WASHINGTON STATE AUTO DEALERS

INSURANCE TRUST BENEFIT PLAN

Summary Plan Description

for the

Content

Summary Plan Description
Washington State Auto Dealers Insurance Trust Benefit Plan

INTRODUCTION

Your Dealer participates in the Washington State Auto Dealers Insurance Trust (WSADIT) Benefit Plan ("Plan").

This Summary Plan Description ("SPD") is effective for the plan year, January 1, 2020 through December 31, 2020. Please read this SPD carefully, and in conjunction with other materials you receive from the insurance carriers.

The benefit options offered under the Plan are listed in Attachment A of the SPD. Only the benefit options selected by your Dealer are available to you to the extent you satisfy the eligibility conditions in the primary insurance contracts for those benefits.

If the Dealer offers benefits other than through the Plan, those benefits are not part of the Plan and are not described in this SPD. For example, if your Dealer covers you under a health reimbursement arrangement ("HRA") or a health savings account ("HSA"), the HRA or HSA is not a WSADIT Benefit.

Please read this booklet carefully, and in conjunction with other materials you receive from the insurance carriers pertaining to the various benefits available under the Plan. Please do not interpret any statement in this booklet to mean that your participation in the Plan is a guarantee of continued employment or is intended to be an employment contract of any form with your employer.

PLEASE NOTE: Plan Coverage is governed by more formal legal plan documents, including the insurance contracts. Every effort has been made to provide clear and accurate information. In the event of any discrepancy between this booklet and the formal plan documents, the formal documents will govern.

IMPORTANT PLAN INFORMATION

Legal Name of The Plan:	Washington State Auto Dealers Insurance Trust Benefit Plan
Plan Number:	501
Name, Address and Telephone Number of Plan Sponsor:	Board of Trustees of the Washington State Auto Dealers Insurance Trust 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 or P.O. Box 6 Mukilteo, WA 98275-0006 (425) 771-7359 or (206) 859-2600 You or your covered eligible dependent may obtain a complete list of the employers that participate in the Plan upon written request to the Third Party Administrator. The list is available for examination by you or your covered eligible dependent at the Plan's office during normal business hours. You or your covered eligible dependent may receive from the Plan's office, upon written request, information as to whether a particular employer is a participating employer in the Plan and, if so, the employer's address.
Employer Identification Number of the Trust:	91-6056560
Type of Welfare Plan:	Medical, Dental, Vision, Group and Voluntary Life, Accidental Death and Disability, Short and Long Term Disability
Type of Plan Administration:	**Insurer Administration.** Benefits are provided through the insurance contracts listed in Attachment A of the SPD. The Trust holds the primary insurance contracts. **Third Party Administration.** Day-to-day administration of Plan is carried out by the Third Party Administrator. **COBRA Administration.** Continuation coverage of group health plan coverage under COBRA is administered on behalf of Plan Administrator by the COBRA Administrator.
Name, Address and Telephone Number of Plan Administrator:	Board of Trustees of the Washington State Auto Dealers Insurance Trust 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 or P.O. Box 6 Mukilteo, WA 98275-0006 (425) 771-7359 or (206) 859-2600

Name, Address and Telephone Number of Third Party Administrator.	Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 or P.O. Box 6 Mukilteo, WA 98275-0006 (425) 771-7359 or (206) 859-2600
Name, Address and Telephone Number of COBRA Administrator	Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 or P.O. Box 65 Mukilteo, WA 98275-0065 (425) 771-7359 or (206) 859-2600
Name and Address of Agent for Service of Process:	Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 (425) 771-7359 or (206) 859-2600 Service of legal process also may be made on the Plan Administrator or a Trustee.
Eligibility requirements for benefits, statement of conditions pertaining to eligibility to receive benefits:	See applicable Benefit Booklet
Description or summary of benefits:	See applicable Benefit Booklet
Cost sharing, co-payment, deductibles, continuation of benefits, annual or lifetime caps or other limits on benefits under the Plan; extent to which preventive services are covered under the Plan; whether, and under what circumstances, existing and new drugs are covered; whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of- network services; any conditions or limits on the selection of primary care providers or providers of specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service:	See applicable Benefit Booklet
Circumstances that may result in disqualification or ineligibility for, or denial, loss, forfeiture, or suspension of any benefits, including benefit limitations or exclusions:	See applicable Benefit Booklet
Source of Contributions:	Employer and Employee Contributions, or Employer Contributions only

