐ 1st of the month following date of hire ☐ 30 day waiting period ☐ 60 day waiting period

☐ 90 day waiting period ☐ 180 day waiting period ☐ Class: _____

Employer Contribution for Employee: _____ Employer Contribution for Dependents: _____

Please note: Employer must contribute at least 75% of Employee Only coverage

Class probationary periods- Please indicate the class and corresponding probationary below.

Class 1	Class Name *("Admin," "Physicians")*:	Probationary Period:
Class 2	Class Name:	Probationary Period:
Class 3	Class Name:	Probationary Period:

SECTION III: PLAN ELECTION (Check the boxes you wish to offer under your group health plan.)

ENROLLMENT

DENTAL PLANS

Directions: Enter **X** to select the plans your group wishes to offer to your employees.

I. DELTA DENTAL OF WASHINGTON . . . . . .

☐ **PLAN A** ☐ ORTHO 1 ☐ ORTHO 2

☐ **PLAN B** ☐ ORTHO 1 ☐ ORTHO 2

☐ **PLAN C** ☐ ORTHO 1 ☐ ORTHO 2

☐ **PLAN D** ☐ ORTHO 1 ☐ ORTHO 2

☐ **PLAN E** ☐ ORTHO 1 ☐ ORTHO 2

☐ **PLAN F** ☐ ORTHO 1 ☐ ORTHO 2

☐ **PLAN G** ☐ ORTHO 1 ☐ ORTHO 2

☐ **EXPERIENCE GROUP** Please complete below rates

☐ **Experience Plan Choice 1**

Employee Only	$
Employee & Spouse/Domestic Partner	$
Employee & Spouse/Domestic Partner & 1 Child	$
Employee & Spouse/Domestic Partner & 2 Child	$
Employee & 1 Child	$
Employee & 2+ Children	$

☐ **Experience Plan Choice 2**

Employee Only	$
Employee & Spouse/Domestic Partner	$
Employee & Spouse/Domestic Partner & 1 Child	$
Employee & Spouse/Domestic Partner & 2 Child	$
Employee & 1 Child	$
Employee & 2+ Children	$

II. WILLAMETTE DENTAL . . . . . .

☐ Pooled Willamette ☐ Experience Willamette

ENROLLMENT (Cont.)

VISION PLANS

Directions: Enter **X** to select the plans your group wishes to offer to your employees.

III. VISION SERVICE PLAN . . . . . .

☐ PLAN 1 ☐ PLAN 2 ☐ PLAN 3 ☐ PLAN 4

LIFE PLANS

Directions: Enter **X** to select the plans your group wishes to offer to your employees.

Employers are required to enroll all eligible employees in a basic life plan. Employers may elect to offer employees the opportunity to purchase additional payroll-deducted voluntary products.

IV. STANDARD INSURANCE COMPANY | BASIC LIFE . . . . . .

☐ **$10,000** ☐ **$15,000** ☐ **$25,000** ☐ **$50,000**

☐ **1x Annual Salary** ☐ **2x Annual Salary** ☐ **2.5x Annual Salary** ☐ **Other** _____

Class 1	Class Name *("Admin," "Physicians")*:	Rate	Benefit Maximum
Class 2	Class Name:	Rate	Benefit Maximum
Class 3	Class Name:	Rate	Benefit Maximum

☐ **Basic Life Dependent Benefit** Plan Rate _____

V. STANDARD INSURANCE COMPANY | VOLUNTARY LIFE. . . . . . .

☐ **Voluntary Term Life (VTL)** (by employee election, employee paid)

☐ Brokered Rates ☐ Non-Brokered Rates

☐ **Voluntary Accidental Death & Dismemberment (VAD&D)** (by employee election; employee paid)

☐ Brokered Rates ☐ Non-Brokered Rates

GROUP DISABILITY PLANS

Base LTD is an employer-paid benefit that requires 100% employee participation. If Base LTD is in place, employers may elect to offer employees the opportunity to purchase additional voluntary Buy-Up LTD.

VI. STANDARD INSURANCE COMPANY | LONG TERM DISABILITY. . . . . . .

☐ **Base Long Term Disability** (100% participation, employer paid)

☐ **Voluntary Buy-Up Long Term Disability (Buy-Up LTD)** (by employee election; employee paid)

Class 1	Class Name *("Admin," "Physicians")*:	Rate	Max Pre-disability Earnings
Class 2	Class Name:	Rate	Max Pre-disability Earnings
Class 3	Class Name:	Rate	Max Pre-disability Earnings

VII. DISABILITY PLANS | Short Term Disability. . . . . . .

☐ **Base Short Term Disability** (100% participation, employer paid)

Class 1	Class Name *("Admin," "Physicians")*:	Rate	Max Pre-disability Earnings
Class 2	Class Name:	Rate	Max Pre-disability Earnings
Class 3	Class Name:	Rate	Max Pre-disability Earnings

SECTION IV: CARRIER INFORMATION

Delta Dental of Washington
9706 4th Ave NE
Seattle, WA 98115

Willamette Dental of WA, Inc
910 NE 82nd St
Vancouver, WA 98665

Vision Service Plan
600 University St, Ste 2004 Seattle, WA 98101

Standard Insurance Company
1100 SW 6th Ave
Portland, OR 97204

Western Healthcare Insurance Trust (WHIT) Subscription Agreement

1) Subscribe to Trust. As a participating employer of the Western Healthcare Insurance Trust, _____ (hereafter, "Employer" or "we"), subscribes to the Western Healthcare Insurance Trust Agreement and acknowledges receipt of the Trust Agreement governing the Western Healthcare Insurance Trust, restated effective May 1, 2015, (Dr. 12/2/14) and subsequent amendments.

