2021 Participation Agreement

1. EMPLOYER INFORMATION

Effective Date_____

Legal Name_____

'dba' Name_____

If you have multiple "dba", please provide a separate listing of each locations name, address and TIN.

Tax Identification Number (TIN)_____

Street Address _____

City_____ State_____ Zip Code_____ County_____

Phone Number_____ Fax Number_____

Billing Address (if different) _____

City_____ State_____ Zip Code_____ County_____

Primary Contact_____Title_____

Phone Number_____ E-mail Address_____

Billing Contact _____Title_____

Phone Number_____ E-mail Address_____

Owner/President _____Title_____

Washington Hospitality Association Member ID Number_____

NAICS Code_____ UBI Number _____

Monthly Invoice Sorting Alphabetically_____ or by Divisions/Locations_____
(please provide separate listing of divisions/locations)

2. PLAN SELECTIONS

KAISER PERMANENTE SELECTED MEDICAL PLAN(S):

- ❑ Diamond Plan (*Access PPO $500 Deductible)*
- ❑ Emerald Plan *(Access PPO $1,000 Deductible)*
- ❑ Sapphire Plan (*Access PPO $1,500 Deductible*)
- ❑ Jade Plan (*HMO $2,500 Deductible*)
- ❑ Pearl Plan (*HMO $2,500 Deductible)*
- ❑ HSA Plan (*HMO $2,500 Deductible)*
- ❑ Quartz Plan *(Access PPO $2,500 Deductible)*
- ❑ Ruby Plan (*Access PPO $3,000 Deductible*) □□ No Spouse
- ❑ Opal Plan (*Access PPO $5,000 Deductible)*
- ❑ Onyx Plan (*HMO $5,000 Deductible)*
- ❑ Topaz Plan (*HMO $5,000 Deductible)*
- ❑ Zircon Plan *(HMO $5,000 Deductible)*
- ❑ Virtual Plus 1000
- ❑ Virtual Plus 2000
- ❑ Virtual Plus 3000
- ❑ Virtual Plus 5000

SELECTED DENTAL PLAN(S):

- ❑ Delta Dental Option 1
- ❑ Delta Dental Option 2
- ❑ Delta Dental Option 3
- ❑ Delta Dental Option 4
- ❑ Delta Dental Option 5
- ❑ Delta Dental Option 6
- ❑ Delta Dental Orthodontic Rider $1,000
- ❑ Delta Dental Orthodontic Rider $1,500
- ❑ Delta Dental Orthodontic Rider $2,000

- ❑ Willamette Dental Plan

- ❑ Dental Health Services Select Plan
- ❑ Dental Health Services Voluntary

SELECTED VISION PLAN(S):

- ❑ Ameritas Vision Perfect Plan 1
- ❑ Ameritas EyeMed Materials Only Plan 2 (included in medical)
- ❑ Ameritas EyeMed Plan 3
- ❑ Ameritas Focus VSP Plan 4
- ❑ Ameritas Voluntary Vision Perfect Plan 5
- ❑ Ameritas Voluntary EyeMed Materials-Only Plan 6
- ❑ Ameritas Voluntary EyeMed Plan 7
- ❑ Ameritas Voluntary Focus VSP Plan 8
- ❑ Ameritas Vision Perfect-Materials Only Plan 9
- ❑ Ameritas Voluntary Vision Perfect-Materials Only Plan 10

LIFE & VOLUNTARY PLAN(S):

- ❑ Basic Life & AD&D - $10,000
- ❑ TransSelect 20 Year Term
- ❑ AccidentSelect

OTHER:

- ❑ ComPsych EAP
- ❑ Teladoc
- ❑ CDHP Benefits – Separate Agreement with Vimly is required.

RATES – Please do not add lines of coverage together – Renewing Groups Only

All Kaiser plans meet Medicare Part D standard for Credible Coverage.

	EE	EE/SP	EE/1CH	EE/2CH	EE/SP/1CH	EE/SP/2CH
Medical Plan 1						
Medical Plan 2						
Medical Plan 3						
Dental Plan 1						
Dental Plan 2						
Ortho Plan						
Vision Plan						
Basic Life/AD&D		N/A	N/A	N/A	N/A	N/A
EAP		N/A	N/A	N/A	N/A	N/A
Teladoc		N/A	N/A	N/A	N/A	N/A
TransSelect	Age Rated	N/A	N/A	N/A	N/A	N/A

Caution: Under the Patient Protection and Affordable Care Act, excluding certain employees from eligibility could cause your plan to fail non-discrimination requirements under federal law. To avoid potential penalties, employers should consult with their own advisors before excluding employees from eligibility. HIHIT and the carriers are not able to give employers legal or tax advice.

COBRA AND TEFRA

COBRA provides for a self-payment continuation of benefit coverage in certain circumstances. TEFRA requires that the coverage of the active employees, who are age 65 or older and who are covered by their employer's health plan and by Medicare, be primary to Medicare. There are 'small employer exceptions' to both COBRA and to TEFRA. **The trustees have decided not to invoke the exception and will treat all employers as subject to COBRA-*like benefits* and to TEFRA.**

3. ELIGIBILITY & PARTICIPATION

The following categories of employees are not required to participate in the plan but may choose to participate as eligible employees: employees covered by TriCare, Medicare, or another similar plan.

