AWC Employee Benefit Trust

Employer Master Participation Agreement

The AWC Employee Benefit Trust is a plan sponsor for health coverage through the following insurance carriers:

Medical			Dental		Vision	EAP	Life & LTD
Regence	ASURIS NORTHWEST HEALTH	KAISER PERMANENTE	DELTA DENTAL Delta Dental of Washington	Willamette Dental Group	vsp vision care	ComPsych	TheStandard
1111 Lake Washington Blvd N. Suite 900 Renton, WA 98057	528 E Spokane Falls Blvd, Suite 301 Spokane, WA 99202	2715 Naches Ave. SW Renton, WA 98057	400 Fairview Ave N Seattle, WA 98109-5371	Willamette Dental of Washington, Inc. 6950 NE Campus Way Hillsboro, OR 97124	3333 Quality Drive Rancho Cordova, CA 95670	NBC Tower 455 N. Cityfront Plaza Drive Chicago, IL 60611-5322	Standard Insurance Company 1100 SW 6th Ave Portland, OR 97204

Date form completed

Effective date

If you are making a change, describe it here:

Employer demographic information

Employer proper name

Pseudonyms/DBA/non-technical employer name/short name

Physical address

Mailing address (if different)

Phone number

Tax ID

Contact/form completed by:

Name	Title	Phone number	Email

Employer policies

Coverage start date, pick one

☐ First day of the month after date of hire.

If the employee's hire date is the first day, or first working day of the month, start the employee's coverage:

☐ The first day of that month

☐ The first of the month following date of hire

☐ Employees are retroactively covered back to the first day of the month in which they are hired.

☐ Employees have a probationary period and then are covered the first of the month following the date probationary period is complete.

How long is the probationary period? _____

Coverage termination date

☐ Yes ☐ No First of the month following date of termination/retirement. If no, explain below:

Varying group policies

☐ Yes ☐ No We have different coverage start and/or termination policies for different groups within our organization. If yes, explain below:

Spouse/Domestic Partners

☐ Yes ☐ No Spouse/Domestic Partners are eligible to be covered on the employer's plan

☐ Yes ☐ No We have a more generous Domestic Partner policy than required by Washington state law (RCW 48.44.900).

☐ Same and opposite gender ☐ Same gender only ☐ Opposite gender only

Number of employees eligible for any employer-sponsored plan

	Full-time employees*	Part-time employees**	Seasonal employees	Elected officials***	LEOFF 1's
Medical					
Dental					
Vision					
Long-term disability					
Life					
EAP					

* The minimum hours for full-time eligibility are: _____

**The minimum hours for part-time eligibility (must be at least 20 hours/week): _____

***Elected officials include ☐ Mayor ☐ Council Other _____

Legal agreements

Changes to the Master Participation Agreement: I understand I may make changes to this document to be effective the first day of any month when adequate notice is provided:

- For addition of plan(s), or a change from one plan to another, an updated copy of the Master Participation Agreement should be sent to the AWC Trust office 45-60 days prior to the desired addition/change effective date.
- For termination of a single line of coverage, an updated copy of the Master Participation Agreement should be sent to the AWC Trust office 60 days prior to the desired termination date.
- **Fees**: Cities, towns and non-city entities must be members of the Association of Washington Cities, paying an annual membership fee. AWC Trust rates and requirements are subject to review and/or change by the AWC Trust Board of Trustees at any time.

Life and long-term disability

- We hereby (1) elect to participate in the group life and/or disability insurance coverage under the Association of Washington Cities Employee Benefit Trust (Trust) group life and disability insurance policies issued by Standard Insurance Company; (2) agree to remit premiums on or before the premium due date; (3) agree to be bound by the coverages available to all present and future eligible employees; (4) agree to make the elected coverage available to all present and future eligible employees.
- We understand that the group insurance policies contain limitations and exclusions not described in this Master Participation Agreement. We understand that Certificates of Insurance giving a complete description of the insurance coverage(s) will be provided. We agree to distribute those certificates to insured participants. We agree not to distribute any other description of the terms of insurance coverage(s) without prior written approval of Standard Insurance Company.
- We understand that no insurance coverage for any participant will be in effect prior to the latest of: (a) requested effective date; (b) approval by Standard Insurance Company; and (c) approval of evidence of insurability, if required.

Employer acknowledgement and signature

The AWC Employee Benefit Trust is maintained and administered in accordance with the Trust Agreement (as amended periodically), the terms of which are incorporated by reference into this Master Participation Agreement. Employers should review the Trust Agreement, including specifically its terms regarding joining, participating, and terminating participation in the Trust. A copy will be is provided to you upon joining the Trust, and an updated copy will be reissued when the Trust Agreement is amended and restated. Additional agreements are outlined within the Interlocal Agreement required by the AWC Trust.

Premium payments are due on or before the 10th of the month in which coverage is active. Payment may be submitted online or by paper check, mailed to the address indicated on your bill.

