Group Administrative Guide

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Foreword

Dear Employer:

The Washington Alliance for Healthcare Insurance Trust (WAHIT), also referred to as the "Trust", is an employer governed Trust that began in June 1997. The Trust has arranged group insurance contracts with Premera Blue Cross, USAble Life, Vision Service Plan and ComPsych to provide insurance coverage for medical, dental, vision, life, accidental death and dismemberment (AD&D), and EAP.

WAHIT is pleased to provide this ***Group Administrative Guide***, as a ready reference to employers who participate in WAHIT's benefit programs. This reference material will provide your company ongoing assistance with the day-to-day administration of the benefit programs. When your group completes the *Master Application for Insurance Coverage* to participate in WAHIT, you agree to the Terms of Selection and Participation in WAHIT including adhering to the rules established in the *Group Administrative Guide* and the health service contracts, insurance policies, and other service contracts between WAHIT and each respective carrier.

Your organization, as an ERISA benefit plan sponsor, needs to administer the plans based on a clear understanding of your responsibilities under the law. Please become familiar with the general terms, conditions and limitations of the health service contracts, insurance policies, booklets/certificates of insurance, and WAHIT's rules as expressed in this *Group Administrative Guide*.

This *Group Administrative Guide* is a summary of the terms, conditions and limitations by which WAHIT, Premera Blue Cross and any other service contractors or insurance companies administer the eligibility rules and the plans of benefits i.e. "coverage." While we have attempted to make this Group Administrative Guide as accurate and complete as possible, it is not to be construed as an insurance contract, a booklet, or a certificate of insurance. The contracts between WAHIT and the service contractors or insurance companies, and the benefit booklets and certificates of insurance set forth the actual terms, conditions and limitations of coverage.

As Trustee, I would like to acknowledge the following WAHIT advisors for their collaboration in putting this *Group Administrative Guide* together:

Vimly Benefit Solutions, Inc. (Vimly) – Billing and Eligibility Administrator
Ekman Cushing Maxwell, P.S. – Legal Counsel
Advanced Professionals Insurance & Benefit Solutions – Benefit Consultant
Premera Blue Cross – Health Service Contractor

It is a pleasure to have your organization as a participating member of WAHIT.

F. Bentley Lovejoy
Trustee

Employer Contact Sheet

PREMERA BLUE CROSS			
Claims Address:	**Claims** PO Box 91059 Seattle, WA 98111-9159	**Customer Service:**	**425.918.5900** **800.722.1471** www.premera.com
EXPRESS SCRIPTS PRESCRIPTION SERVICES			
Mail Order Prescription Claims: (applicable to all medical plans, excluding HSA plans)	**Express Scripts** PO Box 650022 Cincinnati OH 45274-7000	**Retail Prescription Claims:**	**Express Scripts** PO Box 14711 Lexington, KY 40512
Customer Service	**800.391.9701**	**Customer Service**	**800.626-6080**
USABLE Life			
Claims Address:	**USAble Life** PO Box 1650 Little Rock AR 72203-1650	**Customer Service:**	**800.370.5856** custserv@usablelife.com
VISION SERVICE PLAN		**COMPSYCH GUIDANCE RESOURCES**	
Claims Address:	**Vision Service Plan** Customer Service/Claims PO Box 997105 Sacramento, CA 95899-7105	**Website:**	www.GuidanceResources.com
Customer Service:	**800.877.7195**	**Employers: If you have misplaced the company ID for your employees to login to Guidance Resources, you may email Vimly to request the company code.**	
VIMLY BENEFIT SOLUTIONS, INC.			
Physical Address:	**Vimly Benefit Solutions, Inc.** 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275	**Mailing Address:**	**Vimly Benefit Solutions, Inc.** PO Box 6 Mukilteo, WA 98275
Employer Billing, Premium Payments (Payment by faxed check requires authorization), Enrollment, Eligibility, COBRA, Trust Correspondence & Other Supplies		**206.859.2690** 866.422.1264 (fax) WAHIT@vimly.com	
Consumer Directed Health Plan Customer Service and Administration		**flexspending@vimly.com**	

Employer Eligibility and Requirements

Eligibility and Enrollment Requirements

In order to participate in the Trust, the employer must agree to define the enrollment requirements on their annual Group Master Application and then apply these requirements in a non-discriminatory fashion for all employees in determining their eligibility, enrollment, waiting period, minimum hours and contribution. These requirements can be changed at renewal. These may not be changed during the year without a formal request submitted to the administrator and written approval from the Trust. If the employer, as a result of an acquisition, merger, or other circumstances, wishes to add a new group or expand the group of eligible employees to the plan, they should contact their producer. Please see the Underwriting Guidelines and Quote Assumptions, as provided by your producer for a more detailing listing of employer requirements.

Renewal Process

All renewal information is sent to the employer's producer. The Trust does not send any renewal rates or other renewal information to the group. The Trust sends a renewal proposal to the producer 45-60 days prior to the renewal date. The producer is responsible for contacting the group regarding the new rates and any benefit changes.

A completed Group Master Application is required for all renewing groups, regardless of any plan or benefit changes. Open enrollment occurs during the month prior to the renewal date (i.e. the open enrollment for January would be the month of December). Renewals must be returned to Advanced Professionals Insurance & Vimly Benefit Solutions no later than 15 days before the renewal date.

Maintaining Administrative Records

The employer is responsible for keeping accurate records of any information relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, plan beneficiaries, and other records necessary to administer the benefit plan. The Trust and its affiliated contractors have the right at any time during the employer's regular business hours to request, inspect, or audit the employer's records related to the administration of the benefit plan, and any records retained by a third party entity engaged by the employer to administer portions of the employer's business, related to the information necessary to administer the benefit plan.

WAHIT Core/Non-Core Benefits

A participating employer must select one of WAHIT's two core benefit packages, Mandatory Option 1 (Medical and Life/AD&D) or Mandatory Option 2 (Dental and $20K Life/AD&D) for eligible employees and dependents. WAHIT does not permit a participating employer to offer a competing non-WAHIT plan unless there has been full advance disclosure to the Trust and the Trust has delivered a written acceptance of this practice to the participating employer.