Funding Medium:	Employer and Employee Contributions are accumulated in the Trust. The Trust is the contract holder for the primary insurance contracts with the insurance companies and health care service contractors through which benefits are provided. The Trust remits the required insurance premiums to the insurance companies and health care service contractors for the primary insurance contracts.
Name, Title and Business Address of Trustees:	Connor Ryan, Trustee Chair Mike Blade, Trustee Doug Overturf, Trustee Patty Johnson, Trustee Washington State Auto Dealers Insurance Trust c/o Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275
Plan Year:	January 1st through December 31st
Date of the end of the year for purposes of maintaining the plan's fiscal records	December 31st
Renewal date of WSADIT Benefit Plan insurance contracts:	Currently September 1st (subject to change)
Claims processing and appeal procedures and remedies under the Plan for redress of denied claims:	See Benefit Booklet All claims are sent to and processed by the insurance company or health care services contractor. The insurance company or health care services contractor is responsible for the review of denied benefit claims. Neither the Plan or its Trust, nor your Dealer is responsible for the review of denied benefit claims. In some cases, you may be entitled to appeal a denial of a medical or dental benefit claim to an independent review organization. You must follow the procedures and satisfy the deadlines described in the Benefit Booklet, including the deadlines to file any appeal of a claim denial with the insurance company. If you do not follow the procedures and satisfy the deadlines, you will lose your right to file suit in state or federal court, because you will not have exhausted your administrative remedies — which generally is a requirement for filing a lawsuit.
Amendment or Termination of the Plan and Trust:	The Board of Trustees may amend or terminate the Plan or Trust at any time and for any reason.

ELIGIBILITY

Employee Eligibility

Employees are generally eligible for those benefits which the Dealer has elected to offer to its employee under the Master Application with the Trust. Employees who perform the required minimum hours of service and who complete required probationary periods, if any, with the Dealer will be eligible to participate in the Plan.

Please see the eligibility section in the Benefit Booklets for more information.

Dependent Eligibility

Refer to the Benefits Booklet for the specific rules governing Dependent eligibility.

A domestic partner may be an eligible dependent for some benefits. To be eligible, your domestic partner must be registered as such with the State of Washington or is a domestic partner by affidavit, as described in the applicable Benefit Booklet.

ENROLLMENT

Open Enrollment

Your Dealer may require you to attend an orientation or enrollment meeting to enroll. Required enrollment forms are provided by the Dealer when you are first hired and annually thereafter during the open enrollment period for the Plan.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan. You must request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose coverage under a Medicaid plan or CHIP (Children's Health Insurance Program) because you, or your dependent was no longer eligible for the coverage, you may request coverage under the Plan no later than 60 days after the date coverage under the Medicaid plan or CHIP terminates.

If you or you dependent becomes eligible (through a Medicaid plan or under a CHIP plan) for a premium assistance subsidy with respect to coverage under the Plan, the eligible employee may request coverage under the Plan no later than 60 days after the date the employee or dependent is determined to be eligible for the premium assistance subsidy.

To request special enrollment or obtain more information, the Third Party Administrator using the information provided in the "Important Plan Information" section of the SPD.

When Coverage Begins

Refer to the Benefits Booklet for the benefit for the rules governing when coverage begins.

When Coverage Ends

Generally, coverage for you (the employee) ends on the last day of the month for which premiums have been paid and in which one of the following events occur:

- the contract between the Trust and the insurance carrier or health care service contractor is terminated;
- the applicable premium for a benefit is not paid when due or within the applicable grace period;
- an employee ceases to be an eligible employee; or
- the Dealer ceases to be a participating employer in the Plan;

When Dependent Coverage Ends

Coverage ends for your dependents on the date coverage ends for you (the employee) as stated in the above section. Also, coverage for your dependent ends on the last day of the month for which premiums have been paid and in which your dependent no longer is eligible as a dependent (for example, when your dependent child reaches a limiting age).

