SUMMARY PLAN DESCRIPTION SUPPLEMENT for Plan Participants and Beneficiaries of the

WASHINGTON COMMERCIAL CONSTRUCTION HEALTH TRUST PLAN
as of January 1, 2020

Your employer participates in the Washington Commercial Construction Health Trust (the "Trust"). The Trust is a multiple employer welfare arrangement sponsored by the Washington Commercial Construction Health Group (the "Industry Group"), which is created to serve members of Associated Industries of the Inland Northwest in the Construction industries by offering welfare benefits, such as medical, dental, vision, life and disability insurance, to eligible employees of participating employers in the Industry Group. The Trust hereby establishes the Washington Commercial Construction Health Trust Plan (the "Plan") to consolidate certain health and welfare benefit programs under one unified plan and to provide for uniform rules and policies for the programs offered through the Plan. The Plan and Trust are governed by the Trust Administration Committee, as described further below.

This wrap around document contains Summary Plan Description ("SPD") information for the programs and benefits provided to Plan Participants and enrolled Dependents through the Plan and is intended to address certain information that may not be addressed in the insurance booklets or summaries provided by the insurance providers.

The benefits provided by the Plan (including information about who is eligible to receive benefits) are summarized in the booklet or benefits summary issued by the insurance provider providing the benefits. This SPD supplement is intended to be read in conjunction with and as a supplement to the benefit summaries and other plan documents that may be provided to you.

This SPD, the Trust Agreement, the Group Administrative Guide**,** your employer's Group Master Application ("GMA") on file with the Trust, the insurance booklets and contracts or policies issued by the insurance companies that provide benefit coverage and the enrollment forms on which you and your dependents sign up for coverage collectively constitute the plan document. In the event of a conflict between the provisions of the various plan documents, the insurance policies will control with respect to the benefits provided by each such policy, unless superseded by applicable law.

The Plan's third-party administrator, Associated Industries Management Services ("AIMS"), has the employer's GMA and the insurance contracts, policies, booklets and other plan documents available for your examination. If you have questions about the Plan or a benefit it provides, you can find more information at www.aimstpa.com or by calling AIMS as 800-274-5309.

Trust Administrative Committee's Discretion.

The Trust Agreement provides that the Trust Administrative Committee has the discretion to interpret the provisions of the Plan. In exercising fiduciary responsibilities, the Trust Administrative Committee will have discretionary authority (a) to determine whether and to what extent Participants and enrolled dependents are entitled to Plan benefits, and (b) to construe the Plan terms. The Trust Administrative Committee will be deemed to have properly exercised such discretionary authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously. Any interpretation or determination by the Trust Administrative Committee made in good faith, which is not contrary to law, is conclusive and binding on all persons affected.

The Trust Administrative Committee has hired various insurance companies to provide benefits to eligible Plan participants. The Trust Administrative Committee has delegated to these insurance companies and to the Plan's third-party administrator, AIMS, the authority to administer the Plan and provide information relating to the amount of benefits, eligibility and other Plan provisions.

An interpretation of Plan benefits is subject to review by the relevant insurance carrier and the insurance carrier is responsibility for its decision. An interpretation of plan eligibility, plan funding, selection of benefit providers or other non-benefit related issues is subject to review by the Trust Administrative Committee. No individual trustee, employer or employer association, or any individual employed by an employer or employer association, has any authority to interpret or change this SPD or the Plan.

The Trust Administrative Committee reserves the right to make any changes it deems necessary to promote efficiency, economy and better service for the Plan participants and their covered dependents. The Trust Administrative Committee has no obligation to furnish benefits beyond those that can be provided by the Trust. The Plan is provided to the extent that money is currently available to pay the cost of such Plan.

Employer Eligibility.

An employer must be a member in good standing of Associated Industries of the Inland Northwest and the Industry Group in order to participate in the Trust. Participating employers must have two enrolled employees to be eligible. If the group falls below two employees, it will not be eligible for coverage or renewal. The Trust reserves the right to require an employer to seek different coverage if the group falls below two employees.

Terms specific to your employer's enrollment in the Plan and Trust may be found in the Group Master Application ("GMA") completed by your Employer to enroll as a participating member employer in the Plan. Your employer's GMA is available from the Third-Party Administrator upon request.

Employee Eligibility.

Employees of a participating employer who have satisfied the conditions stated in the employer's GMA are eligible to participate in the Plan, provided the applicable premium is received on their behalves. Conditions set forth in the employer's GMA may include, but are not limited to, one or a combination of the following:

- Limitations to employee scheduled to work at least a specified number of hours per week (at least 20 hours);
- Limitation to a particular class or classes of employee; or
- Completion of a permissible waiting period (not to exceed three months).

