Group Administration Guide

Effective December 1, 2022

Dear Group Administrator:

Thank you for your participation in the Washington Technology Industry Association.

The Washington Technology Industry Association Employee Benefit Trust is a collection of endorsed member companies brought together by the Association to provide a comprehensive employee benefits program offered exclusively to our members.

By being a participant in this benefit trust and an active member of the WTIA, your company is helping to foster a robust technology climate in Washington State. This Group Administrative Guide is designed to enable a group administrator to efficiently look up various administrative requirements and guidelines of the Trust.

Once again, thanks for your membership, and enjoy the benefits of the WTIA Employee Benefit Trust.

Please Note: This Group Administrative Guide is a summary of the terms, conditions, and limitations by which the Trust and any service contractors or insurance companies administer the eligibility rules and the benefit plans (i.e., "coverage.")

The contracts between the Trust 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.

TABLE OF CONTENTS

(click on the topic to go directly to the page)

DIRECTORY OF CONTACTS **5**
INTRODUCTION **6**
EMPLOYER ELIGIBILITY AND REQUIREMENTS **7**
NEW AND RENEWING BUSINESS 7
MEDICAL 7
COVERAGE REQUIREMENTS AND SELECTIONS 7
COMPULSORY 7
ADDITIONAL PRODUCTS AVAILABLE 7
ELIGIBILITY AND ENROLLMENT REQUIREMENTS 8
RENEWAL PROCESS 8
MAINTAINING ADMINISTRATIVE RECORDS 8
EMPLOYEE AND DEPENDENT ELIGIBILITY **9**
ELIGIBLE EMPLOYEE 9
EMPLOYEES PERFORMING EMPLOYMENT SERVICES IN HAWAII 9
ELIGIBLE DEPENDENT 9
TAX IMPLICATIONS FOR DOMESTIC PARTNER COVERAGE 10
ELIGIBLE EMPLOYEES AND DEPENDENTS AGE 65 AND OLDER 10
ORIENTATION PERIOD 10
PROBATIONARY PERIOD 11
EFFECTIVE DATE OF COVERAGE 11
ENROLLMENT **12**
ENROLLING EMPLOYEES AND DEPENDENTS 12
EMPLOYEE AND DEPENDENT COVERAGE ENROLLMENT RULES 12
ENROLLMENT/CHANGEFORM 12
COMPLETING THE ENROLLMENT FORM FOR A NEW EMPLOYEE 13
COMPLETING THE FORM FOR A NEW DEPENDENT 13
CARRIER ID CARDS 14
MEDICAL & DENTAL ID CARD 14
VISION ID CARDS 14
SPECIAL ENROLLMENT 14
INVOLUNTARY LOSS OF COVERAGE 14
NEW DEPENDENT DUE TO MARRIAGE, BIRTH, OR ADOPTION 15
STATE MEDICAL ASSISTANCE & CHILDREN'S HEALTH INSURANCE PROGRAM 15

TABLE OF CONTENTS

(click on the topic to go directly to the page)

COVERAGE TERMINATION ... **16**
- EMPLOYEE AND DEPENDENT TERMINATION OF COVERAGE ... 16
- DEPENDENT SPOUSE/CHILDREN TERMINATION OF COVERAGE ... 16
- LIMITATION OF RETROACTIVE TERMINATIONS ... 16
- HOW TO TERMINATE COVERAGE ... 17
- CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) ... 18
  - COBRA ADMINISTRATION BY VIMLY ... 18
  - COBRA ADMINISTRATION BY ANOTHER THIRD-PARTY ADMINISTRATOR ... 18
- FAMILY MEDICAL LEAVE ACT (FMLA) ... 19
- NON-FMLA LEAVE OF ABSENCE ... 20
- LIFE INSURANCE CONVERSION ... 20
- ADMINISTRATIVE REVIEW ... 20
- TERMINATING GROUP COVERAGE THROUGH THE TRUST ... 20

SIMON ... **21**
- WHAT IS SIMON? ... 21
- WHAT CAN SIMON DO? ... 21
- REGISTERING FOR SIMON ... 21
- ACCESSING SIMON ... 21