LOSS OF BENEFITS

The following circumstances may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction or recovery of benefits:

- You will not be eligible for coverage if you or your Dealer do not submit your enrollment forms by the deadline designated by the Plan Administrator.

- If your employment changes so that you no longer satisfy the Plan's eligibility conditions (for example, if you change from full-time to part-time status, or if you move from a non-union position to a position covered by a collective bargaining agreement) you may lose coverage under the Plan. If you lose coverage, you may be eligible for COBRA continuation coverage for some benefits.

- If you do not follow the claims and appeals procedures for a benefit, your claims will not be paid. The claims and appeals procedures set forth specific time periods within which you must submit your claims and/or appeals and also require you to provide certain information requested to evaluate your claims. The claims and appeals procedures are explained in the applicable insurance materials and Benefit Booklets, and to the extent not covered in those materials, described later in this booklet.

- The Plan is entitled to recover any benefits paid to you or your dependents, if you or your dependents obtain reimbursement from another source for an injury or condition which was paid by the Plan.

These circumstances are merely examples – other situations may arise in which the Plan Administrator may determine that you are not entitled to benefits. Such determinations may be reviewed under the applicable claims and appeals procedures.

A rescission of coverage is limited to those instances where an enrollee performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuation of coverage is not a rescission if (i) the cancellation or discontinuance has a prospective effect; or (ii) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

REQUIRED GROUP HEALTH PLAN NOTICES

Continuation of Group Health Plan Coverage under COBRA

If you, your spouse or domestic partner, or another dependent loses medical, dental or vision coverage, you or your covered dependents may have the right to elect to continue that coverage for a limited period of time. For more information, see *Attachment A — COBRA Continuation Coverage*.

Continuation of Group Health Plan Coverage under USERRA

USERRA (the Uniformed Services Employment and Reemployment Rights Act of 1994) provides employees who leave work to serve in the uniformed services of the United States with certain rights upon their return from service. USERRA also permits these employees to elect to continue coverage under their employer's group health plan benefits (medical, dental and vision benefits) for themselves and their dependents for a limited time. For more information, see *Attachment C — USERRA Coverage*.

Continuation of Group Health Plan Coverage under the Family and Medical Leave Act

If you take a leave of absence under the Family and Medical Leave Act, group health plan benefits (medical, dental and vision benefits) may be continued during the leave. For more information, see *Attachment C — FMLA Coverage*.

Special Provisions for Mothers and Newborn Infants

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Mastectomy Provisions

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, please contact the Plan Administrator.

Qualified Medical Child Support Orders

Participants and dependents of the Plan may obtain from the Plan Administrator, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

STATEMENT OF ERISA RIGHTS

Federal law requires that this summary include the following information about your rights under "ERISA." ERISA is a federal law that governs the provision of benefits from employers to employees.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ATTACHMENT A – BENEFIT OPTION INFORMATION