To determine eligibility for participation for you and your enrolled dependents for a specific program, please review the eligibility information contained in the summary of benefits booklet issued by the insurance provider for the specific program.

Dependent Eligibility.

Dependents are generally eligible for enrollment as provided under the applicable benefit booklet, policy or contract. Generally, eligible dependents include the participant's legal spouse, qualified domestic partner, and the dependent children of the participant, spouse or qualified domestic partner.

Termination of Participation.

Generally, your eligibility will terminate at the end of the month in which you no longer satisfy the eligibility criteria set forth in the employer's GMA, the applicable employer or employee premium is not received, the employer ceases to be eligible to participate in the Trust or the Trust ceases to provide a benefit plan. For each particular program, your eligibility for Plan benefits will terminate according to the terms in the booklet or benefits summary issued by the insurance provider, or as otherwise provided by law.

Continuation Coverage.

In the event your coverage would normally terminate you may be eligible to continue your coverage under State or Federal law, include the Family Medical Leave Act ("FMLA"), the Uniformed Services Employment and Reemployment Rights Act ("USERRA") or the Consolidated Omnibus Reconciliation Act ("COBRA"). Additionally, you may be able to convert your coverage to an individual policy to the extent permitted by the insurance carrier or enroll in an individual plan provided through the State or Federal Health Insurance Marketplace (the "Exchange") at www.HealthCare.gov or call 800.318.2596. You may be able to get coverage through the Exchange that costs less than COBRA continuation coverage.

The Plan's major continuation right, COBRA, is described more fully in the initial COBRA notice attached hereto in Appendix A. For conversion coverage, refer to the applicable insurance booklet. You may also contact the Third-Party Administrator for information about qualifying events, qualified beneficiaries, premiums, notice, election requirements and procedures, and duration of coverage.

Continuation coverage of up to 24 months and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is available from the Third-Party Administrator.

Coordination of Benefits with Leave Laws.

State and local leave laws as well as federal laws such as FMLA and USERRA require covered employers to provide paid or unpaid leave to employees in certain situations. Please check with your employer on the leave policies and procedures that are applicable to you for further information on how a leave of absence may impact your benefit coverage under the Plan.

Claims Procedure.

You or your Dependent must file the appropriate forms to receive any benefits or to take any other action under any of the programs, as described in the applicable booklet or benefits summary. Completed forms should be submitted to the appropriate entity described in the applicable booklet or benefits summary. Generally, you or your provider on your behalf will initiate a claim for benefits with the applicable entity administering the benefits program (the claims administrator or the insurance provider). Please review the booklet or benefits summary to determine exactly how to initiate a claim for benefits.

You must exhaust all of the claims review procedures described in the applicable booklet or benefits summary before you are entitled to initiate a lawsuit in state or federal court.

The appeals procedures are described in the applicable booklet or benefits summary. All levels of appeal for claim denials have been delegated to the insurance provider that is responsible for paying the claims. The insurance provider's decisions are conclusive and binding. You are not entitled to appeal the decision of the insurance provider to the Plan Administrator or the Third-Party Administrator.

Plan Information.

Plan Name:

The name of the Plan is the Washington Commercial Construction Health Trust Plan, which is a welfare plan providing group health benefits, prescription drug coverage, dental, vision, disability insurance, life insurance and other similar welfare benefits.

Plan Administrator:

Your employer represents that named Plan Administrator and retains the ability to amend or terminate the company's participation in the Plan. However, the primary duty of interpreting the Plan's terms is delegated to the Trust Administration Committee, as described above. You may request the contact information for your Employer from the Third-Party Administrator.

Third-Party Administrator:

Associated Industries Management Services
1206 N. Lincoln Suite 200
Spokane, WA 99201-2559
www.aimstpa.com
800.274.5309 509.326.6892

Plan Sponsor:

The sponsor of this Plan is your Industry Group, which is created by Associated Industries of the Inland Northwest and operated in accordance with the bylaws approved by the Industry Group member employers. You may receive from the Third-Party Administrator, upon request, information as to whether your employer is a sponsor of the Plan through its Industry Group participation, and if so, the contact information for your employer.

Employer Identification Number and Plan Identification Number:

The employer identification number as assigned by the Internal Revenue Service to the Trust is 46-7048407. The Plan Number is 501.

Plan Year:

The Plan Year is January 1 through December 31. All records of the Plan are maintained on this Plan Year.