Non-core (optional) coverage which can be added to Mandatory Option 1 includes Dental, Vision, EAP, Supplemental Life and AD&D and Dependent Life.

- ❑ If optional Dental is selected by the employer, uncommon eligibility with the medical is allowed for dependents only. Dependents may choose to enroll in medical and dental, medical only or dental only. Dependents that are enrolled in medical, dental or both are required to also enroll in all other optional coverage that the employer selected (except Supplemental Life and AD&D).
- ❑ Employees that are enrolled are required to also enroll in all optional coverage that the employer selected (except Supplemental Life and AD&D).

Non-core coverage which can be added to Mandatory Option 2 includes Vision, EAP, Supplemental Life and AD&D and Dependent Life.

- ❑ Employees and dependents that are enrolled in the mandatory Dental are also required to be enrolled in all optional coverage that the employer selected (except Supplemental Life and AD&D)

Contribution and Participation

The percentage of employer contribution is one of the factors that may be used to establish the participating employer's premium rates. Periodically, the Trust will require participating employers to certify that the minimum participation percentage requirements associated for each contribution percentage are being maintained.

The minimum employer contribution toward premium for eligible employees is 75%. However, WAHIT will accept 50% contribution for eligible employees when there is also 50% or more contribution for dependents.

If the employer contributes 100% of the premium for employee coverage, then 100%[1] of the eligible employees must enroll. The employer does not have the option of excluding employees with coverage elsewhere. The employee does not have the option to refuse coverage even if they have coverage elsewhere.

If the employer contributes 100% of the premium for dependent coverage, then 100%[1], of the dependents must enroll and uncommon dependent medical and dental eligibility is not allowed. The employer does not have the option of excluding dependents with coverage elsewhere. The dependent does not have the option to refuse coverage even if they have coverage elsewhere.

If an employer contributes less than 100% but no less than the Employer minimum contribution expressed above, a minimum of 75%[1] of eligible employees, regardless of coverage elsewhere, must enroll. This includes but is not limited to those covered through other group, individual, government or tribal insurance plans if otherwise eligible for WAHIT coverage. At least 25%[1] of eligible dependents must enroll.

Employees

When the employer contribution toward premium is less than 100%, employees may waive all coverage. Employers must however maintain a minimum participation of 75% of all eligible employees regardless of coverage elsewhere.

Dependents

When Mandatory Option 1 is selected by the employer and employer contribution toward dependent premium is less than 100%, otherwise enrolled dependents may choose to waive either medical or dental, but must enroll in all optional coverage. If both medical and dental are waived, the dependent may not enroll in any optional coverage offered by the employer. If Mandatory Option 2 is selected by the employer and the employer contribution toward dependent premium is less than 100%, dependents may choose to waive all coverage. The employer must however ensure that 25% of all dependents without other coverage are enrolled.

[1]For those employees eligible for Medicare, CHAMPUS/TriCare Primary Payer, employees and their eligible spouses age 65 and older who choose to waive coverage through WAHIT, need not be counted in calculating the percentages.

Employee and Dependent Eligibility

Eligible Employee

Active, full-time employees of the group who satisfy the minimum hour requirement, are paid on a regular basis, and have satisfied the appropriate probationary period (as set forth in the group's annual Group Master Application) are eligible for coverage under this plan. Temporary, Seasonal, Contract, or Employees paid via 1099 are not eligible.

Employees In Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the participating Trust Employer is located) be administered according to Hawaii law. If the participating Trust Employer is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the participating Trust Employer in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the participating Trust Employer there, he or she will no longer be eligible for coverage.

Eligible Dependent

Eligible dependents include:

- ❑ The employee's lawful spouse. However, if the spouse is an owner, partner or corporate officer of the group, who meets the requirements in "Employee Eligibility" (above), the spouse can only enroll as a subscriber.
- ❑ The domestic partner of the employee. Domestic partnerships that are not documented in a state domestic partnership registry must meet all requirements as stated in the signed "Affidavit of Domestic Partnership." All plan provisions stated as applicable to a spouse will also be applicable to a domestic partner. For the purpose of this plan, the use of the term "marriage" will also be applicable to a domestic partnership.
- ❑ An eligible dependent child under 26 years of age who meets one of the following requirements:
  - A natural offspring of either or both the subscriber or spouse.
  - A legally adopted child of either or both the subscriber or spouse.
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
  - A legally placed ward or foster child of the employee or spouse. There must be a court order or other order signed by a judge or state agency, which grants guardianship of the child to the employee or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
- ❑ A dependent child age 26 or older who cannot support himself or herself because of a developmental or physical disability, provided the dependent child was covered on the day before the 26th birthday and the incapacity occurred prior to the 26th birthday. Benefits will be provided for the duration of the disability unless coverage terminates. Within 31 days of the child reaching age 26, the employee will need to furnish the medical carrier with a Request for Certification of Handicapped Dependent form. The medical carrier must approve the request for certification in order for coverage to continue. If the medical carrier approves the request for certification, they will notify Vimly to proceed with the enrollment. The enrollment will be completed with the effective date the first of the month following the child's 26th birthday to provide continuous coverage. Proof of the incapacity and dependency

will be required by the medical carrier not more frequently than one time per year after the child's 26th birthday.

Tax Implications for Domestic Partner Coverage

Federal tax rules govern the tax treatment of domestic partner benefits. Generally, if a domestic partner or his/her dependents are defined as an employee's Internal Revenue Code (Code) Section 105(b) tax dependents, the value of the health coverage is not subject to federal income and employment taxes, and the benefits provided will be tax-free. If a domestic partner or his/her dependents are not Code Section 105(b) tax dependents, generally the employee will be taxed on the premium cost of the insurance provided to the domestic partner.

Whether a domestic partner or domestic partner's child is a tax dependent of an employee is a legal tax question and the employer may need to consult legal counsel for advice on the taxability of the contributions for domestic partner or domestic partner's child coverage as the Trust, its Program Manager (Advanced Professionals & Vimly Benefit Solutions), and its Billing and Eligibility Administrator (Vimly) cannot provide legal or tax advice.