BILLING AND PAYMENTS ... **22**
- ABOUT YOUR BILLING STATEMENT ... 22
- BILLING TIME FRAMES & DELINQUENCY POLICY ... 22
- LATE FEE AND SHORT PAY POLICY ... 23
- RETURN CHECK POLICY ... 23
  - NON-SUFFICIENT FUNDS (NSF) ... 23
  - ACCOUNT CLOSED ... 23
  - PAYMENT STOPPED ... 23
- EXAMPLE OF BILLING AND DELINQUENCY TIME FRAMES FOR MAY INVOICE ... 24
- HOW TO MAKE PAYMENTS ... 24

BILLING FAQS ... **25**

MISCELLANEOUS FAQS ... **27**
- GENERAL ... 27
- INCOMPLETE FORMS ... 27
- WHO DO I CALL ABOUT...? ... 28

DIRECTORY OF CONTACTS

Please contact the appropriate carrier below
for questions regarding claims, benefits, and services.

<table>
<tr><td rowspan="3">Vimly Benefit Solutions, Inc. (Vimly)
Third Party Administrator
Billing and Eligibility Questions</td><td>Customer Service Phone: 425.771.7359 or 206.859.2600
Fax: 425.771.1226
Email: WTIA@Vimly.com
P.O. Box 6 Mukilteo, WA 98275</td></tr>
<tr><td>Vimly COBRA Administration
Phone: 425.771.7359 or 206.859.2600
Fax: 425.771.1226
Email: cobra@Vimly.com
P.O. Box 6 Mukilteo, WA 98275</td></tr>
<tr><td>For forms and resources, please visit
www.washingtontechnology.org</td></tr>
<tr><td>Premera Blue Cross
Medical & Dental Insurance</td><td>Customer Service
Phone: 800.722.1471
7001 220th St. SW, Mountlake Terrace, WA 98043
www.premera.com</td></tr>
<tr><td>Vision Service Plan
Vision Insurance</td><td>Customer Service
Phone: 800.877.7195
600 University St, Ste 2004, Seattle, WA 98101
www.vsp.com</td></tr>
<tr><td>Metropolitan Life Insurance Company
Basic Life & AD&D, Disability, Supp'l Life</td><td>Customer Service
Phone: 800.275.4638
200 Park Avenue, New York, NY 10166
www.metlife.com</td></tr>
<tr><td>Navia Benefit Solution
FSA/HSA Services</td><td>Customer Service
Phone: 866.831.6138 600
Naches Avenue SW Renton, WA 98057
www.naviabenefits.com</td></tr>
<tr><td>Wellspring Family Services
Employee Assistance Plan</td><td>Customer Service
Phone: 800.553.7798
1900 Rainier Avenue South Seattle, WA 98144
www.wfseap.org</td></tr>
<tr><td>Washington Technology Industry Association
Endorsed Sponsor Benefit Programs</td><td>www.washingtontechnology.org
Endorsed Sponsor Benefit Programs</td></tr>
</table>

INTRODUCTIONS

The WTIA established the Trust to make certain health and other employee benefits available to its members. By taking advantage of the members' collective purchasing a complete range of services are available to your employees at a competitive price.

The Trust's offering includes employee benefits for medical, dental, vision, basic life and accidental death & dismemberment, supplemental life and accidental death & dismemberment, short and long-term disability, and employee assistance programs for employer groups with 2+ employees.

Advantages include:

- ❏ Consolidated Administration: one point of contact for billing and eligibility (provided through Vimly)
- ❏ COBRA Administration (provided through Vimly)
- ❏ 24-hour access to forms and summaries on www.washingtontechnology.org
- ❏ Online enrollment, eligibility, and billing access through Vimly's online platform,"SIMON"

This guide is designed to assist you in the administration of your employee benefit plans through the Trust. It is also a summary of the terms and conditions for participating in the program. The guide's purpose is to help you through the day-to-day administration of your employee benefits purchased through the Trust. It is not a contract, booklet of insurance, summary plan description, or a certificate of coverage.