Type of Benefit	Insurance Carrier Name and Policy No.	Address
Medical	Kaiser Health Plan of Washington Consult your Employer for the Policy No.	320 Westlake Ave. N., Suite 100 Seattle, WA 98109-5233
This document incorporates the Kaiser Health Plan of Washington Benefit Booklet. You may obtain a copy at www.kp.org/wa after you create your member log in.		
Dental	Delta Dental PPO (Policy No. 09220)	Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175-0983
This document incorporates the Delta Dental PPO Benefit Booklet. You may obtain a copy at www.wsaditbenefits.com.		
Vision	Group Vision Care Plan (Policy No. 30012378)	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
This document incorporates the Group Vision Care Plan Benefit Booklet. You may obtain a copy at www.wsaditbenefits.com.		
Life and AD&D	Employee Life Insurance and Accidental Death and Dismemberment Insurance (Policy No. 01-00173540)	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066
This document incorporates the Employee Life Insurance and Accidental Death and Dismemberment Insurance Benefit Booklet. You may a copy at www.wsaditbenefits.com.		
Short Term Disability	Weekly Disability Income Insurance (Policy No. 01-00173543)	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066
This document incorporates the Weekly Disability Income Insurance Benefit Booklet. You may obtain a copy at www.wsaditbenefits.com.		
Long Term Disability	Group Long Term Disability Insurance (Policy No. 01-00173541)	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066
This document incorporates the Group Long Term Disability Insurance Benefit Booklet. You may obtain a copy at www.wsaditbenefits.com.		
Voluntary Life	Life Insurance and Accidental Death and Dismemberment Insurance (Policy No. 40-0173542)	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066
This document incorporates the Voluntary Life Insurance and Accidental Death and Dismemberment Insurance Benefit Booklet. You may obtain a copy at www.wsaditbenefits.com.		

ATTACHMENT B - COBRA CONTINUATION COVERAGE

What is COBRA Coverage?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides you and your dependents the right to continue medical, dental, and vision coverage in specified circumstances. Under COBRA, if medical, dental, and vision coverage for you or your dependents terminates as a result of a "qualifying event" (as described in the chart below), you or they will be offered continuation of medical, dental, and vision coverage for up to the length of time indicated. For more information about your rights and obligations under the Plan and under federal law, you should review the applicable benefit options summary plan description or contract the Plan Administrator.

When you become eligible for COBRA you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Participants who elect to continue coverage have the right to add dependents to their coverage under the same terms applicable to active employees during enrollment periods. Children born to, adopted by or placed with a qualified beneficiary during the COBRA period qualify for coverage under COBRA for the remainder of the qualified beneficiary's COBRA period.

COBRA Qualifying Event:	**COBRA Maximum Coverage Duration (actual duration may be shorter)**
Termination of employment (for any reason other than gross misconduct or disability)	18 months (employee and covered dependents)
Reduction in the employee's hours worked	18 months (employee and covered dependents)
Death of the employee	36 months (covered dependents)
Divorce or legal separation	36 months (spouse/former spouse and covered dependent children)
Participant becomes entitled to Medicare benefits (Part A, Part B or both)	36 months (covered dependents)
Dependent child ceases to qualify as a dependent	36 months
Disability	18 or 29 months based on eligibility for Social Security disability benefits
Participant or covered dependent who becomes disabled at any time during first 60 days of COBRA*	29 months

*Disabled individuals must notify the COBRA administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the original 18-month COBRA period expires.

If you or a covered dependent elects COBRA coverage, a second qualifying event during an 18 month COBRA continuation period, your covered dependents can get up to 18 months additional COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. Second qualifying events occur when the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part a, Part B or both) or gets divorced or legally separated during the initial COBRA period. The extension is only available if the second qualifying event would have cause the covered dependent to lose coverage under the Plan had the first qualifying event not occurred.

You and/or your dependents both have independent and separate rights to elect to continue coverage under the medical, dental, and vision plans in which you and/or they were enrolled at the time the qualifying event occurred. You may only change your medical insurance if you are in an HMO plan and are moving to an area not serviced by that HMO and another medical insurer under this Plan provides coverage in the area to which you move.

COBRA Administrator:

See the Important Plan Information section in the SPD. Certain COBRA Notice and Election Forms are provided at the end of this SPD.

Notice Requirement:

If you experience a change in family status that will cause a person to lose coverage under the Plan (such as divorce, legal separation or a child reaching an age that prevents coverage under the Plan), you must notify the Plan Administrator of the change in family status within 60 days so that COBRA continuation coverage may be offered to the affected person(s).

The Cost of COBRA Coverage:

Each month, you, your spouse or your child(ren) will receive a bill for the full premium for coverage with instructions for submitting payment. The cost of the coverage will be 102% of the applicable premium for any period of continued coverage, or 150% of the premium for the 19th through the 29th month of coverage if COBRA is extended due to disability. The first premium must be paid within 45 days of the individual's election to continue coverage, and must cover the number of full months from the date the coverage was lost until the date the first premium for coverage under COBRA is received. In most cases, medical, dental, and/or vision coverage begins from the first day after the day your coverage would otherwise have been terminated to prevent a lapse in coverage.