Eligible Employees and Dependents Age 65 and Older

The Trust is subject to Medicare Secondary Payer rules for the working aged, even for those employers who had fewer than 20 employees in the prior calendar year. The employer must offer its employees, who are age 65 and older (and their spouses and dependents of any age) the same coverage the employer offers to its employees who are under the age of 65. The employer cannot offer any financial incentive or encouragement for the participant to reject the employer's plan and select Medicare coverage. Should an employee with coverage under the Trust choose to enroll in Medicare as well, the Trust will always pay primary and Medicare will pay secondary.

If an employee has Medicare they are eligible for COBRA coverage. If an employee is on COBRA and enrolls in Medicare based on age or disability, then COBRA coverage usually ends on the date of enrollment on Medicare. Please contact Vimly or your COBRA Administrator with questions.

Probationary Period

The probationary period (sometimes referred to as a waiting period) is determined by the employer and is the specific period of time that employees must work for the employer before they become eligible for coverage under the group plan. The period begins on the date the employee is hired or the date the employee entered an eligible class if they did not meet the definition of an eligible employee when they were hired. The probationary period may be 0, 30, or 60 days long. Probationary periods MAY NEVER be waived for individual employees. Employees who are rehired within 90 days of termination will not have to re-satisfy their probationary period.

Effective Date of Coverage

An employee's effective date of coverage is the first day of the month following or coinciding with the end of the probationary period. For example, if an employee was hired on January 1, 2014 and the group had a 30-day probationary period, the effective date would be February 1st. If the same employee were hired January 8, 2014, the probationary period would end February 6th and the employee's effective date would be March 1st. If an employee's probationary period ends on the 1st of the month, that will be the effective date.

REQUIRED ELIGIBILITY CHANGE NOTIFICATION

It is the participating employer's responsibility to report eligibility changes to Vimly within the timelines stated above, in the benefit booklet and in this guide, using one of the following methods:

- ❑ SIMON, Vimly's online enrollment tool
- ❑ The billing statement
- ❑ A written or emailed request from the employer

If the change is not reflected in the billing statement following the request, please provide the written documentation previously submitted as an audit trail of the specific instructions that Vimly was requested to follow on the employer's behalf. Eligibility changes cannot be accepted via phone.

If Vimly is not notified of eligibility changes in the manner stated above, retroactive additions, termination, or other change may not be acceptable to the Trust unless there is sufficient documentation to justify such actions. Such requests must be reviewed by the Trust, and if the Trust deems them to be justified, retroactive adjustments are limited to a maximum of 60 days. Any adjustments beyond 60 days that are recommended by the Trust must then go to the carrier for underwriting audit and approval. It is the participating employer's responsibility to reconcile its premium billings every month and immediately notify Vimly to resolve any issues. Late receipt of enrollment applications may result in postponement of coverage until the next open or special enrollment period as described in the benefit booklet.

Enrollment

Enrolling Employees and Dependents

The employer can enroll employees and/or dependents one of two ways:

- ❑ Through SIMON*, Vimly's online enrollment tool; or
- ❑ By submitting a signed copy of the current Trust Enrollment/Change Form to Vimly via mail, email, or fax.

*Employers using online enrollment must still require and maintain enrollment forms to be completed and signed by all employees in the event of a Trust audit or the need for beneficiary designation information.

Employee and Dependent Coverage Enrollment Rules

The chart below describes the employee and dependent coverage enrollment rules. Groups must satisfy the carrier minimum participation rules.

Coverage	Carrier	Employee Rule	Dependent Rule
Medical	Premera Blue Cross	Employees may waive coverage if Employer contributions are less than 100%. If the Employer contribution is 100%, no employees are allowed to waive coverage.	Dependents may waive coverage if Employer contributions are less than 100%. If the Employer contribution is 100%, no dependents are allowed to waive coverage.
Dental	Premera Blue Cross	Employees may waive coverage if Employer contributions are less than 100%. If the Employer contribution is 100%, no employees are allowed to waive coverage. Dental coverage must match Medical, if offered.	Dependents may waive coverage if Employer contributions are less than 100%. If the Employer contribution is 100%, no employees are allowed to waive coverage. Dental coverage must match Medical, if offered.
Vision	Vision Service Plan	If the group offers it, ALL employees must enroll	Dependents may not waive if enrolled in medical or dental.
Basic Life / AD&D	USAble	Required benefit with Premera medical and/or dental.	N/A
Employee Assistance Program (EAP)	Vivacity	If the group offers it, ALL employees must enroll	N/A
Supplemental Life & AD&D	USAble	Voluntary	N/A
Dependent Life	USAble	N/A	Voluntary

Enrollment/Change Form

To become covered under this plan, employees must first complete a current Trust enrollment form for themselves and include each family member they wish to cover. A copy of the form can be found in the Form Library which is located at www.wahit.com, via SIMON, or the form may be emailed to the Vimly WAHIT Team at wahit@vimly.com.

Upon receipt and acceptance of a timely submitted enrollment form, coverage will begin for employees on the first day of the month following or coinciding with the date the probationary period ends. The completed enrollment form must be submitted to Vimly within **60 days** from the date a new employee becomes eligible for coverage. Coverage for eligible dependents who are included on the employee's enrollment form begins on the employee's effective date.

If the employee or their dependent does not enroll for coverage when initially eligible, coverage will not be available until the next open enrollment period, except when required by court order or special enrollment provisions.

Enrollment will only be accepted for effective dates as of the current or immediately preceding month.

Employers must maintain a signed copy of the Enrollment/Change Form in their records, even if they process the enrollment through SIMON in the event of a Trust audit or the need for beneficiary designation information.

Completing the Enrollment Form for a New Employee

Employers must make sure the enrollment forms are completed accurately and legibly. Errors, ambiguities, and illegible information will require research and will delay employee eligibility. Forms with missing information (such as signature, birth date, date of hire, enrollment reason, etc.) will not be processed. It is the employer's responsibility that the employee plan selections adhere to the rules of the Trust.