EMPLOYER ELIGIBILITY AND REQUIREMENTS

NEW AND RENEWING BUSINESS

Rates are guaranteed for the contract period as sold for individual member groups except under the following circumstances:

- ❏ Government-mandated benefit changes;
- ❏ New or revised government taxes or assessments imposed;
- ❏ Addition of a new plan;
- ❏ An amendment to the benefit plan or contracts
- ❏ Addition or termination of an employer subsidiary, corporate division, or affiliated companies

MEDICAL

Rates may be adjusted for new member groups if any information differs from the original quote and/or to decline the group if it does not subsequently meet underwriting guidelines.

Groups must not have any other medical plans, other than that provided through the Trust.

Groups of 10 or more enrolled employees may select up to 2 plans as permissible per the dual choice matrix. Plan combinations must be within the same network. Heritage Prime and Heritage Plus plans may not be combined, and a minimum of 3 employees must be enrolled in each plan.

COVERAGE REQUIREMENTS AND SELECTIONS

COMPULSORY

- ❏ Medical coverage for groups of 2 or more employees
- ❏ $25,000 Basic Life & AD&D for groups of 2 or more employees
- ❏ 1-3 visit Employee Assistance Program for groups of 2 or more employees

ADDITIONAL PRODUCTS AVAILABLE

- ❏ Dental benefit for groups of 2 or more employees
- ❏ Vision benefit for groups of 2 or more employees
- ❏ Buy-up Basic Life and AD&D up to $250,000 benefit for groups of 2 or more employees
- ❏ Voluntary Life and AD&D Benefit: Employees can choose $10,000 increments up to $500,000. Spouses can choose $5,000 increments up to $250,000, not to exceed 50% of the employee's amount. No minimum participation is required.
- ❏ Short Term Disability: 8 plan offerings
- ❏ Long Term Disability: 8 plan offerings

EMPLOYER ELIGIBILITY AND REQUIREMENTS

ELIGIBILITY AND ENROLLMENT REQUIREMENTS

To be eligible to participate in the Health Trust:

- ❏ Employer must be an active, dues-paying member of the Washington Technology Industry Association (the Endorsed Sponsor).
- ❏ The Employer must have at least one “common-law” employee. A common-law employee is an employee who is neither an owner nor a partner, nor the spouse of an owner or partner.
- ❏ An enrolling group must be headquartered in Washington state or have a clearly defined licensed division in Washington state (all counties except Clark County). Independent healthcare purchasing decisions must be made for any clearly defined licensed divisions in Washington state. In addition, there must be at least one person with contract signing authority residing in the Premera Blue Cross Washington state service area. If the headquarters are outside Washington state, then no employees residing in Clark County or in any other state are eligible for coverage.

In order to participate in the Trust, the employer must agree to define the enrollment requirements on its Group Master Application and then apply these requirements in a nondiscriminatory 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 written request submitted by the employer’s producer to the administrator, which will seek 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, the employer should contact its producer.

RENEWAL PROCESS

All renewal information is sent to the employer’s producer of record. The Trust does not send any renewal rates or other renewal information to the employer. The Trust sends a renewal proposal to the producer 45-60 days prior to the renewal date. The producer is responsible for contacting the employer regarding the new rates and any benefit changes. A completed Group Master Application is not required for renewing groups. Renewals must be returned to WTIA Benefits Program (in writing to the address/email address listed) 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 Group Administrative Guide 9 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.

EMPLOYEE AND DEPENDENT ELIGIBILITY

ELIGIBLE EMPLOYEE

Employees who meet the Group Master Application eligibility requirements and have satisfied the appropriate probationary period are eligible for coverage under this plan. Temporary, seasonal, contract, or employees paid via 1099 are not eligible.

EMPLOYEES PERFORMING EMPLOYMENT SERVICES 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, they will no longer be eligible for coverage.