Reasons COBRA Coverage May Terminate:

Coverage will end before the maximum duration period for any of the following reasons:

- Failure to pay the applicable premium by the due date. There is no grace period.
- Anyone covered under COBRA benefits who becomes covered under Medicare or any other group health plan that does not contain any exclusions or limitations with respect to a pre-existing condition of the individual, other than a pre-existing condition or exclusion that does not apply to or is satisfied by the individual under applicable federal law.
- You or covered dependent becomes enrolled for Medicare benefits.
- The individual is no longer disabled during the 11-month extension of benefits for disability.

Conversion of Medical Coverage:

When medical coverage ends through COBRA, the individuals covered under COBRA benefits are generally eligible to convert their coverage to an individual policy then offered through the insurer. Any

right you may have to conversion coverage is described in the detailed explanation for each benefit, as discussed on pages 4 and 5 of this booklet. If you have elected continued benefits under COBRA, conversion to an individual policy is available only if medical coverage ends as a result of the expiration of the maximum period of coverage under COBRA.

Conversion is available only if coverage is not available through another employer-sponsored medical plan. The applicable insurance company determines what type of individual conversion policy is available. Note that the conversion policy may offer different benefits than those provided under this Plan. No medical examination is required to convert coverage. However, you must make written application and pay the first premium within 30 days after coverage under this Plan ends. Premium rates will be based on the fee schedules established by the individual plan.

ATTACHMENT C - UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA (the Uniformed Services Employment and Reemployment Rights Act of 1994) provides employees who leave work to serve in the uniformed services of the United States with certain rights upon their return from service. USERRA also permits these employees to elect to continue coverage under their employer's group health plan for themselves and their dependents for a limited time.

Continuation of Health Plan Coverage under USERRA

If an employee or an employee's dependent will lose group health plan coverage because the employee will be absent from work to serve in the uniformed services, the employee can elect to continue coverage for the employee and the employee's dependents.

USERRA continuation coverage lasts for up to 24 months after the employee's absence begins. Coverage will terminate before the 24-month period when ANY of the following events occur:

- a premium payment is not made within the required time
- the employee fails to return to work (or apply for reemployment) with his or her Dealer within the time required under USERRA (see the "Returning to Work" section below) following the completion of service in the uniformed services
- the employee loses his or her rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA
- the employee becomes covered under the Plan as an active employee of the Dealer

Please Note: USERRA continuation coverage for a dependent also ends when coverage for a dependent who is not receiving USERRA coverage would end.

Returning to Work

The employee's right to continue coverage under USERRA ends if he or she does not notify his or her Dealer of his or her intent to return to work within the time required under USERRA following the completion of service in the uniformed services by either reporting to work or applying for reemployment as described below:

If the service is less than 31 days or the employee is absent for any period of time for purposes of an examination for fitness to perform service, the employee must return to work by the beginning of the first regularly scheduled work period on the day following the completion of the employee's service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of the employee, as soon as possible.

If service is more than 30 days but less than 181 days, the employee must apply for reemployment within 14 days after completion of service or, if that is unreasonable or impossible through no fault of the employee, the first day on which it is possible to do so.

If service is more than 180 days, the employee must apply for reemployment within 90 days after completion of service.

If the employee was hospitalized for or was convalescing from an injury or illness incurred or aggravated as a result of the employee's service, the time to return to work or submit an application for reemployment is extended to the end of the period necessary for the employee to recover from the illness or injury. This period may not extend for more than two years after the employee's completion of service, except the two-year period may be extended if circumstances beyond the employee's control make it impossible or unreasonable for the employee to report to work within the above time periods.