By signing below, I acknowledge and represent the following on behalf of the employer:

- The employer has received a copy of the Trust Agreement and agrees to abide by all applicable terms and conditions therein.
- The employer provides its answers on this form as part of the procedure required by the Trust to provide or change Trust-sponsored coverage, with the understanding that the Trust relies on this information to ensure compliance with underwriting rules. All information completed on this form is true, correct, and complete.
- The employer is responsible for the accuracy of all employee and dependent enrollment information that the employer submits to the Trust on behalf of its employees, and has received any necessary approvals to submit or make changes to such information on behalf of its employees.
- The employer understands that it is a crime to knowingly provide false, incomplete, or misleading information for the purposes of defrauding the Trust, a health plan, or an insurance company, with penalties including denial of coverage, fines, and/or imprisonment. In addition, the Trust will have the right to collect any claims payments or other damages.

Signature	Printed name
Title	Date

Plan offerings

Complete **one "plan offering" section for each workgroup or bargaining unit** (i.e. public works, police guild, finance, etc.) If all employees are on the same plans – write "all employees."

Name of workgroup/ bargaining unit _____ # employees eligible _____

AWC Trust plan offerings

Part-time staff eligible for: ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ LTD ☐ EAP

Medical # enrolled

You are eligible for plans through either Regence or Asuris, depending on your location. Contact us if you aren't sure which carrier is in your area.

Regence

☐ **Regence BlueShield**
- ☐ AWC HealthFirst® 250
- ☐ AWC HealthFirst® 500
- ☐ High Deductible Health Plan
- ☐ AHN 250
- ☐ Plan A – LEOFF 1 active employees and retirees only
- ☐ Medicare Advantage EGWP – LEOFF 1 retirees only

Asuris Northwest Health

☐ **Asuris Northwest Health**
- ☐ AWC HealthFirst® 250
- ☐ AWC HealthFirst® 500
- ☐ High Deductible Health Plan
- ☐ Plan A – LEOFF 1 active employees and retirees only

Kaiser Permanente

☐ **Kaiser Permanente**
- ☐ Kaiser 200
- ☐ Kaiser 500
- ☐ High Deductible Health Plan
- ☐ Non-copay plan – LEOFF 1 retirees only

☐ **Kaiser Foundation Health Plan of Washington Options, Inc.**
- ☐ Kaiser Access PPO

Dental # enrolled

Delta Dental of Washington

☐ **Delta Dental of Washington**

Dental
- ☐ Plan A
- ☐ Plan B
- ☐ Plan C
- ☐ Plan D
- ☐ Plan E
- ☐ Plan F
- ☐ Plan G
- ☐ Plan J

Orthodontia
- ☐ Plan I
- ☐ Plan II
- ☐ Plan III
- ☐ Plan IV
- ☐ Plan V

Willamette Dental Group

☐ **Willamette Dental of Washington, Inc.**
- ☐ $10 copay
- ☐ $15 copay

Employee Assistance Program # enrolled

ComPsych GuidanceResources® Worldwide

☐ **ComPsych**
- ☐ 1-6 sessions - Standard and included when enrolled on any AWC Trust plan.
- ☐ 1-8 sessions
- ☐ 1-10 sessions

Employees with no other AWC Trust coverage
- ☐ 1-6 session
- ☐ 1-8 session
- ☐ 1-10 session

Vision # enrolled

vsp vision care

☐ **Vision Service Plan**
- ☐ $0 copay
- ☐ $10 copay
- ☐ $25 copay
- ☐ $10/15 copay

☐ Second pair option rider

Tax favored accounts

hsabank own your health

☐ **HSA Bank**
- ☐ HSA

navia benefit solutions

☐ **Navia Benefit Solutions**
- ☐ FSA
- ☐ HSA
- ☐ HRA
- ☐ COBRA, applies to FSA or HRA

More plan offerings —>

Plan offerings *continued*

Name of workgroup/bargaining unit _____

Life* # enrolled _____

☐ **The Standard**

- ☐ Basic life
  - ☐ Flat rate amount: $ _____
  - ☐ Salary based: _____ x salary, up to a maximum of $ _____

  Note: Maximum benefit is the lesser of 3x salary or $500,000.
- ☐ Accidental Death & Dismemberment
- ☐ Dependent Life
  - ☐ Option 1: $1,000
  - ☐ Option 2: $2,000
  - ☐ Option 3: $5,000
  - ☐ Option 4: $10,000
- ☐ Employee additional life
- ☐ Spouse additional life

*If previous life and/or LTD coverage was not through the AWC Trust, list previous carrier and termination date:

Long-term disability* # enrolled _____

☐ **The Standard**

- ☐ Option 1: 60%; 90-day
- ☐ Option 2: 60%; 180-day
- ☐ Option 3: 67%; 90-day
- ☐ Option 4: 67%; 180-day

- ☐ Low risk option 1: 60%; 90-day
- ☐ Low risk option 2: 60%; 180-day
- ☐ Low risk option 3: 67%; 90-day
- ☐ Low risk option 4: 67%; 180-day

Safety employees, transit drivers, and electrical workers are excluded from low risk options.

Premium contributions

Do employees pay toward their LTD coverage? ☐ Yes ☐ No

If yes,

Amount employee pays _____ %

Amount employer pays _____ %

Updates and changes:

If adding or increasing life or long-term disability, are you aware of any employee who is currently disabled or has a current/potential health risk that could reslut in a claim? If yes, include an attachment with name, date of birth, and last four of SSN. ☐ Yes ☐ No

Other non-AWC plan offerings

	Name of plan/sponsor	# employees eligible	# employees enrolled
Medical			
Dental			
Vision			
Life			
Long-term disability			
EAP			
Tax-favored account(s) HSA/HRA/FSA			