2) Status of Trust and Status of Employer. The Trust is a "multiple employer welfare arrangement" (MEWA) under federal law, 29 USC 1001(40), and a Group Insurance Arrangement for IRS reporting purposes. The employer is the plan fiduciary of the WHIT plans to which it subscribes, but the Employer and Trust agree in this Agreement that the Employer is delegating certain responsibilities to the Trust, as set forth herein, specifically in Section 9.

3) Payment of monthly contributions. The employer agrees to pay the contribution amounts established by the Trustees ON OR BEFORE THE 25th OF THE MONTH PRIOR TO THE COVERAGE MONTH for the coverage lines indicated above.

4) Adjustment to contribution rates. We understand that the Trustees have the authority to adjust the contribution rates for the benefit programs from time to time. We further understand that benefits shall not be provided by the Trust during any month for which contributions are not paid. The Trustees shall give 30 days advance written notice of changes to contribution rates.

5) Delinquencies. We acknowledge that in the event of contribution delinquencies, the Trust is allowed to charge the participating employer for liquidated damages, interest, attorney fees, audit fees and other associated costs; and the employer will be liable for such charges.

6) COBRA (continuation of coverage under federal law).
a) General. We understand that COBRA may apply to certain of the Trust's benefit programs for certain employers.
b) Employer's responsibility. We agree that we, the employer, are responsible for all COBRA administration in relation to Trust coverages, including all notices, elections, processing of contributions, etc. and that the Trust will not be sending any COBRA notices, election forms, etc. However, subject to Section 6(c) hereof, we understand that if we timely transmit lawful COBRA self-payments to the Trust, continuation coverage will be provided by the Trust.
c) Withdrawal of employer from Trust. We agree that in the event we terminate our participation in a Trust plan that is subject to COBRA, the Trust will not continue COBRA coverage for our employees or former employees on COBRA coverage from the Trust, but that we will be responsible for such coverage.

7) Certify to Eligibility. We further certify that all employees, as will be reported on the billing forms or electronic data system, meet the eligibility requirements in paragraph 8 hereof, and the criteria for participation in the benefit programs as described in the carriers' applications we complete at initial enrollment.

8) Eligibility Rules. The minimum eligibility requirements for participation in the Trust are:
a) The employee must be employed in a group of employees designated by the participating employer on a basis that precludes individual selection (except for voluntary plans).
b) The employee must be employed on a permanent, full-time basis defined as 20 hours or more per week.
c) The employee must be performing the usual duties of his/her occupation at a place of business designated by the employer.
d) The employee must be compensated in the form of wages or salary for services presently being performed.

9) Preparation and Distribution of Various Plan Documents: Summary Plan Descriptions and Plan Booklets.
We understand that employees participating in the Trust are entitled to certain information under federal law, and that the Trust does not maintain addresses for all employees**.**
a) Preparation. The Trust (and/or the Trust insurance carriers) will prepare the Summary Plan Description, Summary Annual Report, HIPAA notices and other descriptive material for WHIT benefit plans.
b) Distribution. Thus, we accept the responsibility to promptly distribute to our employees the "Summary Plan Description" that the Trust sends to us, the benefit booklets/certificates that the insurance carriers send to us for distribution, and any other notices that we receive from the Trust or insurance carriers for distribution to employees.
c) IRS Form 5500. The Trust accepts the responsibility to prepare the annual IRS Form 5500 for the benefit plans listed in Section III hereof, and timely file it with the IRS.

10) Effective Date and Termination. This Agreement shall become effective on the date signed below, and shall remain in effect unless terminated by either party in accordance with the terms of this agreement. The Employer or Trust may terminate

this Agreement effective the first of any month, provided written notice is given at least 10 days in advance to the other party. The Trust may also terminate coverage effective the first of any month for the Employer's failure to remit contributions when due. **Written notice of termination by an employer must be received by the Trust at least 10 days prior to the first day of the month for which coverage is to be terminated, or contributions for coverage will be due for that month.**

11) Cedar Health Trust Relationship. We understand that WHIT offers the above-listed benefit plans to participating employers of Cedar Health Trust, but WHIT is not responsible for any statements made by Cedar Health Trust related to WHIT benefit plans, and Cedar Health Trust is not authorized to answer questions on benefits or contribution rates for WHIT. Employer will contact the WHIT Trust Office c/o Vimly Benefit Solutions at (206) 859-2600 or whit@vimly.com with questions regarding WHIT benefit plans. We also understand that WHIT does not have any administrative or fiduciary responsibility for Cedar Health Trust; WHIT and Cedar Health Trust are separate, unrelated entities.

The below signed applicant acknowledges it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Authorized Signature: _____ Date: _____

Title: _____