Name: _____ HRN#: _____

Makah Tribe
PO Box 115 Neah Bay, WA. 98357

Washington Health Benefit Exchange
Financial Sponsorship Agreement

The Washington Health Benefit Exchange has created the Washington Healthplanfinder, an online marketplace for individuals and families to purchase free and low cost health insurance. Premiums are based on income, age, family composition and the Qualified Health Plan selected.

For eligible Contract Health Services members, who are over 138% of Federal Poverty Level and do not qualify for other Alternate Resources; the Makah Tribe will sponsor (pay) the premium for a bronze-level plan after tax credits (if any) have been applied.

Please read each item below. Your signature at the end of this form is your agreement with the terms and conditions listed below:

- ❒ I agree to provide the information and documents necessary to apply for coverage through the Washington Healthplanfinder. I understand that the information I give to the Washington Healthplanfinder is subject to verification by federal and state officials.
- ❒ I understand that the Certified Tribal Assister (and Tribal Sponsor Representative) for the Makah Tribe will complete the application with me and will partner with my account to have ongoing access. The Tribal Assister will be able to help me with eligibility reviews, report changes and make payments on my behalf.
- ❒ I understand that the application is subject to ID proofing and I will be asked to verify personal information as part of the security measures by the Washington Healthplanfinder. I agree to provide any documents requested to establish my identity and eligibility for enrollment.
- ❒ I understand that the amount sponsored by the Makah Tribe will be the premium due AFTER tax credits have been applied. This will result in my paying **NO monthly premium**.
- ❒ I understand that I may select a bronze-level plan which contracts with the Sophie Trettevick Indian Health Center and its providers. I understand that I must go to a participating provider when I am referred for specialty care.
- ❒ I understand that I am responsible for reading and understanding the benefits of my health plan and, in order for CHS to pay my out of pocket costs (if any), I must meet all of the CHS requirements, including obtaining a purchase order and giving notice of emergency care.
    - For members at or below 300% of Federal Poverty level, there is no cost sharing, and deductibles or coinsurance will not apply.
    - For members above 300% for the FPL, out of pocket costs will be eligible for payment by CHS if the requirements are met.
- ❒ I will notify the STIHC Benefits Coordinators who will inform the HBE, of any change in income of $150 or more, lasting two months or more.

- ❒ **I understand that a change in income could change the tax credits that I am eligible for. If I am required to pay back a portion of the tax subsidy because I failed to report a change of income, or misrepresented my income, the resulting tax burden will be my responsibility.**
- ❒ I will notify the STIHC Benefits Coordinators who will inform the HBE of any changes in my mailing or street address, family member changes or other circumstances that affect my eligibility for coverage
- ❒ I understand that the financial sponsor will pay on my behalf until:
    - I am no longer eligible for Contract Health Service (I move out of the CHSDA for more than 180 days or fail to meet the requirements)
    - I become eligible for an alternate resource such as Apple Health or Medicare
    - I move out of the state and can no longer be covered by the Washington Health Benefit Exchange
    - The financial sponsor decides to terminate the sponsorship program (if that occurs, I will receive written notice prior to termination)

  If any of the above occurs, and I am no longer eligible for sponsorship by the Makah Tribe, I may elect to continue the coverage through Washington Healthplanfinder at my own expense (or apply for coverage in the state I reside). If I elect not to purchase coverage on my own, it will be my responsibility to apply for the necessary waiver and prove to the federal authorities (IRS) that I am exempt from the Individual mandate.

- ❒ The Makah Tribe has given me a copy of Health Care Coverage Rights and Responsibilities.

I understand that by signing this document, I am certifying that the information I have provided is true to the best of my knowledge.

*Signature:*_____ *Date:*_____

*Please Print Name:*_____

*Financial Sponsor Representative:*_____ *Date:*_____

*Please Print Name:*_____

Important changes to report to the STIHC Benefits Coordinator

- Changes of income for anyone listed on my application
- Changes in family structure, for example, I get divorced or separated from my spouse/significant other or my dependents move out of my home
- Changes in the way in which I file federal income taxes or if someone else is going to claim me or my dependents
- Changes in my physical or mailing address