Trustees:

The Trust Administrative Committee is made up of three Trustees, who are appointed by the Industry Group's participating employers. The names and addresses of the Plan Trustees who are currently serving on the Trust Administration Committee are available, upon request, from the Third-Party Administrator.

Legal Service of Process:

Legal process may be served upon the Plan and Trust via the Trust Administrative Committee as follows:

Washington Commercial Construction Health Trust
Administrative Committee
1206 N. Lincoln Suite 200
Spokane, WA 99201-2559

Type of Plan and Funding Medium:

This is a fully insured employee welfare benefit plan. Each benefit under the Plan is administered by the insurance provider for that benefit, as described in the applicable booklet or benefits summary. The funding medium through which benefits are provided is the Trust. The Trust is a multiple employer welfare arrangement established and maintained by the participating employers through the Industry Group sponsor.

The primary function of the Trust is to obtain benefit contracts with insurance and other benefit providers and act as the policyholder of group policies issued by insurance providers. The insurance provider is responsible for payment of claims according to the coverage levels described in the applicable booklet or benefits summary. Each participating employer shall pay to the Trust the amount of contributions required to maintain coverage for the employer's Participants. Depending on the program and your employer's designations in its GMA, contributions may be funded either wholly or partially by your employer, and either wholly or partially by the Participants. The employer contributions and employee payroll deductions are received and held by the Trust pending payment of insurance premiums and administrative expenses.

Insurance Providers:

Below are the names and addresses of the insurance providers that are contracted with the Plan. Please note: Your employer has the option of electing which of the Trust's plan benefits will be available to its employees. Accordingly, you may not be eligible for benefits from all of the providers identified below.

Regence BlueShield/Asuris Northwest Health, medical insurance
1800 Ninth Avenue, Seattle WA 98101
Regence: 1.888.370.6156 www.regence.com
Asuris: 1.888.370.6162 www.asuris.com

Delta Dental of Washington, dental insurance*
9706 Fourth Avenue NE, Seattle WA 98115
800.554.1907 www.deltadentalwa.com

Vision Service Plan (VSP), vision insurance*
600 University St. Suite 2004, Seattle WA 98101
800.877.7195 www.vsp.com

Standard Insurance Company, life, accident and disability insurance*
920 SW 6th Avenue, Portland OR 97204
800.848.5132 www.standard.com

Magellan Health Services EAP, employee assistance plan*
14100 Magellan Plaza Drive MO-10, Maryland Heights, MO 63043
800.450.7281 www.magellanhealth.com

* The contracts and insurance policies for these benefits are held by the Associated Employer Trust, which is sponsored by Associated Industries of the Inland Northwest and which contracts with the Trust to make these programs available to eligible employees of the employers who participate in the Plan and Trust.

Qualified Medical Child Support Orders.

If the Plan receives a qualified medical child support order recognizing the right of any child of a Participant to enrollment under the Plan, such child shall be enrolled as required under the terms of the order and in accordance with ERISA Section 609. A "qualified medical child support order" is a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or Dependent is eligible under this Plan, and which clearly specifies the following:

1. The name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the

name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such alternate recipient.
2. A reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined.
3. The period to which the order applies.

An "alternate recipient" is any child of a Participant who is recognized under the medical child support order as having a right to enrollment under this Plan with respect to the Participant.

The applicable insurance carrier administers its own procedures for determining whether medical child support orders are qualified medical child support orders ("QMCSO Procedures"). A Participant or enrolled Dependent may obtain from the Third-Party Administrator, without charge, a copy of the Plan's applicable QMCSO Procedures.

HIPAA Special Enrollment Rights.

Federal law requires the Plan to provide "Special Enrollment Period" for certain individuals who previously refused coverage or individuals who became dependents through marriage, birth, adoption, or placement for adoption (as described further below).

The Plan will provide a Special Enrollment Period for an employee, spouse, domestic partner or dependent who is eligible, but not enrolled in the Plan, if each of the following conditions is met:

- He or she is eligible, but not enrolled, for coverage under the terms of the Plan;
- He or she had other health plan coverage at the time coverage was previously offered;
- He or she states in writing when declining enrollment that the other coverage was the reason for declining enrollment (if required by the Plan Administrator at the time the individual previously declined enrollment);
- He or she loses coverage because (1) his or her COBRA continuation coverage expires, (2) the employee or dependent is no longer eligible for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including as a result of failure to pay premiums on a timely basis or termination of coverage for cause); or (3) the employer ceases making contributions toward such coverage; and
- He or she requests a special enrollment right within thirty days after the exhaustion or termination of other coverage.