Eligible Full-Time Employees must work 30 hours per week per ACA. Eligible Part-Time Employees must work a minimum of 20 hours per week.

3A. Total Number of **ALL** Employees on Payroll +_____

3B. Less employees not eligible to enroll: -_____

3C. Less the Employees in a new hire Probationary Period: -_____

3D. Less the number of employees covered under a government plan or other group coverage (valid waivers): -_____

3E. Total Number of Employees ***Eligible*** to enroll (**3A** minus **3B** minus **3C** minus **3D)**: =_____

3F. Total Number of ***Eligible*** Enrolling Employees: _____

3G. Percentage of enrolled employees to total ***Eligible*** employees (**3F** divided by **3E)**: = _____
(Percentage of enrolled employees to total eligible employees must be at least 50%.)

Note: Only list employees who are deemed eligible at time of initial enrollment or renewal
Do not include employees who are deemed ineligible at time of initial enrollment or renewal (i.e. seasonal)

4. EMPLOYEE CONTRIBUTIONS

The minimum employer contribution percentage to participate in the Trust is 50% of the employee premium for the least expensive plan offered. The Patient Protection and Affordable Care Act has additional participation, eligibility and benefit minimum requirements to satisfy non-discrimination rules. Employers should consult with their own legal and tax advisors to determine how these rules may impact their plan**.**

% of Employee rate paid by the employer_____ % of Dependent rate paid by the employer_____

5. EMPLOYEE CLASSIFICATIONS

Class I: _____ Eligible employees must be working _____ hours per week.
(must not be more than 30hrs)
- ❑ 1st of the Month Following Date of Hire
- ❑ 1st of the Month Following 1 month
- ❑ 1st of the Month Following 2 months

Class II: _____ Eligible employees must be working _____ hours per week.
(must not be more than 30hrs)
- ❑ 1st of the Month Following Date of Hire
- ❑ 1st of the Month Following 1 month
- ❑ 1st of the Month Following 2 months

Class III: _____ Eligible employees must be working _____ hours per week.
(must not be more than 30hrs)
- ❑ 1st of the Month Following Date of Hire
- ❑ 1st of the Month Following 1 month
- ❑ 1st of the Month Following 2 months

6. EMPLOYEE PROBATIONARY PERIOD, ETC.

Waiving Employer Probationary Period (For New Groups Only)

- ☐ Yes, waive the employer probationary period for all current eligible employees
- ☐ No, the employer probationary period, as stated, will apply to all current eligible employees

Employee Transfers from Part-Time to Full-Time Status:

- ☐ Employer probationary period begins upon the date an eligible employee transfers to full-time status
- ☐ Employer probationary period is retroactive to an eligible employee's original date of hire.

Employee Return from Lay-off or Leave of Absence:

- ☐ Employer probationary period begins upon the date an eligible employee returns to work
- ☐ Employee is effective the 1st of the month following return to work if rehired within 3 months. Otherwise employer probationary period begins again.

Include Coverage for Domestic Partners who are not registered with the State of Washington and their Dependents (there is no cost difference):

- ☐ Yes
- ☐ No

**The probationary period in effect at the time an employee is hired must be met before they are eligible for group coverage. Any probationary period changes made at future open enrollments apply to new hires going forward*

7. ACCOUNTABLE OFFICER'S AGREEMENT AND CERTIFICATION

By execution of this Participation Agreement and Participation Requirements, the participating employer agrees to be bound by all terms and conditions of the Participation Requirements, current Trust Agreement and by any existing or future amendments to the Trust Agreement governing the Hospitality Industry Health Insurance Trust, including, without limitation, paying the required monthly premium, paying any late fees imposed by the plan administrator on account of employer's late payment of contributions and furnishing necessary information on covered persons. Copies of these documents are on file with the Hospitality Industry Health Insurance Trust.

If page 5 has been completed, applicant has appointed the named Producer of Record with respect to the coverage requested. No producer has the authority to guarantee that the health carrier will accept this application for coverage and no producer has the authority to contract on behalf of the health carrier.

Under Washington law, it is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the carrier. Penalties may include imprisonment, fines, and denial of benefits.

Signature by applicant's authorized representative shall constitute applicant's 1) request for coverage; 2) acknowledgement and acceptance of all terms, conditions and information contained within this application form; and 3) certification that all information provided by applicant on this form is accurate and complete.

_____ _____

Printed Name of Group Representative | Title

_____ _____

Signature of Group Representative | Date

8. INSURANCE PRODUCER INFORMATION – Must be authorized by H.I.H.I.T.

Name of Agency_____

Name of Producer_____

Address_____

City_____ State_____ Zip_____

E-mail Address_____ Phone_____

I have appointed _____ as my producer of record with respect to the coverage

described in this application, effective _____/_____/_____.