ELIGIBLE DEPENDENT

Eligible dependents include:

- ❏ The employee's lawful spouse, unless legally separated. 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 themselves because of a developmental or physical disability, provided the dependent child was covered on the day before the child's 26th birthday and the incapacity occurred prior to the 26th birthday. Benefits will be provided for the duration of the disability unless the employer's coverage through WTIA terminates or the subscriber's coverage under the WTIA plan 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, it 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 28th birthday.

TAX IMPLICATIONS FOR DOMESTIC PARTNER COVERAGE

Federal tax rules govern the tax treatment of domestic partner benefits. Generally, if a domestic partner or their 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 their 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, the WTIA, HR Benefits, Inc., (HRBI) 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. Medicare Secondary Payer rules apply as required under Federal rules for any employee who has Medicare.

ORIENTATION PERIOD

The Affordable Care Act provides that a reasonable and bona fide employment-based orientation period is a permissible eligibility condition (similar to an employee having to be in an eligible job classification and meet the minimum hours worked threshold) that employers may require new employees to satisfy prior to being considered an eligible employee and completing a probationary period.

During the orientation period, an employer and employee could evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. Upon completion of the orientation period, assuming the employee has satisfied all other eligibility requirements, the eligibility waiting period would then commence.

The maximum allowed length for an orientation period is one month. The one-month orientation period would be determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Also, if an employee's start date in an otherwise eligible position is Oct. 1, the last permitted day of the orientation period is Oct. 31.

If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month.

For example, if the employee's start date is Jan. 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is Aug. 31, the last permitted day of the orientation period is Sept. 30.

PROBATIONARY PERIOD

The probationary period (sometimes referred to as a waiting period) is determined by the employer and is the specified 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.

Employees who are rehired within 6 months 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 1st, and the group had a 30-day probationary period with no orientation period, the effective date would be February 1st. If the same employee were hired January 8th, 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.

If you chose Date of Hire (DOH) as the first day of your probationary period, then depending upon your selection, the effective date will always be the 1st of the month following DOH, even if DOH is the 1st of the month, OR the effective date will be the 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

ENROLLMENT

ENROLLING EMPLOYEES AND DEPENDENTS

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

1. Through SIMON*, Vimly's online enrollment tool;or
2. By submitting a signed copy of the 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 Trust administers uncommon eligibility between all lines of coverage, excluding life and employee assistance program (EAP). Therefore, if a spouse/domestic partner or dependent children are to be covered, their coverage may be different than the subscriber's (employee's) coverage, but the spouse/domestic partner or dependent children may not elect coverage that the employee has not chosen. Life coverage is an employer-paid benefit and all employees must be enrolled, even if they waive all other coverages. Also, EAP is bundled with medical coverage and is not a stand-alone product.

ENROLLMENT/CHANGE FORM

To be covered under this plan, employees must first complete an 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.washingtontechnology.org. Alternatively, the employer can also contact Vimly for a copy of the form.

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 that 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.

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.

Additionally, MetLife requires an Evidence of Insurability form to be completed for late enrollees (those who do not enroll within the first 31 days of first becoming eligible) and for any amounts above the Trust's guarantee issue amount for voluntary life coverage. Coverage will be made effective the first of the month following the date of approval from MetLife. Forms are available at www.washingtontechnology.org.

ENROLLMENT

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. It is advised that the employer complete steps 1-4 and 9 below and that the employee completes steps 5-8.

1. Write the company name in the "Employer Name" box.
2. Write the effective date of the enrollment being requested in the "Effective Date" box.
3. Write the date of the employee's hire in the "Date of Hire" box.
4. Check the appropriate box in the "Check One" section.
5. Enter the employee's information, including name, date of birth, gender, Social Security Number, mailing address, phone number, and employee class in the "Personal Information" section.
6. Check the appropriate coverage boxes in the "Plan Selection" section on the second page. If unsure of your coverage, consult the employer's Group Master Application or Producer.
7. Complete the "Dependent Information" and Prior Medical Coverage sections, if applicable. In addition, it is very important the Beneficiary Designation information be completed.
8. On the signature page, the employee must sign and date the left box. Forms without a signature will be returned and delay employee eligibility.
9. 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". For employers with dual-option coverage, plan selections must be noted in this section only.