Please Note: The Plan requires a premium for USERRA continuation coverage. The amount of the premium depends on the length of service the employee performs. If service is for fewer than 31 days, he or she must pay the regular employee share, if any, of the premium for health plan coverage. If service is for 31 or more days, the Plan may require the employee to pay up to 102% of the full premium (the Dealer's share plus the employee's share, if any, plus 2% for administrative costs). This is the same as the normal COBRA premium.

Electing and paying for USERRA coverage

Follow the same procedures that apply for the election of COBRA and the payment of COBRA premiums, including all required election and payment deadlines. See *Attachment B — COBRA Continuation Coverage*.

Reinstatement in Health Plan Coverage Upon Return from Uniformed Service

If group health plan coverage for the employee or the employee's dependents terminated due to the employee's service in the uniformed services of the United States (whether at the beginning of or during that service), and the employee is entitled to reinstatement with his or her Employer under USERRA, the coverage must be reinstated when the employee becomes reemployed. (Under USERRA, the employee has a right to reemployment only if certain requirements are satisfied, including timely return to work or application for reemployment as described in "Returning to Work" above.) No exclusion or waiting period may be imposed in connection with the reinstatement of coverage upon reemployment, if that exclusion or waiting period would not have been imposed had coverage not been terminated by reason of the employee's service in the uniformed services. A health plan, however, may impose an exclusion or waiting period as to illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

USERRA and COBRA Continuation Coverage

Both the USERRA continuation coverage and COBRA continuation coverage rules may apply when an employee is absent from work to perform service in the uniformed services. The employee's absence generally results in a COBRA qualifying event – a loss of coverage due to the employee's termination of employment or reduction in hours. The employee has the right to elect to continue coverage under both COBRA and USERRA. This means that the employee and other COBRA qualified beneficiaries are entitled to the greater protection under COBRA or USERRA.

If you (the covered employee), your spouse or domestic partner, or your dependent child would lose group health plan coverage (Medical, Dental, or Vision coverage) under the WSADIT Benefit Plan because of a "qualifying event," you or your affected family may be eligible to elect to continue coverage for a limited time. This continued coverage is called "COBRA coverage." (You may have health insurance coverage options other than COBRA coverage. See "Are There Other Coverage Options Besides COBRA Coverage?" at the end of this Attachment B.)

The general rules governing COBRA coverage, including the maximum period of COBRA coverage and when COBRA coverage terminates before the applicable COBRA maximum coverage period expires, are described in the Benefits Booklet for your applicable WSADIT Medical Benefit or WSADIT Dental Benefit. The same COBRA provisions described in your WSADIT Medical Benefit apply to your Vision Services Benefits.

COBRA NOTICE OF QUALIFYING EVENT

INSTRUCTIONS: ***Use this Notice of Qualifying Event when ANY of the following events occur*:**

- A spouse covered under the Plan has divorced or legally separated from the covered employee.
- A spouse whose Plan coverage was eliminated or reduced in anticipation of divorce or legal separation divorces the covered employee.
- A child covered under the Plan has ceased to be a dependent under the terms of the Plan.

Complete, date, sign, and mail, personally deliver or fax this Notice of Qualifying Event to the COBRA Administrator at:

Mail	Personal Delivery	FAX
Benefit Solutions, Inc. P.O. Box 65 Mukilteo, WA 98275-0065 ***Attention:*** WSADIT COBRA	Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 ***Attention***: WSADIT COBRA	(425) 771-1226 ***Attention:*** WSADIT COBRA

Domestic Partners: treat the termination of a domestic partnership as a divorce.

You must provide timely written notice of the qualifying event. You are not, however, required to use this form of Notice of Qualifying Event. Check the most recent Summary Plan Description for more information on your obligation to notify the COBRA Administrator of a divorce, legal separation or child's loss of dependent status. (If you do not have a copy, you may request one from the COBRA Administrator).

Questions? Call the COBRA Administrator at (425) 771-7359 or (206) 859-2600.

DEADLINE: Mail this Notice within 60 days after the later of **(1)** the date of Event you identify in Event Description below OR **(2)** the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the Event. (The postmark is the date of mailing.)