- ❑ Write the company name in the "Employer Name" box
- ❑ Write the effective date of the enrollment being requested in the" Effective Date" box
- ❑ Write the date of the employee's hire in the "Date of Hire" box
- ❑ Check the appropriate box in the "Event Description" section
- ❑ Enter the employee's information, including name, date of birth, gender, Social Security Number, mailing address, and phone number in the "Employee Information" section. Annual salary and class need to be completed only if applicable.
- ❑ Complete the "Dependent Information" section, if applicable. Include full name, date of birth, gender and social security number.
- ❑ Check the appropriate coverage boxes in the "Plan Selection" section on the second page. If you are unsure of your coverage, consult your Group Master Application or Producer.
- ❑ Complete the "Beneficiary Information" section.
- ❑ On the signature page, the employee **must** sign and date the left box. Forms without a signature will be returned and delay employee eligibility.
- ❑ On the signature page, the group administrator must sign and date the right box and check the appropriate boxes in the section "For Employer Use Only"

Completing the Form for a New Dependent

- ❑ Write the company name in the "Employer Name" box
- ❑ Write the effective date of the enrollment being requested in the" Effective Date" box

- ❑ Indicate the qualifying event in the "Event Description" section
- ❑ Enter the employee's information in the "Employee Information" section
- ❑ Enter the dependent's information in the "Dependent Information" section
- ❑ If the employee is enrolling a newborn and they don't have a Social Security Number (SSN) yet, the enrollment can be sent in without the SSN. When one is assigned, notify Vimly so it can be added to the file.
- ❑ If the employee is enrolling a new domestic partner, a signed affidavit is also required
- ❑ Circle "add" next to the dependent's name
- ❑ In the "Plan Selection" section, indicate the coverage the dependent is being enrolled in.
- ❑ On the signature page, the employee must sign and date the left box and the group administrator must sign and date the right box

Carrier ID Cards

Medical and/or Dental ID Cards

Premera Blue Cross will issue ID cards and generally take 10-12 business days for cards to arrive once the carrier has received the enrollment. Replacement ID cards can be ordered directly from the carrier by calling their customer service phone number or visiting the carrier's website and registering. However, if a new ID card is needed due to a name or address change, the ID card request (along with the updated name/address information) MUST be processed through Vimly at wahit@vimly.com.

If an eligible employee needs services prior to receiving their ID cards and providing it is a covered treatment or service, the employee or their provider may contact the carrier's Customer Service directly to obtain the employee's ID number and confirm benefits. If the eligible employee needs a prescription and providing it is a covered drug and treatment, the employee has the option of paying for the medication and submitting the paperwork to the carrier for reimbursement.

Please note: Vimly does not have access to individual id numbers with the Premera. Enrollees must contact Premera Customer Service directly to obtain this number.

Vision ID Cards

VSP does not issue individual ID cards. VSP members and their covered dependents simply provide the last 4 digits of the member's SSN and complete name to a VSP Provider to access

Special Enrollment

An employee and/or their dependent may be able to enroll outside of the annual open enrollment period if they experience one of the following special enrollment events. Employees can then enroll themselves (if not previously enrolled), and their dependents, as applicable, in available coverage.

Involuntary Loss of Coverage

If an employee declines enrollment for themselves or their dependents when initially eligible due to having other coverage, and they then lose that coverage, they may be eligible to enroll in this plan provided that they submit an Enrollment/Change Form within 60 days of the date of loss of coverage. Loss of other coverage may include exhaustion of COBRA continuation coverage, loss of coverage due to divorce, legal separation, termination of employment, reduction of hours, or loss of an employer's contribution toward the coverage. Coverage will be effective the 1st of the month following the date the other coverage was lost. If application is not made within 60 days, the employee and/or dependent(s) must wait until the next open enrollment period to enroll.

New Dependent Due to Marriage, Birth, or Adoption

If the employee has new dependents as a result of marriage, birth, adoption, or placement for adoption, they may be eligible to enroll themselves and/or their dependents, as applicable, provided that they submit an Enrollment/Change Form within 60 days after the marriage, birth, adoption, or placement for adoption. Coverage will be effective the 1st of the month following timely receipt of application due to marriage. Coverage will be effective as of the date of birth, date of adoption, or date the child was placed with the employee for adoption due to birth or adoption/placement for adoption. If application is not made within 60 days, the employee and/or dependent(s) must wait until the next open enrollment period to enroll.

Automatic Newborn Coverage: A newborn child will automatically be provided coverage available under the plan for routine care, illness, accidental injury, or physical disability, including congenital anomalies, for up to 21 days following the birth when the employee or the employee's spouse is eligible for maternity benefits under this plan.

State Medical Assistance and Children's Health Insurance Program

If the employee and/or dependent(s) qualify for premium assistance through the state's medical assistance program or Children's Health Insurance Program (CHIP), or they no longer qualify for health coverage under the state's medical assistance program or CHIP, they may be able to enroll themselves and/or their dependents, provided they submit an Enrollment/Change Form within 60 days from the date they qualify for premium assistance or no longer qualify for health coverage under the state's medical assistance program or CHIP. Coverage will be effective 1st of the month following application. If application is not made within 60 days, the employee and/or dependent(s) must wait until the next open enrollment period to enroll.

Coverage Termination

Coverage will end without notice on the last day of the month for which premiums have been paid and in which one (1) of the events listed below for employees and/or dependents occur. For complete details about coverage termination, please refer to the appropriate benefit booklet.

Please note Basic Life insurance, Voluntary Life insurance and Long Term Disability coverage ends on the day employment ends.

Employee and Dependent Termination of Coverage

Coverage will end for the employee and dependents when ANY of the following occur:

- ❑ The contract between the Trust and the insurance carrier is terminated
- ❑ The next monthly premium is not paid when due or within the grace period
- ❑ The employee dies or is otherwise no longer eligible as an employee (for example, the employee's employment terminates)
- ❑ The participating employer ceases to meet the Trust's continued participation requirements
- ❑ The participating employer notifies the Trust that it no longer wishes to participate in the Program. Such notice must be received prior to the next premium due date, otherwise the participating employer will be charged for an additional month's premium.

Dependent Spouse / Children Termination of Coverage

Coverage will end for a spouse and/or dependent(s) when ANY of the following occur:

- ❑ The spouse legally separates or divorces from the employee, or the marriage is annulled
- ❑ The domestic partner's relationship with the employee ends
- ❑ The child no longer meets the requirements for dependent coverage.

