WASHINGTON STATE AUTO DEALERS

INSURANCE TRUST BENEFIT PLAN

Summary Plan Description

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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, 2021 through December 31, 2021. 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. These other materials, coupled with this booklet, constitute a Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA").

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 additional 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 and Prescription Drug, Dental, Vision, Group and Voluntary Life, Accidental Death and Disability, Short-Term 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, 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
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.
Plan Funding:	Employers and Employees contribute toward the cost of Employee and Dependent coverage. These contributions are accumulated in the Trust. The Trust is the contract holder for the primary insurance and third-party administrator contracts through which benefits are provided. The Trust remits premiums to insurance companies and third-party administrators.
Cost and Contributions	Your Employer may make significant contributions to purchase the benefits offered under this Plan. Your Employer may modify the level of Employer and Employee contributions at any time, for any reason.
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:	September 1st (subject to change)
Summary of Benefits:	Attachment A lists the benefit programs available under the Plan and the name and contact information for the

	insurance company or third-party administrator responsible for providing the benefits. You may ask for detailed explanations for each benefit, without cost to you, by making a request to the Plan's Third Party Administrator. Such explanations will describe: eligibility requirements; a description of any cost-sharing requirements (i.e., premiums, deductibles, coinsurance, copays); any annual or lifetime caps on benefits payable; the extent to which preventive services are covered; whether, and under what circumstances, existing and new drugs, medical tests, devices, and procedures are covered; rules (if any) relating to the use of network providers, including any limits on the selection of primary care and specialty medical care providers; conditions or limits applicable to obtaining emergency medical care; and, any provisions requiring preauthorization (sometimes called prior authorization) or utilization review as a condition to obtaining a benefit or service under the Plan.
Claims processing and appeal procedures and remedies under the Plan for redress of denied claims:	All claims are sent to and processed by the insurance company or third-party administrator (TPA) responsible for providing the benefits. The insurance company or TPA is responsible for the review of denied benefit claims. In some instances, you may be entitled to appeal a denial of a medical claim to an independent review organization. You must follow the procedures and meet all the deadlines described in the applicable Benefit Booklet, including the deadlines to file any claim appeals. 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. Neither the Plan or its Trust, nor your Dealer is responsible for the review of denied benefit claims.

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 applicable Benefit Booklet(s) for more information.

Dependent Eligibility

Refer to the applicable Benefit Booklet(s) for the specific rules governing each benefit's 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 a domestic partner by Affidavit, as described in the applicable Benefit Booklet(s).

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.

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

When Coverage Begins

Refer to the Benefit Booklet(s) for the benefit's 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).

Plan Amendments or Termination

The Board of Trustees may amend or terminate the Plan or Trust at any time and for any reason. Participating Dealers choose which benefit options to offer and may cease to offer any benefit available under the Plan at any time. These changes may be made without prior notice to Employees and their dependents.

LOSS OF BENEFITS

When Benefits May Not Be Paid

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.
- 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. As an example, if your group health plan pays for your medical expenses after a car accident and you later receive compensation from the car insurance company, the Plan has the right to require you to repay the cost of the benefits provided to you. This is known as "subrogation." If applicable, your Benefit Booklets will explain the insurer's subrogation process in greater detail.

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.

Rescission of Coverage

A rescission of coverage is when your eligibility for a benefit is terminated retroactively. A rescission of coverage is limited to those instances where an enrollee commits 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 B — 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 the Family and Medical Leave Act ("FMLA") applies to your Employer and you take a leave of absence under FMLA, group health plan benefits (medical, dental and vision benefits) may be continued during the leave if you continue to pay any required employee contributions. Your Employer will provide you with prior written notice of the terms and conditions of your leave and your payment responsibilities. Subject to certain limited exceptions, if you fail to return to work after your FMLA leave, your Employer has the right to recover any contributions made on your behalf while you were away.

Special Provisions for Mothers and Newborn Infants

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth. The Newborns' and Mothers' Health Protection Act provides that neither the mother nor the newborn baby may be sent home less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Caesarean section. If the provider determines a longer stay is medically necessary, the group health plan cannot require the provider to request prior authorization for the extended stay. Nothing in the law prohibits the mother or child from going home in less than 48 (or 96) hours so long as the provider and mother agree that it is safe to do so.