COMPLETING THE FORM FOR A NEW DEPENDENT

1. Write the company name in the "Employer Name" box.
2. Write the effective date of the enrollment being requested in the "Effective Date" box.
3. Indicate the qualifying event in the "Event Description" section.
4. Enter the employee's information in the "Employee Information" section.
5. Enter the dependent's information in the "Dependent Information" section.

   a. If the employee is enrolling a newborn and they don't have a Social Security Group Administrative Guide 15 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.

   b. If the employee is enrolling a new domestic partner, a signed affidavit is also required.

6. Circle “add” next to the dependent’s name.

7. In the “Plan Selection” section, indicate the coverage the dependent is being enrolled in. Also indicate the dependent’s Prior Medical Coverage, if applicable.

8. 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 & DENTAL ID CARD

Premera Blue Cross will issue ID cards, and it generally takes 10-12 business days for cards to arrive once Premera has received the enrollment. Replacement ID cards can be ordered directly from Premera by calling their customer service phone number or visiting the Premera 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 WTIA@Vimly.com.

If an eligible employee needs services prior to receiving their ID cards,the employee or their provider may contact Premera’s customer service directly to obtain the employee’s ID number and confirm benefits. If the eligible employee needs a covered prescription, the employee has the option of paying for the medication and submitting a claim to Premera for reimbursement.

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 benefits.

SPECIAL ENROLLMENT

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

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 non-COBRA coverage due to divorce, legal separation, termination of Group Administrative Guide 16 employment, reduction of hours, or loss of an employer’s contribution toward the non-COBRA coverage.

Please note that special enrollment is not available if COBRA coverage ended before the maximum coverage period was exhausted. Special enrollment is not available when the employee's contribution was reduced but not lost entirely.

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 due to 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 & 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 the first 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. Please refer to the live conversion option on Page 20.

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 isterminated.
- ❏ 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.

EMPLOYEE AND DEPENDENT TERMINATION OF COVERAGE

Coverage will end for a spouse or domestic partner 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.

It is the responsibility of the employee to notify the participating employer when an enrolled dependent is no longer eligible to be covered as a dependent under the program. The participating employer must then notify the billing administrator, Vimly, within 30 days of the date the participating employer was notified of such event.

LIMITATION OF RETROACTIVE TERMINATIONS

0-30 Days from the Requested Coverage Termination Date

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

The termination request must be submitted via the Employee Enrollment form (the form is Group Administrative Guide 18 used to enroll, cancel, change, or waive coverage) regardless of how you submit your termination request(i.e., via the monthly invoice, email, fax, or SIMON). Please note, if you submit the termination request via SIMON, you must send the completed form separately to Vimly via mail, email, or fax. Vimly will not be able to process the retroactive termination without it.

COVERAGE TERMINATION

If you fail to provide a completed form, or if the above 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 retroactively from the requested date of coverage will not be honored. Instead, the coverage will be terminated at the end of the month in which the request is received. 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 program. 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:

- ❑ Submit the termination through Vimly's online enrollment tool, SIMON. Be sure to indicate the reason for termination and confirm the employee's address iscurrent.
- ❑ Send an email to Vimly at WTIA@Vimly.com:
  - Make sure to include the employee's name, termination date, termination reason, and an updated address, if applicable.
- ❑ Mail or fax a letter on the company's letterhead toVimly.
- ❑ 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 the dependent in coverage until the next open enrollment period unless a special enrollment qualifying event occurs.

COVERAGE TERMINATION

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

All employees and their dependents covered through the Trust who experience a qualifying event are eligible for COBRA continuation coverage, regardless of the number of employees the employer employs. An employer cannot opt out of the COBRA coverage offered by the plan. It is the employer's responsibility to notify Vimly in writing within 30 days from the date an employee or covered dependent experiences a COBRA qualifying event. Neither the Trust, Premera, 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
- ❑ Termination of a domestic partnership

COBRA ADMINISTRATION BY VIMLY

The Trust's benefits administrator, Vimly, will automatically provide COBRA administration for the medical, dental, vision, and EAP coverage offered by the Trust at NO cost to employers. Vimly will handle all COBRA administration and notices for the Trust plans that the employer has enrolled in, ensuring compliance with the regulations and guidelines required by COBRA. This includes sending the initial COBRA notice to newly eligible employees and spouses. Please note Vimly cannot offer COBRA administration services for non-Trust plans at this time.