Limitation of Retroactive Terminations

0 – 30 Days from the Requested Coverage Termination Date

Employers may request to terminate members' coverage retroactively if the request is received within 30 days from the requested date of coverage termination.

30 – 60 Days from the Requested Coverage Termination Date

Retroactive terminations received between 30 -60 days from the requested date of termination of the employee and/or dependent coverage will be considered only if all of the following ACA conditions are met:

- ❑ Premium has not been paid by the employee/dependent for coverage after the requested effective date of termination of coverage;
- ❑ There was no expectation of coverage by the employee/dependent after the requested effective date of termination of coverage;
- ❑ The group health plan only covers those who are considered either active or COBRA employees.

If you fail to provide proof that the above three conditions are not satisfied, member coverage termination will only be approved for the last day of the month the request is received. No retroactive termination will be allowed.

Over 60 Days from the Requested Coverage Termination Date

Any requests received to terminate coverage over 60 days from the requested date of coverage termination will not be allowed. Instead, the coverage will be terminated at the end of the month in which the request is received.

Important Consideration

COBRA law requires that the Employer notify the administrator within 30 days of an employee's COBRA qualifying event. Therefore, should you submit a termination request that is more than 30 days after the coverage termination date, you may possibly jeopardize the COBRA rights of your employee and/or their dependent.

It is the responsibility of the employee to promptly notify their employer when an enrolled dependent is no longer eligible to be covered as a dependent under the Trust. The employer must then notify Vimly as soon as possible, but no later than 30 days from the date the participating employer was notified of such event.

How to Terminate Coverage

An employer can terminate coverage for an employee and/or their enrolled dependents through one of the following ways. Please be sure to indicate the reason for termination, last day worked, and confirm the employee's address.

- ❑ SIMON, Vimly's online enrollment tool.
- ❑ Send an email to Vimly at wahit@vimly.com.
- ❑ Mail or fax a letter on the company's letterhead to Vimly.
- ❑ Make a notation on the monthly Trust invoice and return the invoice with your payment. The notation must include the reason for termination and termination date.
- ❑ Dependents Only: In addition to the ways listed above, a dependent's coverage may also be terminated by submitting a completed Trust Enrollment/Change Form. The form should be completed as follows:
  - Enter the date coverage should terminate in the "Effective Date" box
  - Choose "Other" and write in the event in the "Event Description" section (i.e. divorce, other coverage, etc.)
  - Enter the employee's information
  - Enter the dependent's information, circling "Delete" next to the dependent name
  - On the signature page, have the employee sign and date the left box and the group administrator sign and date the right box.

Please note that if an employee terminates coverage for a dependent, they cannot re-enroll them in coverage until the next open enrollment period unless a special enrollment qualifying event occurs.

Rehire Policy

If an employee is laid off or terminated from employment and then rehired within three months of the date the employee's coverage ended, then the employee will have the option of enrolling on plan effective the first of the month following or coinciding with his/her date of rehire. The employee will not be required to satisfy another probationary period. Employers may not choose to apply a probationary period – this is mandatory for all employer groups. This policy applies only to employees with active coverage in place prior to the termination of employment or layoff. Partial probationary period accrued

prior to a rehired date will not be credited. This policy does not apply to employees who lose coverage due to a reduction of hours.

The eligible rehired employee will have 30 days from the date of rehire to submit a new Enrollment/Change Form for coverage. The rehire policy does not create an open enrollment or special enrollment for adding dependents that may have not been on the coverage before.

Leave of Absence

Coverage for an employee and enrolled dependent(s) may be continued for up to 90 days when the employer grants the employee a leave of absence and full premium continue to be paid. The employer must notify Vimly of the date the employee leave of absence begins. The 90-day leave of absence period counts toward the maximum non-COBRA continuation of coverage (COC) and the maximum COBRA continuation period, except as prohibited under the FMLA (Family and Medical Leave Act of 1993). If coverage is terminated during a leave of absence, the employee will have to wait until Open Enrollment to enroll again unless COC or COBRA continuation is elected (subject to the employee's eligibility for continuation of coverage) and there is no break in coverage as of the date the employee returns to active work. If an employee is terminated from employment during the leave of absence and COC or COBRA is elected, the continuation of coverage begins on the date the employee began the leave of absence. If an employee is subsequently rehired, the Rehire Policy above applies.

COBRA (for employers with 20 or more employees)

Please note: The information below is for informational purposes related to WAHIT, and is not legal advice. For questions regarding compliance and issues and legal advice, please consult your professional benefits advisor and/or legal counsel.

COBRA is a Federal law that provides for self-pay continuation of group health plan benefits when certain events occur that cause coverage under a group health plan to cease. COBRA requires that if a covered employee or other "qualified beneficiary" loses group health plan coverage due to termination of employment or any one of several other specified events, then the plan administrator must offer the employee or other "qualified beneficiary" the opportunity to elect COBRA continuation of coverage.

COBRA generally applies to group health plans maintained by employers that employ at least 20 full-time equivalent employees on more than 50 percent of its typical business days in the previous calendar year. The employer is the legal plan sponsor and must determine whether COBRA applies to its group health plan. It is recommended that employers seek legal advice when making this determination.

It is the employer's legal responsibility to process the termination within 30 days from the date an employee or dependent experiences a COBRA qualifying event. Neither the Trust nor Vimly will be held liable for an employer's failure to provide accurate and timely notification of COBRA qualifying events.

COBRA qualifying events include:

- ❑ Termination of employment (for any reason other than gross misconduct)
- ❑ Reduction in hours (falling below the minimum required hours worked for coverage)
- ❑ Employee death
- ❑ Loss of dependent status (reaching age 26 for children)
- ❑ Divorce or legal separation

All COBRA coverage is subject to changes available during open enrollment, including the employer's change of medical, dental, or vision coverage. Moreover, COBRA coverage terminates when the employer coverage terminates with the Trust.

COBRA Administration by VIMLY

The Trust benefits administrator, Vimly, can provide COBRA administration for medical, dental, vision, and EAP products offered through the Trust for no fee. Vimly will handle all COBRA administration and notices for the plans that the employer has enrolled in, ensuring compliance with the regulations and guidelines required by COBRA. Please note Vimly cannot offer COBRA administration services for non-Trust plans at this time.