After an employee, spouse, domestic partner or dependent gives the completed request of enrollment to the Plan Administrator, his or her enrollment is effective no later than the first day of the next calendar month.

The Plan will also provide a Special Enrollment Period for an employee or dependent as follows:

- For an employee who is eligible but not enrolled in the Plan and declined coverage under the Plan during a prior Enrollment Period, (1) at the time of his or her marriage, and (2) at the time an individual becomes his or her dependent through marriage, birth, adoption, or placement for adoption;
- For a spouse of a participant (1) at the time of his or her marriage or (2) at the time an individual becomes a dependent of the participant through birth, adoption, or placement for adoption;
- For an individual who becomes a dependent of the participant through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period will extend for 30 days after the marriage, birth, adoption, or placement for adoption. For a Special Enrollment due to marriage, enrollment is effective no later than the first day of the

month following the date the Employer receives the request for enrollment. For a special enrollment due to birth, adoption, or placement for adoption, enrollment is effective as of the date of the birth, adoption, or placement for adoption.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

An individual seeking enrollment during a Special Enrollment Period may be required to provide documentation of the event that qualifies him or her for the Special Enrollment Period.

HIPAA Preexisting Condition Limitation.

There are no preexisting condition limitations in the Plan.

ERISA Rights.

This statement of ERISA rights is required by federal law and regulation. As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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.

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

c. 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.

d. 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.

e. 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. However, effective for plan years beginning on or after January 1, 2014, any preexisting condition exclusions will be eliminated from the Plan.

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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 domestic relations order or 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 the Plan, you should contact the Plan Administrator or the Third-Party 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 1-800-998-7542.

Right to Amend or Terminate Plan.

The Trust Administrative Committee has reserved the right to amend or terminate the Plan or any Plan benefit described in this SPD for any reason or for no reason at any time. Furthermore, your employer intends this Plan to be a continuing program but reserves the right to change or discontinue any benefit it previously had chosen to provide through the Plan for any reason or for no reason at any time. As a result, you may receive different benefits than those described in this SPD supplement or the applicable benefit booklet, or such benefits on different conditions, or no benefits. This may happen while you are actively employed by the Employer or after you terminate employment. No employee of the Employer or individual Trustee has the authority to amend or modify the Plan by any oral promise or representation nor to amend or modify any Plan benefit or provision of any insurance contract or policy.

In order that the Plan may carry out its obligations to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Participants, the Trust Administrative Committee expressly reserves the right, in their sole discretion at any time and from time to time, but on a nondiscriminatory basis, to:

- Terminate or amend the Plan;
- Alter or postpone the method of payment of any benefit;
- Construe the provisions of the Plan and determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities or inconsistencies or omissions. Any construction or determination by the Trust Administrative Committee made in good faith shall be conclusive on all persons affected thereby;
- Reduce or eliminate any plan subsidy; and
- Amend or rescind any other provision of the Plan.

The Trust may be terminated by the Trust Administrative Committee in writing at any time, subject, however, to all of the requirements and procedures for plan terminations. The Trust Agreement provides that all assets remaining after payment of all expenses incidental to the dissolution or termination of the Trust shall be used to provide benefits for which the Trust was established.

APPENDIX A

To provide options for individuals who lose health coverage from an employer-sponsored insurance plan, the Federal Government enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), commonly known as "COBRA." The following will explain your rights under the law and what should be done if you (or a covered dependent) experience a COBRA "qualifying event." A qualifying event is an event that occurs whereby an employee or covered dependent would no longer be eligible to continue under a group health plan. **We request that you and your covered dependents take the time to read this important notification.**

COBRA LAW - With a few exceptions, employers with twenty or more employees that provide health benefits are required to offer employees (and/or their covered dependents) the right to a temporary extension of group insurance (called "continuation coverage") upon experiencing a qualifying event. Your employer has enrolled in a large group Associate Health Plan and, as such, you are eligible for COBRA/OBRA/DEFRA coverage. An individual experiencing a qualifying event is referred to as a "qualified beneficiary" and receives many of the rights granted to similarly-situated active employees as it relates to group insurance plans.

Continuation coverage is different from converting to individual coverage after termination of employment. The major advantages of COBRA are that participants will receive the same group plan benefits as a similarly-situated active employee and will be charged the company's group rate (plus a maximum of two percent as an administrative fee). These COBRA rates may (or may not) be less than the premiums charged under a conversion policy so it is recommended that you contact the insurer directly to receive a quote. With many conversion policies, benefits are reduced and premiums are based upon the age and sex of the converting members. Another difference is that COBRA allows for covered dependents to independently continue their health coverage and retain COBRA rights throughout their continuation time frame.