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 ("QMCSO")

A QMCSO is a court or administrative agency order that requires a dependent to be covered by a group health plan. Participants and dependents of the Plan may obtain from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

Mental Health Parity

Your group health plan cannot require you to pay more for covered mental health and substance disorder benefits than you would pay for any other medical or surgical benefit. It also cannot impose treatment-duration limitations any greater than those for other covered medical benefits. To the extent your group health plan covers mental health or substance disorder treatment, the benefit provided will comply with this and any other state law related to mental health parity.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

This federal law prohibits discrimination in group health plan coverage and employment based on genetic information. This Plan is operated and maintained in a manner consistent with GINA.

STATEMENT OF ERISA RIGHTS

Federal law requires that this summary include the following information about your rights under the Employee Retirement Income Security Act of 1974 ("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 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 at 1-866-444-3272.

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

This notice explains COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Benefit Program summaries, or contact the Plan Administrator or a designated Human Resources representative.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy individual health insurance through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may also qualify for a thirty (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 does not accept late enrollees.

What is COBRA Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA Qualifying Event	Maximum Coverage Duration
Termination of employment (for any reason other than gross misconduct)	18 months – all qualified beneficiaries
Reduction in Employee's hours worked	18 months – all qualified beneficiaries
Death of the Employee	36 months – spouse & dependent children
Divorce or legal separation	36 months - spouse & dependent children
Employee's Medicare *entitlement*. Entitlement is the same as enrollment.	36 months - spouse & dependent children
Child ceases to qualify as a "dependent child"	36 months – dependent child

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Employee Notice Requirements: If you experience a change in family status that will cause a person to lose coverage under the group health plan (such as divorce, legal separation, Medicare entitlement, or a child reaching an age that prevents coverage), you must notify the COBRA Administrator of the change in family status within sixty (60) days. It is important to offer COBRA continuation coverage to these individuals on a timely basis.

Extending the 18-month continuation period:

There are ways an 18-month period of COBRA continuation coverage may be extended:

- Disability Extension: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- Second Qualifying Event Extension: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Coverage Options Other than COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Enrolling in Medicare Instead of COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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.

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 Benefit Booklet (detailed explanation for each benefit), as discussed on pages 5 and 6 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.

ATTACHMENT D – YOUR PRIVACY RIGHTS

This following Privacy Notice describes the legal obligations of the Plan and your legal rights regarding your Protected Health Information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your Protected Health Information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

This Notice applies only to the Attachment A benefits that constitute group health plans, unless otherwise excepted in accordance with ERISA Section 733.

We are required to provide this Notice of Privacy Practices ("Notice") to you pursuant to HIPAA.

The HIPAA Privacy Rule protects certain medical information known as "Protected Health Information" (PHI) only. Generally, Protected Health Information is individually identifiable health information, including demographic information, which relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan's Third Party Administrator.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

YOUR RIGHTS:

You have the following rights with respect to your Protected Health Information.

Right to Inspect and Copy:

- You have the right get an electronic or paper copy of your medical record or other health information we have about you. Make your request in writing and submit it to our Privacy Official or designated Human Resources representative.
- We will provide a copy within 30 days of your request. We may charge a reasonable, cost-based fee for the copying.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Make your request in writing and submit it to our Privacy Official or designated Human Resources representative. Provide a reason that supports your request.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Make your request in writing and submit it to our Privacy Official or designated Human Resources representative. We will not ask you for the reason for your request.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- To request a limitation, make your request in writing and submit it to our Privacy Official or designated Human Resources representative. In the request, tell us 1) what information you want us to limit; 2) whether you want to limit our use, our disclosure, or both; and, 3) to whom the limits apply (for example, disclosure to your spouse).

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one free accounting per year but will charge a reasonable, cost-based fee if you ask for another one within 12 months. We have 60 days to provide you with the information you have requested.
- To request an accounting, make your request in writing and submit it to our Privacy Official or designated Human Resources representative. State the time period you wish to review.