If you would like Vimly to do COBRA administration, a separate Agreement is required. Please contact Vimly's COBRA Department for more information and/or for a copy of the COBRA administration agreement to complete. Employers are cautioned that they must continue administering their COBRA coverage until they receive a copy of the signed and approved Vimly administration agreement with the effective date noted on the first page. Vimly will not assume responsibility for administration until the effective date.

Should an employee or dependent elect COBRA coverage, Vimly will send a monthly billing statement to the COBRA participant and they will remit premiums directly to Vimly. Therefore, the COBRA participants will not appear on the employer's monthly Trust invoice.

Continuation of Coverage (For Employers Not Subject to COBRA)

This section applies only if the participating employer's group health plan IS NOT subject to COBRA.

If an employee or dependent's group health coverage ends, the employee and/or covered dependent may choose to extend their coverage for up to three months via continuation of coverage (COC) if:

- ❑ The participating employer's group health plan is not subject to COBRA;
- ❑ The employee/dependent is not eligible for COBRA coverage; and
- ❑ The group coverage ends for reasons other than rescission.

The employer must notify Vimly of the employee and/or dependent's COC election within 60 days of the date the coverage ended under the group plan. If COC is elected, the participating employer must comply by collecting the applicable premium from the employee and subsequently maintain the employee's name and premium on the employer's billing form for the applicable months. The employer should note a "3" next to the name, per the legend on the billing. Continued coverage may end before the end of the three (3) month period if the premium is not paid when due, or if the employer terminates its participation in the Trust. However, continuation may not exceed a three-month period, and employers may not have internal employer policies that allow for post termination extension of coverage in excess of 3 months.

The employer must include the premium for the employee's continuation coverage as part of the group's premium payment. Employers may not simply forward the employee's personal check to Vimly with the employer's monthly payment. Personal checks are not accepted on group accounts.

Please Note: All available COC coverages are subject to benefit changes that may occur as a result of the employer's change of medical, dental or vision coverage and the employer's termination of coverage.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) provides that covered employers must grant an eligible employee up to a total of 12 work weeks (26 for military caregiver leave described below) of job-protected, unpaid

leave during any 12-month period, or substitute paid leave if the employee has accrued it, for one or more of the following reasons:

- ❑ For the birth and care of the newborn child of the employee
- ❑ For placement with the employee of a child for adoption or foster care
- ❑ To care for an immediate family member (spouse, child, or parent) with a serious health condition
- ❑ To take medical leave when the employee is unable to work because of the employee's serious health condition
- ❑ Any qualifying exigency during a family member's active duty service of the family member being called to active duty in a foreign country
- ❑ Military caregiver leave to care for a qualifying service member who has a serious injury or illness. The employee must be the service member's spouse, sibling, child, parent or next of kin.

All private sector employers with 50 or more employees in 20 or more work weeks in the preceding calendar year are subject to FMLA. FMLA also applies to all public agencies, including state, local and federal employers and local education agencies (e.g., school districts).

An employee is eligible for FMLA if:

- ❑ The employee was employed for at least 12 months with the employer (not necessarily consecutively),
- ❑ The employee worked at least 1,250 hours during the 12-month period before the leave, and
- ❑ The employee must notify his or her employer that FMLA leave is being requested

During FMLA leave, the employer must continue to pay the employee's benefit coverage as if they were still actively working. The employer's obligation to provide health coverage under FMLA ceases if an employee's portion of the premium payment is more than 30 days late, after providing the employee a 15-day written notice.

According to FMLA regulations, if an employer changes the health plan during the employee's leave, the change applies to the employee as if he or she is still working.

Non-FMLA Leave of Absence

Coverage for an employee and enrolled dependent(s) may be continued for up to 90 days when the employer grants the employee a leave of absence and full premium rates continue to be paid. The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited under the FMLA (Family and Medical Leave Act of 1993).

Life Insurance Conversion

The group life insurance conversion privilege is explained in the USAble Summary Plan Description. Employers have an obligation to make employees aware of the life insurance conversion privilege at the time of termination. Employees have 31 days from the date of termination to apply with USAble for an individual life insurance policy without submitting evidence of insurability.

Administrative Review

The Trust has established procedures for employers, members, and their dependent(s) to request a review of non-claim decisions affecting their coverage. If the request for review involves eligibility, enrollment, disenrollment, waiting periods, late payment, reinstatement of delinquent employers, and similar issues concerning the day-to-day administration of the Trust, the employer or their agent/producer should contact Vimly. Requests may not be directly submitted by employees or dependents, but must come

through the employer. Requests for review must be in writing and must be submitted to Vimly within 180 days of the event.

Upon the receipt of a request for review, a review committee will consider the matter and notify the employer and agent/producer in writing of its decision.

Terminating Group Coverage Through the Trust

To terminate participation in the Trust, send a letter on company letterhead to Advanced Professionals & Vimly Benefit Solutions. Please indicate the last day of coverage. Your coverage can only terminate at the end of a coverage month. Mid-month termination dates are not allowed. After your plan has been cancelled you will be provided with a final billing that will outline any additional funds needed for adjustments prior to the plan termination, or with a refund check for any overpayments made prior to plan termination.

SIMON

What is SIMON?

SIMON is a cloud-based platform that supports online enrollment, employee communication, and benefits education, that may be accessed at any time.

SIMON was designed to help our clients meet their goals. Whether they want to increase participation, simplify enrollment, improve employee communication or support defined contribution plans, SIMON provides a better way to provide a comprehensive program while engaging and educating employees.

What Can an Employer Do Using SIMON?

Using SIMON, employers can centrally administer and manage their employee benefits programs, including being able to:

- ❑ Enroll new employees
- ❑ View benefits data for an existing employee
- ❑ Add or change benefits for an existing employee or dependent
- ❑ Add dependents for an existing employee
- ❑ Change demographic data for an existing employee
- ❑ View and/or print benefits-related forms and documents
- ❑ Use SIMON Tiles to access important websites and view important messages
- ❑ View and pay invoices
- ❑ Generate reports

Registering for SIMON

Access to SIMON requires the employer and their designated employees or contractors to register. The employer must agree to provide Vimly with accurate, complete registration information and it is their responsibility to inform Vimly of any changes to that information.