This appointment shall remain in effective until rescinded in writing by group's authorized representative.

Commissions are authorized and paid by H.I.H.I.T. Commissions may be paid only to producers who are licensed and appointed with each of the carriers for the products selected by the group.

DEFINITIONS

* "Insurance Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate Insurance. "Insurance Producer" does not include title insurance agents. RCW 48.17.010

SIGNATURE OF INSURANCE PRODUCER

I certify to the best of my knowledge that the information on this application is accurate and complete. Under Washington law, it is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the carrier. Penalties may include imprisonment, fines, and denial of benefits.

_____ _____

Printed Name of Insurance Producer Title

_____ _____

Signature of Insurance Producer Date

CARRIER CONTACT INFORMATION

Vimly Benefit Solutions : 12121 Harbour Reach Dr, Ste. 105, Mukilteo, WA 98275; Customer Service 206.456.9940
Kaiser Permanente : 601 Union Street, Suite 3100, Seattle, WA 98101; Customer Service 888.901.4636
Delta Dental of Washington : 400 Fairview Ave N Suite 800 Seattle, WA 98109; Customer Service 800.367.4104
Dental Health Services, Limited Health Care Service Contractor : 100 West Harrison Street, Suite S-440, South Tower, Seattle, Washington 98119; Customer Service 206.633.2300
Willamette Dental of Washington, Inc. 6950 NE Campus Way, Hillsboro, OR 97124 Customer Service 855.433.6825
Ameritas : P.O. Box 81889, Lincoln, NE 68501; Customer Service 800.659.2223
TransAmerica : 433 Edgewood Road NE, Cedar Rapids, IA 53499 Customer Service 800.797.2643

PARTICIPATION REQUIREMENTS

1. Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc will be the sole medical carrier.

2. H.I.H.I.T. coverage is available to current members of the Washington Hospitality Association. Participating employers must be a regular or allied member of the Washington Hospitality Association. Only individuals who are employees of the Employers so described shall be eligible to participate. Groups must be domiciled in Washington State.

3. Participant coverage obtained through this application may be terminated for the following reasons: (A) Non-payment of premiums; (B) Participant eligibility requirements are no longer met; or (C) Membership with the Washington Hospitality Association is terminated.

4. Failure to return a completed Participation Agreement (PA) prior to the effective date may result in coverage delay or termination. For renewing groups, the PA must be received by December 25th for a January 1st renewal date, which is the anniversary date of H.I.H.I.T. For new business, the PA, member applications and full payment must be received no later than the 25th of the month prior to the effective date. Failure to provide all required information may delay implementation of eligibility and benefit coverage.

5. After the initial payment, regular monthly payments are due on or before the 1st day of the month of coverage. Participating employers are subject to late payment fees and termination of participation in the Trust if payments are not received timely. If payment is not received the month following the premium coverage month, a late fee of 1.5% of premiums or $20, whichever is greater.

6. Rates are based upon the number of employees actually enrolled in the plans. Rates released for bid are not final and will be adjusted based on the actual members received at time of enrollment. Rates are guaranteed until January 1 of the following calendar year in which the group is enrolled.

7. At least two (2) eligible employees must enroll in the plan to establish an employer account in the Trust. Plans with no enrollment will be terminated at the end of the plan year. Groups with a minimum of 10 subscribers may choose two or three medical plans and a minimum of 3 subscribers must enroll in each plan offered. An employer/employee relationship must exist, with the employee represented on the payroll as receiving a wage or commission.

8. Each employer establishment determines if part-time employees are eligible for coverage. Part-time employment is 20 to 29 hours per week; full-time employment is 30 hours per week and benefits must be offered.

9. Coverage for new employees becomes effective the first of the month following or coincident with the probationary period, as defined by the employer. Up to three (3) separate classes of employees may be established by the employer. Probationary periods for employees must be non-discriminatory.

10. The employee, their legal spouse, including state registered domestic partners as required by Washington State law, and/or children up to the age of 26 are eligible to enroll. There is no age limit for dependents who are incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the employee or member for support and maintenance. Domestic partners who are not registered with the State of Washington can also be eligible dependents under the Trust, if the employer elects to include them, by marking "yes" on the domestic partner election option on the Participation Agreement.

11. The employer must contribute at least fifty percent (50%) of the employee's healthcare premium. At least fifty percent (50%) of an employer's eligible employees must enroll in the plan to establish an employer account in the Trust, excluding those with a valid waiver due to other coverage.

12. Plan changes by the employer may only be made during the open enrollment period. Plan changes by the employee and dependents may only be made during the open enrollment period unless a special enrollment entitlement has been met.

13. All employer groups are subject to COBRA benefits. It is the responsibility of the employer group to distribute the COBRA general notice.

14. All plans will be considered non-grandfathered by the carriers. Final guidance has not been issued for the Federal Patient Protection and Affordable Care Act. Additional benefit changes may be necessary once final guidance is received and additional rate impact for these changes may apply