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.

COBRA ADMINISTRATION BY ANOTHER THIRD-PARTY ADMINISTRATOR

Although Vimly COBRA administration is free to employers and automatically available, the Trust understands there may be employers who have non-Trust products as well and prefer to contract with another COBRA Third-Party Administrator (TPA) to do the COBRA administration of all their plans. If an employer wants to waive Vimly COBRA services and they have contracted with another TPA to do the COBRA administration, the employer must Group Administrative Guide 20 complete a Waiver Form and return it to Vimly as soon as administratively possible. If the TPA elects to remit the collected COBRA premiums to Vimly directly, the employer will not see COBRA participants on the monthly Trust invoice.

If the TPA elects to remit the collected COBRA premiums to the employer, Vimly will bill the COBRA participant's premiums to the employer on the monthly Trust invoice along with their active employees.

Please note the Trust has determined that Vimly COBRA administration can only be waived if the employer has contracted with another TPA to do COBRA administration. The employer cannot waive Vimly COBRA administration of the Trust plans and do it themselves.

COVERAGE TERMINATION

Important: Even if an employer waives Vimly COBRA administration services and uses another TPA, please be aware that Vimly must continue to be advised of all Trust COBRA elections, terminations, or changes so that Vimly can notify the carrier(s). The carriers will only accept eligibility updates and premium payments from Vimly. Failure to notify Vimly of these elections/changes will result in a delay of coverage for the participant.

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family Medical Leave Act of 1993 (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 incapacity during pregnancy, medical care during pregnancy, 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 their employer that FMLA leave is being requested

During FMLA leave, the employer must continue to pay the same share of the premium as if the employee 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 they were still working. If the employee drops coverage during the FMLA leave, or does not return to work as scheduled, coverage can be terminated. The end of FMLA leave is a COBRA qualifying event. The maximum COBRA period would start at that point, and would be in addition to the period of FMLA leave.

COVERAGE TERMINATION

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 MetLife plan booklet. 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 Aetna 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, the Trust’s Service Company 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 Washington Technology Industry Association. 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 Vimly's 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 SIMON DO?

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 or dependent
- ❏ View and/or print benefits-related forms and documents
- ❏ Use SIMON Tiles to access important websites and view important messages
- ❏ View and pay invoices

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.

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 last day of the month prior to 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. 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 cut-off 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.

ABOUT YOUR BILLING STATEMENT

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. Subscribers will be listed in alphabetical order. Premiums due are listed in the appropriate column. Examples are medical, dental, and life.

There is a total for each subscriber on the right-hand side of the bill. The column heading "Elections*" describes the coverage level being billed.

M = Medical
D = Dental
V = Vision

1 = Employee Only
2 = Employee & Spouse
3 = Employee, Spouse & Children
4 = Employee & Children

BILLING TIME FRAMES & DELINQUENCY POLICY

It is the Trust's policy to receive premium payments prior to the coverage effective date. This document outlines the billing time frames and the subsequent delinquency policy if payment is received outside of the timelines. You must maintain membership in the sponsoring association in order to purchase benefits through the Trust. An employer will be terminated upon notice from the Trust's sponsoring association that the employer is no longer a member of the association. In the event the association notifies the Trust's Service Company that the employer is no longer a member of the association, the Trust Administration Office will send a termination notice to the employer, pursuant to the process outlined above under Termination of Coverage for Failure to Pay Premium.

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 be treated the same as if payment has not been received by the 1st of the month. If any of these events occur, the group must provide a cashier's check and 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.

BILLING AND PAYMENTS

If payment has not been received by the 1st day of the coverage month, the group will be sent notification via email or mail 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. (See Payments, Late Fees, Termination, and Reinstatement Policy for additional details.)