Vimly will send an email inviting the Group Master Application Signer and/or to the person designated to register. Each registration is for a single person only. Vimly does not permit a) any other person using the registered sections under your name; or b) access through a single name being made available to multiple users on a network. The employer is responsible for preventing such unauthorized use and any unauthorized use must be reported to Vimly immediately. Vimly reserves the right to terminate SIMON access if Vimly determines these rules are not being followed.

Please contact Vimly at wahit@vimly.com to request a registration invite.

Accessing SIMON

Employers can access SIMON by going to https://www.simon365.com.

Billing and Payments

Employer groups are billed the second week of the month prior to the month of coverage, and payment is due on or before the 1st day of the month of coverage. Please pay as invoiced. Credits or charges for enrollment changes that were received after the monthly cutoff period will be reflected on the following month's invoice. Premiums that are not paid as billed may result in a delay of claim processing resulting in pended coverage.

If you feel that your billed amount is incorrect, please contact Vimly. They will review your account with you and ensure that any issues are resolved promptly.

The first page of the billing statement is used for reconciliation purposes and shows the billed amount for the previous month, prior period coverage adjustments, and payments received. If there is an unpaid balance or credit on the account, it will also be shown on this page. Subsequent pages of the billing statement list the current month's billing detail of employees and corresponding premiums.

Employers are required to audit the billing statement each month to ensure that any changes that have been submitted to Vimly in a timely manner prior to the monthly cutoff are reflected on the bill. Eligibility errors that persist due to the failure of the employer to audit the billing statement and notify Vimly immediately upon discovery may not be corrected retroactively.

Billing Time Frames & Delinquency Policy

It is the Trust's policy to receive premium payments by the coverage effective date. This document outlines the billing time frames and the subsequent delinquency policy if payment is received outside of the timelines.

Groups may be terminated for non-payment as per the delinquency policy. Checks returned for Non-Sufficient Funds (NSF), Account Closure, or Stopped Payment will not be considered as having been paid in terms of the delinquency timeline. If any of these events occur, the group may be required to provide a Cashier's Check for future payment or may be required to provide proof that the business is still active. If payment is not received by the due date, the group's coverage will be suspended until received. If payment is not received by the end of the coverage month, coverage will be terminated retroactively to the last month in which payment was made in full.

If payment has not been received by the 10th day of the coverage month, the group will be sent a delinquency email requesting payment. If payment has not been received by the end of the coverage month, a letter will be sent to the group notifying them of the cancellation of their coverage through the Trust.

If a group is terminated for non-payment, they have one reinstatement opportunity, which must occur within 60 days of the last month in which payment was made in full. Reinstatement will be at the discretion of the insurers and must be requested in writing and submitted to Vimly. If the group is not reinstated, they cannot reapply for coverage through the Trust for 12 months.

Late Fee Policy

The Trust imposes a late fee for premiums remitted after the 10th of the coverage month. The late fee will be the greater of 1.5% of the unpaid balance or $20.

Late fees are assessed each month. If a group's balance is past due, the late fee will be charged for each period in which the invoice was outstanding. If a late fee is assessed on an invoice and the premium is remitted without the late fee, payment may be returned due to not paying as billed.

Example of Billing and Delinquency Time Frames for May Invoice

April 12	May invoice is calculated and mailed
May 1	Payment is due
May 10	The group is considered delinquent if the May premium is not received and they will be assessed a late fee. A delinquency email requesting payment of all past due premiums to be remitted. The group's producer is included on this communication.
May 12	Vimly calculates the June invoice. If the May premium was not received by May 10h, the June invoice will reflect the unpaid balance and any assessed late fees.
May 31	If payment has not been received, a letter advising that coverage has been retroactively terminated is sent to group, producer, program manager, and all applicable carriers

Employers who collect employee contributions for employee or dependent coverage and do not promptly pay those premiums towards coverage may be in violation of ERISA and subject to penalties. The timeliness of payments may also affect COBRA coverage if you are responsible for forwarding COBRA premium on the COBRA participant's behalf. COBRA coverage is dependent upon the participant being in good standing with their coverage premiums. If either situation applies to your group, please contact your legal advisor for more information. The Trust, Advanced Professionals & Vimly Benefit Solutions, and Vimly are not tax or legal consultants and cannot provide further information on your responsibilities.

How to Make Payments

Payments may be made via any of the following methods:

- ❑ ACH - through SIMON, Vimly's online enrollment tool
- ❑ Company Check – Remit a check that reflects the company name and is payable to Washington Alliance for Healthcare Insurance Trust (or WAHIT). The employer should list their Trust account number on the check.
- ❑ Check by Fax/Email – A $15 fee is assessed for each payment processed. To utilize this method, two checks will need to be sent to Vimly by fax or email: 1) Company check payable to WAHIT for the invoiced amount, and 2) Company check payable to Vimly for $15.

Billing FAQs

I know my payment is going to be late. Who do I call?

If your payment will be late, contact Vimly. Please be aware that a late payment may result in your coverage being suspended until payment is received. Late fees may still apply.

I sent in a change and it is not reflected on my invoice. Why?

Changes for the month being billed may not be reflected on the bill if the changes were received by Vimly after the invoices are run. For example, if a dependent termination notice was received on March 15th, the April bill would already have been generated and the change would not be reflected until the May invoice. Retroactive charges and credits for enrollments and terminations will be reflected on the following month's invoice.

When do I need to submit changes to ensure that they are on my next invoice?

Please submit enrollment changes as soon as possible. Generally, changes received by Vimly by the 10th of the prior month will be reflected on the next month's invoice.

I have a new employee that should have coverage this month but I have already paid this month's bill. What should I do? What is the effect on the employee's coverage?

Please send the completed enrollment forms to Vimly and pay as billed. Although adjustments will be reflected on the next invoice, the employee's coverage will be processed for submission to the appropriate carriers within two business days.

I believe my invoice is incorrect. What should I do?