Please Note: If you fail to mail this Notice within the 60-day period, the spouse and dependent child(ren) **WILL LOSE THEIR RIGHT TO ELECT COBRA COVERAGE.**

1. Identify the Employee

Print Name of Employee:	Address of Employee:

2. Event Description (Check A or B and complete)

❑**A**. Employee and spouse: ☐ divorced ☐ legally separated	Date of divorce/legal separation:
Print name of spouse:	Address of spouse:

❑**B**. Employee's child ceased to be an eligible dependent under the Plan. Reason child ceased to be eligible dependent (check one): ☐ Attained age 26 ☐ Other (explain):

Print name of child:	Date child ceased to be dependent (for example, date attained age 26):

Address of child: ☐ Same as employee's address ☐ Different address (provide address below)

3. Certification, Signature, Date and Telephone Number

I certify that the above information is true and correct.

I am the (check one): ☐ Employee ☐ Spouse or former spouse ☐ Former dependent child
☐ Other (explain):

Signature:	Print Name:
Date:	Telephone Number:

FOR OFFICE USE ONLY

Date of Postmark: _____, 202_

Was Notice timely? ☐ Yes ☐ No If "No", retain envelope. Has envelope been retained? ☐ Yes ☐ No

COBRA NOTICE OF SECOND QUALIFYING EVENT

INSTRUCTIONS: ***Use this Notice of Second Qualifying Event when (1) a spouse or dependent child is receiving COBRA coverage due to the covered employee's termination of employment or reduction in hours of employment AND (2) any of the following events (second qualifying events) occur during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours:***

- A spouse who is receiving COBRA coverage becomes legally separated or divorced from the covered employee.
- A child who is receiving COBRA coverage ceases to be a dependent under the terms of the Plan.
- The covered employee dies while one or more qualified beneficiaries are receiving COBRA coverage.

Complete, date, sign, and mail, personally deliver or fax this Notice of Second Qualifying Event to the COBRA Administrator at:

Mail	Personal Delivery	FAX
Benefit Solutions, Inc. P.O. Box 65 Mukilteo, WA 98275-0065 ***Attention:*** WSADIT COBRA	Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 ***Attention***: WSADIT COBRA	(425) 771-1226 ***Attention:*** WSADIT COBRA

Domestic Partners: treat the termination of a domestic partnership as a divorce.

You must provide timely written notice of the second qualifying event. You are not, however, required to use this form of Notice of Second Qualifying Event. Check the most recent Summary Plan Description for more information on your obligation to notify the COBRA Administrator of a COBRA second qualifying event. (If you do not have a copy, you may request one from the COBRA Administrator). **Questions?** Call the COBRA Administrator at (425) 771-7359 or (206) 859-2600.

DEADLINE: Complete, sign and mail, personally deliver or fax this Notice of Second Qualifying Event within 60 days after the date of the second qualifying event. (The postmark is the date of mailing.)

Please Note: If you fail to mail this Notice within the 60-day period, the spouse and dependent child(ren) **WILL LOSE THEIR RIGHT TO EXTEND COBRA COVERAGE.**

1. Identify the Employee

Print Name of Employee:	Address of Employee:

2. Identify Initial Qualifying Event

☐ Termination of Covered Employee's Employment ☐ Reduction in Hours of Covered Employee's Employment

3. Event Description (Check A or B and complete)

❑**A**. Employee and spouse: ☐ divorced ☐ legally separated	Date of divorce/legal separation:
Print name of spouse:	Address of spouse:

❑**B**. Employee's child ceased to be an eligible dependent under the Plan. Reason child ceased to be eligible dependent (check one): ☐ Attained age 26 ☐ Other (explain):

Print name of child:	Date child ceased to be dependent (for example, date attained age 26):

Address of child: ☐ Same as employee's address ☐ Different address (provide address below)

4. Certification, Signature, Date and Telephone Number

I certify that the above information is true and correct.