If a group is terminated for non-payment, the Trust, in its sole discretion, may reinstate an employer's coverage upon written request. The Trust's Service Company, in exercising its sole discretion, will consider factors that include, but are not limited to, payment of all past due benefit payments, payment of late fees, and payment of the next month's benefit payment. The final reinstatement decision will be at the discretion of the insurers.

Payment of delinquent premiums and all balance due must be submitted along with the reinstatement request. Any employer whose coverage is reinstated must pay future benefit payments by automatic funds transfer. If an employer is terminated a second time in a twentyfour (24) month period, request for reinstatement must be made in writing by the employer to the Trustees, who may, in their sole discretion, allow reinstatement.

LATE FEE AND SHORT PAY POLICY

The Trust imposes a 5% late fee for premiums remitted after the 5th of the coverage month. 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. Failure to include the late fee with the premium payment may incur additional fees.

RETURN CHECK POLICY

The Trust charges fees for returned checks and requires specific check replacements as follows:

NON-SUFFICIENT FUNDS (NSF)

- ❏ Checks returned due to non-sufficient funds: $50.00 fee per check, per return
- ❏ Any employer who submits an NSF check may be required to make all future payments by automatic funds transfer.

ACCOUNT CLOSED

- ❏ Checks returned due the account being closed: $50.00 fee per check, per return.
- ❏ Any employer who has a check returned as Account Closed may be required to make all future payments by automatic funds transfer.

PAYMENT STOPPED

- ❏ Checks returned due to payment stopped: $50.00 fee per check, per return, unless the Administrative Office has been notified and the check has been replaced prior to the notice being received from the bank.
- ❏ Any employer who has a check returned as Account Closed will be required to make all future payments by automatic funds transfer.

BILLING AND PAYMENTS

Employers are cautioned that: (1) If an employer withholds monies from an employee's pay for the purpose of contributing to the payment of premiums and the employer does not promptly make those payments, the employer may be in violation of ERISA and subject to penalties, and (2) The timeliness of payments may affect COBRA participants' eligibility since COBRA is only available when the employer remains in good standing with the Program. If this applies to you, your legal counsel can advise you.

EXAMPLE OF BILLING AND DELINQUENCY TIME FRAMES FOR MAY INVOICE

April 5	Cut-off for May payments and enrollment changes
April 7	May invoice is calculated and mailed
April 30	May payment is due
May 5	The group is considered delinquent if the May premium is not received and they will be assessed a late fee. An email requesting payment of all past due premiums to be remitted by May 31st is sent to the group. The group's producer is included on this communication.
May 7	Vimly calculates the June invoice, which will reflect the current charges, as well as any unpaid balances and assessed fees, if applicable.
May 31	If payment has not been received, a letter advising that coverage has been retroactively terminated is sent to group, producer, program manager, endorsing sponsor, and all applicable carriers.

HOW TO MAKE PAYMENTS

Payments may be made via any of the following methods:

- ❏ Electronic Funds Transfer (EFT) – You must fill out the EFT form.
- ❏ Online – You may use Vimly's online platform, SIMON, to send payments to Vimly, at no additional charge.

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 or terminated until payment is received. Late fees will 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 1st of the prior month. For example, if a dependent termination notice was received on March 8th, 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. Please pay each invoice as billed.

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 1st 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. Although adjustments will be reflected on the next invoice, the employee's coverage will be processed for submission to the appropriate carriers within three 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 1st 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 1st.)

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 terminated, 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 5th 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

BILLING FAQS

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 10th, 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 FAQ

GENERAL

What is a Group Master Application?
This is the agreement the employer signs indicating the plan(s)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 group numbers are seven 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 but can only do so during the open enrollment period. 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.washingtontechnology.org 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 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.

MISCELLANEOUS FAQ

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:** The employee 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 "For Producers" section of the website: www.washingtontechnology.org
- ❏ **"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 Washington Technology Industry Association 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 Washington Technology Industry Association 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.