Get a copy of this Privacy Notice

You can ask our Privacy Official or designated Human Resources representative for a paper copy of this Notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel we have violated your rights, you can file a written complaint with the Plan by contacting our Privacy Official or designated Human Resources representative at {phone #].
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share**.** If you have a clear preference for how we share your information in the situations described below, tell us what you want us to do, and we will follow your instructions. Provide a written Authorization to our Privacy Official or designated Human Resources representative that we may keep in your file. You make revoke your written Authorization, in writing, at any time.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, personal representatives, or others involved in your care.

- Share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

We never share your information unless you give us written permission for:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

To Treat You

We can use your PHI and share it with other professionals who are treating you. For example, we might share information about your prior prescriptions to a pharmacist to help him or her determine if a new prescription will interact with a current medicine and make you sick

To Run our Plan

We can use and share your health information to run our Plan. For example, we might use your PHI for conducting a quality assessment of our benefits, to submit claims to a stop-loss insurer, to arrange for medical reviews, or other routine and general administrative Plan activities.

We can *never* use your PHI in making employment or compensation decisions.

To Bill for Your Services

We can use and share your health information to bill and get payment from health plans or other entities and to determine the benefits owed to you under the Plan.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your Protected Health Information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.

We must follow the duties and privacy practices described in this Notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you.

The effective date of this Notice is: October 1, 2020.

ATTACHMENT E – PREMIUM ASSISTANCE UNDER MEDICAID & CHIP

If you or your children are eligible for Medicaid or CHIP (the Children's Health Insurance Program) and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877- KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
http://myalhipp.com/ Phone: 1-855-692-5447	http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA - Medicaid**
The AK Health Insurance Premium Payment Program http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid: http://www.indianamedicaid.com Phone 1-800-403-0864
CALIFORNIA - Medicaid	**IOWA – Medicaid**
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	https://dhs.iowa.gov/ime/members Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563
COLORADO – Medicaid and CHIP	**KANSAS – Medicaid**
Health First Colorado: https://www.healthfirstcolorado.com/ Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884

KENTUCKY – Medicaid	NORTH CAROLINA – Medicaid
KY Integrated Health Ins. Premium Payment Program https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 KY Medicaid: https://chfs.ky.gov	https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
LOUISIANA – Medicaid	**NORTH DAKOTA – Medicaid**
www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-695-2447 or 1-855-618-5488	http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MAINE – Medicaid	**OKLAHOMA – Medicaid and CHIP**
http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 / TTY: Maine relay 711	http://www.insureoklahoma.org Phone: 1-888-365-3742
MASSACHUSETTS – Medicaid and CHIP	**OREGON - Medicaid**
http://www.mass.gov/eohhs/gov/departments/masshealth Phone: 1-800-862-4840	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MINNESOTA – Medicaid	**PENNSYLVANIA – Medicaid**
https://mn.gov/dsh/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
MISSOURI – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	http://www.eohhs.ri.gov/ Phone: 855-697-4347 Direct RIte Share Line: 401-462-0311
MONTANA – Medicaid	**SOUTH CAROLINA – Medicaid**
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	https://www.scdhhs.gov Phone: 1-888-549-0820
NEBRASKA – Medicaid	**SOUTH DAKOTA - Medicaid**
http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEVADA – Medicaid	**TEXAS – Medicaid**
https://dhcfp.nv.gov Phone: 1-800-992-0900	http://gethipptexas.com/ Phone: 1-800-440-0493
NEW HAMPSHIRE - Medicaid	**UTAH – Medicaid and CHIP**
https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number: 1-800-852-3345, ext 5218	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW JERSEY – Medicaid and CHIP	**VERMONT - Medicaid**
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW YORK – Medicaid	**VIRGINIA – Medicaid and CHIP**
https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	https://www.coverva.org/hipp/ Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282

WASHINGTON - Medicaid	WISCONSIN – Medicaid and CHIP
https://www.hca.wa.gov/ Phone: 1-800-562-3022	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WEST VIRGINIA - Medicaid	**WYOMING - Medicaid**
http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Dep't of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Option 4, Ext. 61565

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