If you believe the rates are incorrect or you are owed a credit that is not reflected, please contact Vimly to discuss. Please do not make adjustments to your payment without first contacting Vimly. Incorrect or unexplained adjustments could result in a delay processing your payment and the pending of your coverage. Checks remitted for amounts that differ from the billed invoice may be returned.

If there are additions or deletions that have been submitted to Vimly and are not yet reflected on your bill, please remember that bills are prepared approximately 3 weeks in advance of the coverage month, and a change that was not received by the 10th of the prior month will not be reflected on the next month's invoice (that is, for a change to be reflected on the May invoice, Vimly must receive notification no later than April 10th).

I have been told my coverage is "suspended." What does that mean?

This usually means payment has not been received by the due date and that the carrier is pending payment of claims until premium is received for the coverage month. Suspended coverage is not cancelled, but it delays payment of claims until payment is received and accepted. If claims have been pended and you believe your premium payments are current, please contact Vimly to verify that all payments have been received.

What do I do if I did not receive an invoice this month?

Please contact Vimly to request that an invoice be re-sent to you. You may also sign into SIMON to access your current invoice.

How do I change the billing/administrative contact or address for the group?

Please send Vimly notification in writing of the new administrative contact or address for the group. An email is sufficient.

What is my balance forward? I thought I paid my bill last month. Why is it showing up?

If your payment was received after the 10th of the prior month, it is possible your next invoice will show a balance forward. If you have specific questions about a balance forward, please contact Vimly.

How is the money I remit going to be applied? Will I be notified?

Each payment is applied to the earliest outstanding month. If you remit payment for your November invoice but have not paid for October, payment will be applied to October premiums.

How do I request a billing adjustment?

Please pay as billed. Submit enrollment changes and any billing adjustments you feel are necessary to Vimly for adjustment on a future invoice.

What is a retroactive adjustment?

It is an adjustment applied to an invoice for past premiums that should be credited or charged. For example, if an employee was added effective January 1st and Vimly received the enrollment form January 14th, the employee would not be added to the invoice until March. On that invoice, there would be an adjustment charge for the January and February premiums in addition to the March premium. Please pay as billed and allow Vimly to make premium adjustments for you.

Miscellaneous FAQs

General

What is a Group Master Application?

This is the agreement the employer signs during the renewal or open enrollment process. It indicates the plan selected as well as the employer's policies such as probationary periods, part-time to full-time transfer, and required hours. If you do not have a copy of your Group Master Application, please contact your producer.

What is my Vimly account number?

This number is assigned to you by Vimly. If you do not know your Vimly account number, please check your most recent billing statement. Vimly account number may also be referred to as Vimly locator number.

What is my group number?

This is a number assigned to you by the insurer to identify your company. Medical and dental group numbers are eight digits for Premera Blue Cross and are on your ID card. If you are unsure of your group number, feel free to contact Vimly and they will be happy to provide that information to you.

What is a hire date?

This is the first day that an employee actually worked for your company, not the date of a job offer.

What is open enrollment?

Open enrollment is the month prior to the employer's annual plan renewal. During this period, employees may add and drop coverage and/or dependents with no other qualifying event or make coverage changes as allowed by the employer. Employers may also change the coverage that is offered. To confirm your renewal month, check your Group Master Application or ask your producer.

How do I change a name or address?

Send an email or fax to Vimly that includes the current information and, in the case of a name change, the previous name. Vimly will update the information and advise the carriers. In the case of a name change, the medical carrier will issue a new ID card.

Where do I find enrollment forms, benefit summaries, and other plan information and forms?

Those documents can be found on the Trust's website, www.wahit.com or through SIMON. If you have any additional questions about your coverage, please contact the carrier or your producer.

How do I pay for my former employee's coverage per a severance agreement we have in place?

An employer may pay for their former employee's coverage due to a severance agreement. However, the terminated employee is not considered an eligible employee under the rules of the Trust and therefore cannot be left on active coverage. The former employee must be terminated from active coverage and the employer can pay for the former employee's COBRA or Continuation of Coverage (COC), as appropriate, coverage when elected. Please contact Vimly's COBRA Department for additional information on how to administer this.

Incomplete Forms

Will I be notified if I send in an incomplete form?

Yes. Vimly will attempt to contact you and/or your producer if there is a problem with an enrollment form. If Vimly is unable to contact you, the incomplete form will be returned with a letter explaining why the form could not be processed.

What are some common problems with enrollment forms?

- ❑ *Effective date:* Please consult the "Employee and Dependent Eligibility" and "Enrollment" sections for information on effective dates. If you have questions about your probationary period or what the effective date should be for an employee, Vimly will be happy to help you.
- ❑ *Illegible handwriting:* If handwriting is hard to decipher, it is likely an error may be made when enrolling an employee that will cause coverage problems later. Please ensure all forms are completed legibly or typed.
- ❑ *Mailing address:* Employees should include their street address, city, state, and zip code in the "Employee Information" section. Frequently employees write their street address but neglect to include a city, state, or zip code.
- ❑ *Signature:* Both the employee and employer must sign the enrollment form.
- ❑ *Outdated Forms:* Be sure to check the Trust's website for the most up-to-date forms. Forms are located in the Forms Library in the "Employers" section of the website: www.WAHIT.com.
- ❑ *"For Employer Use Only" section:* Please make sure that you check the appropriate plans the employee has elected. This is especially important when dual choice is offered within a carrier.

Who Do I Call About…?

My renewal?

Specific questions about your renewal, including definition of terms and the differences between options should be directed to your producer. Renewal information is provided by Advanced Professionals & Vimly Benefit Solutions directly to your producer. If you believe you should have received renewal paperwork and have not yet received it, please contact your producer immediately.

Clarification on what benefits the plan covers?

For information relating to what types of services are covered, refer to the plan booklet, contact the carrier's customer service, or contact your producer.

Claims?

Questions about claims should be directed to the carrier's customer service. Please note that neither Vimly nor Advanced Professionals & Vimly Benefit Solutions pay claims nor do they have any information about pending, denied, or approved claims.

Credit for a deductible paid to prior provider?

This question would be directed to the carrier's customer service.