OLYMPIC BENEFITS TRUST

KAISER PERMANENTE® Ameritas fulfilling life vsp VISION DELTA DENTAL® Delta Dental of Washington

2025 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 _____E-mail Address_____

Member of: Thurston County Chamber of Commerce or ☐ In Area Member ☐ Out of Area Member

Member Since:____/____/____ ☐ New Group or ☐ Renewal

Notes:

2. PLAN SELECTIONS

KAISER PERMANENTE SELECTED MEDICAL PLAN(S):

- ❑ Access PPO $1000 Deductible
- ❑ Access PPO $2000 Deductible
- ❑ Access PPO $2500 Deductible
- ❑ Access PPO $3000 Deductible
- ❑ Access PPO $5000 Deductible
- ❑ Access PPO HSA $2500 Deductible
- ❑ Access PPO HSA $6000 Deductible - Embedded
- ❑ Core HMO $2000 Deductible
- ❑ Core HMO $3000 Deductible
- ❑ Core HMO $5000 Deductible
- ❑ Core HMO 3/9
- ❑ Virtual Plus $2000 Deductible
- ❑ Virtual Plus $3000 Deductible

SELECTED DENTAL PLAN(S):

- ❑ Ameritas Plan 1 - (MAC) NO Ortho
- ❑ Ameritas Plan 1 - (MAC)
- ❑ Ameritas Plan 2 - $1,000 NO Ortho
- ❑ Ameritas Plan 2 - $1,000
- ❑ Ameritas Plan 3 - $1,500 NO Ortho
- ❑ Ameritas Plan 3 - $1,500
- ❑ Ameritas Plan 4 - $2,000 NO Ortho
- ❑ Ameritas Plan 4 - $2,000
- ❑ Delta Dental of Washington Plan B
- ❑ Delta Dental of Washington Plan D
- ❑ Delta Dental of Washington Plan E
- ❑ Delta Dental of Washington Optional Orthodontia Rider #1
- ❑ Delta Dental of Washington Optional Orthodontia Rider #2

SELECTED VERDE TPA PLAN(S):

- ☒ COBRA Administration (Required)

The trust is not only COBRA eligible, it needs to be COBRA compliant. COBRA Administration is mandatory.

Optional TPA Services

- ❑ Flexible Savings Account (FSA) Administration
- ❑ Dependent Daycare Account Administration
- ❑ Health Reimbursement Account (HRA) Administration

SELECTED VISION PLAN(S):

- ❑ Ameritas Plan 1- EM $10/$10 $150
- ❑ Ameritas Plan 2 - EM $10/$25 $150
- ❑ Ameritas Plan 3 - EM $20/$20 $150
- ❑ Ameritas Plan 4 - EM $10/$10 $180
- ❑ Ameritas Plan 5 - EM $10/$25 $180
- ❑ Ameritas Plan 6 - EM $20/$20 $180
- ❑ Ameritas Plan 1 - VSP $10/$10 $150
- ❑ Ameritas Plan 2 - VSP $10/$25 $150
- ❑ Ameritas Plan 3 - VSP $20/$20 $150
- ❑ Ameritas Plan 4 - VSP $10/$10 $180
- ❑ Ameritas Plan 5 - VSP $10/$25 $180
- ❑ Ameritas Plan 6 - VSP $20/$20 $180
- ❑ VSP Vision Plan A
- ❑ VSP Vision Plan B
- ❑ VSP Vision Plan C

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. OBT 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

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

3A. Total Full Time Eligible Employees _____

3C. How many qualified waivers? _____

3D. How many non qualified waivers? _____

3B. Total Enrolling = _____

Valid Waivers:

Spousal/parental group coverage, Medicare/Medicaid, Champus/ChampVA/military coverage, Military coverage

Retiree coverage, COBRA from previous employer, Tri-Care

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)

Kaiser: 75% must enroll (less valid waivers)

Delta Dental of Washington: 2-4 All Must Enroll, 5+ 100% (less valid waivers) **VSP Vision: 100% must enroll or match dental/medical enrollment**

Ameritas Dental: 2-4 All Must Enroll, 5+ 75% (less valid waivers) **Ameritas Vision: 100% must enroll or match dental/medical enrollment**

4. EMPLOYEE CONTRIBUTIONS

The minimum employer contribution percentage to participate in the Trust is 75% 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 be a minimum of 30hrs)

- ❑ 1st of the Month Following Date of Hire
- ❑ 1st of the Month Following 30 Days
- ❑ 1st of the Month Following 60 Days
- ❑ 90 Days

Class II:_____ Eligible employees must be working_____hours per week.
(must be a minimum of 30hrs)

- ❑ 1st of the Month Following Date of Hire
- ❑ 1st of the Month Following 30 Days
- ❑ 1st of the Month Following 60 Days
- ❑ 90 Days

Class III:_____ Eligible employees must be working_____hours per week.
(must be a minimum of 30hrs)

- ❑ 1st of the Month Following Date of Hire
- ❑ 1st of the Month Following 30 Days
- ❑ 1st of the Month Following 60 Days
- ❑ 90 Days

6. EMPLOYEE PROBATIONARY PERIOD

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

**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. Prior Carrier Information

Medical Carrier Name_____ Start Date:_____ End Date:_____

Dental Carrier Name_____ Start Date:_____ End Date:_____

8. 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 Olympic Benefits 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 Olympic Benefits Trust.

If section 9 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) acknowledgment 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

9. INSURANCE PRODUCER INFORMATION - MUST BE AUTHORIZED BY OBT

Name of Agency_____

Name of Producer_____

Address_____

City_____ State_____ Zip_____

NPN: _____ Tax ID _____

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. **Please provide a copy of your WA state producer license as well as proof of E&O insurance and appointment with all necessary carriers.**

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

RATES Please do not add lines of coverage together TO BE COMPLETED BY TBS

RL:

	Carrier*	EE	EE/SP	EE/Children	EE/Family
Medical Plan 1					
Medical Plan 2					
Medical Plan 3					
Dental Plan					
Ortho Plan					
Vision Plan					

*DD - Delta Dental of Washington 400 Fairview Ave N, Seattle, Washington 98109-5371
*AD - Ameritas Dental 5900 O Street, Lincoln, NE 68501
*AV - Ameritas Vision 5900 O Street, Lincoln, NE 68501
*VSP - VSP Direct 3333 Quality Drive, Rancho Cordova, CA 95670