I am the (check one): ☐ Employee ☐ Spouse or former spouse ☐ Former dependent child
☐ Other (explain):

Signature:	Print Name:
Date:	Telephone Number:

FOR OFFICE USE ONLY

Date of Postmark: _____, 202_
Was Notice timely? ☐ Yes ☐ No If "No" retain envelope. Has envelope been retained? ☐ Yes ☐ No

COBRA NOTICE OF DISABILITY

INSTRUCTIONS*: Use this form when the Social Security Administration (SSA) has determined that a qualified beneficiary was disabled on any day during the first 60 days of COBRA coverage, when the COBRA qualifying event was the covered employee's (a) termination of employment OR (b) a reduction of hours*. *Please Note:* If SSA made the disability determination before the termination of employment or reduction of hours, you may still use this Notice of Disability to report the earlier disability determination, so long as the qualified beneficiary remains disabled and you provide this Notice of Disability by the deadline described below. Complete, date, sign, and mail, personally deliver or fax this Notice of Disability to the COBRA Administrator at:

Mail	Personal Delivery	FAX
Benefit Solutions, Inc. P.O. Box 65 Mukilteo, WA 98275-0065 ***Attention:*** WSADIT COBRA	Benefit Solutions, Inc. 12121 Harbour Reach Dr., Suite 105 Mukilteo, WA 98275 ***Attention***: WSADIT COBRA	(425) 771-1226 ***Attention:*** WSADIT COBRA

Check the most recent Summary Plan Description for more information on your obligation to notify the COBRA Administrator of a disability. (If you do not have a copy, you may request one from the COBRA Administrator.) **Questions?** Call the COBRA Administrator at (425) 771-7359 or (206) 859-2600.

DEADLINE: Complete, sign and mail, personally deliver or fax this Notice within 60 days after the latest of (1) the date of SSA's disability determination; (2) the date of termination of employment or reduction of hours; OR (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice must also be mailed, delivered or faxed within 18 months after the termination of employment or reduction of hours. (The postmark is the date of mailing.) If you fail to notify the COBRA Administrator of a qualified beneficiary's disability within the 60-day period and 18-month period, all COBRA qualified beneficiaries **WILL LOSE THEIR RIGHT TO EXTEND COBRA COVERAGE BEYOND 18 MONTHS**.

REQUIRED DOCUMENTATION: You must include a copy of SSA's determination of disability with this Notice of Disability. If, however, you cannot provide a copy, complete, sign and mail, personally deliver or fax this Notice by the Deadline above. The COBRA Administrator will contact you.

1. Identify the Employee

Print Name of Employee:	Address of Employee:

2. Identify Initial Qualifying Event

Initial Qualifying Event was: ☐ Termination of employment ☐ Reduction in hours	Date of Initial Qualifying Event:

3. Identify Disabled Qualified Beneficiary

Name of Disabled Qualified Beneficiary:	Address: ☐ Same as employee's address ☐ Different address (provide address)

4. Identify All Other Qualified Beneficiaries (Attach Sheet with Additional Names if Necessary)

Print Name of Qualified Beneficiary:	Address: ☐ Same as employee's address ☐ Different address (provide address)
Print Name of Qualified Beneficiary:	Address: ☐ Same as employee's address ☐ Different address (provide address)
Print Name of Qualified Beneficiary:	Address: ☐ Same as employee's address ☐ Different address (provide address)

5. Social Security Administration Disability Determination

Date of SSA Disability Determination: Date Qualified Beneficiary Became Disabled (according to SSA determination):

Have you enclosed a copy of SSA's Disability Determination ☐ Yes ☐ No

6. Certification, Signature, Date and Telephone Number

I certify that the above information is true and correct. I am the: ☐ Employee or Former Employee ☐ Disabled Qualified Beneficiary ☐ Other Qualified Beneficiary ☐ Other (explain):

Signature	Print Name:
Date:	Telephone Number:

FOR OFFICE USE ONLY

Social Security Administration determination of disability enclosed? ☐ Yes ☐ No

Date of Postmark: _____, 202_

Was Notice timely? ☐ Yes ☐ No If "No," retain envelope. Has envelope been retained? ☐ Yes ☐ No