EMPLOYER AND QUALIFIED BENEFICIARY'S RESPONSIBILITIES - When you or your covered dependents experience a qualifying event, you will be sent a notification explaining your rights to elect COBRA continuation coverage. The Plan Administrator shall provide this notification within forty-four days from the date of the qualifying event (or as soon as administratively possible). You or your dependents have the responsibility to notify our office of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Keep in mind; qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the plan would have occurred.

If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you are requested to contact the Plan Administrator immediately. Even if you elect not to continue coverage, it is vital you have the information necessary to make an informed decision.

AI MANAGEMENT SERVICES INC will know when certain qualifying events (i.e. reduced work hours, employment termination, death of an employee or the employee's entitlement to Medicare) occur. You and your covered dependents will be responsible for notifying our office of a divorce, legal separation or when a dependent loses his/her "dependent status." **You or your dependents have sixty days to notify the Plan Administrator of these qualifying events. If the Plan Administrator is not notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension described below, you must also notify us within sixty days of a determination by Social Security that you or a dependent are "disabled."**

COBRA QUALIFYING EVENTS - Listed below are qualifying events for which you and/or your covered dependents are able to continue coverage under COBRA. As shown, the maximum continuation coverage time frame depends upon the qualifying event experienced. To be considered a qualified beneficiary, you or your dependent must have been enrolled on the group plan on the day prior to the qualifying event. One exception to this rule is when a child is born to (or placed for adoption with) an employee during the COBRA continuation period. These children will receive all the rights of a qualified beneficiary throughout the COBRA continuation period.

Qualifying Events That Yield a Maximum of Eighteen Months' Coverage (Experienced by the Employee)

1) Termination of employment (for reason other than "gross misconduct");
2) Reduction of employee's work hours.

Qualifying Events That Yield a Maximum of Thirty-six Months' Coverage (Experienced by a Covered Dependent)

1) Death of the employee;
2) Divorce or legal separation;
3) Employee is entitled to Medicare but dependents are not;
4) Dependent child who no longer meets the plan's definition of a "dependent."

Special Medicare Extending Rule - If an active employee becomes entitled to Medicare and later experiences a termination of employment or reduction in work hours, covered dependents may be eligible for thirty-six months of continuation coverage from the date of the Medicare Entitlement. In this situation, dependents shall be eligible for a minimum of eighteen months of COBRA continuation coverage.

EXTENDING COBRA COVERAGE - After electing to continue coverage under COBRA, there are certain situations that may allow qualified beneficiaries to increase the time frame of continuation coverage. If the initial qualifying was termination of employment or a reduction in work hours, qualifying individuals may be eligible to increase their time frame under COBRA. In each of the two situations described below, eligible individuals must notify the Plan Administrator (in writing) as explained.

Disability Extension - If the qualifying event is an employee's termination or reduction in work hours and you or a covered dependent are determined to be "disabled" by Social Security (under Title 11 or Title XVI) either before that qualifying event or within sixty days of such event, you and your covered dependents are eligible for an additional eleven months of coverage (yielding a total of twenty-nine months). For this extension to apply, evidence of disability under the Social Security Act must be provided to the Plan Administrator within the initial eighteen month continuation coverage time frame and within sixty days from the date of Social Security's determination.

Multiple Qualifying Events - If you experience a qualifying event that entitles you and your covered dependents to less than thirty-six months of continuation coverage (including the disability extension described above) and during your period of continuation coverage your covered dependents experience a second (or "multiple") qualifying event, the period of continuation coverage for your covered dependents may be extended under COBRA from eighteen months (or twenty-nine months if disabled) to thirty-six months. The maximum continuation period is thirty-six months regardless of how many qualifying events your covered dependents experience. It is the responsibility of you or your covered dependents to notify the Plan Administrator within sixty days of the multiple qualifying event. Employees who experience a reduction in work hours followed by termination of employment shall only be eligible for eighteen months of continuation coverage under COBRA. To be considered a multiple qualifying event, such event must have caused the qualified beneficiary to lose coverage had the first qualifying event not occurred.

FAMILY AND MEDICAL LEAVE ACT - Under the Family and Medical Leave Act of 1993 (FMLA), eligible employees have the right to take up to twelve weeks of unpaid leave to care for themselves or a relative. If you elect to take this leave and later notify the company that you will not be returning, you have the ability to continue your coverage for eighteen months from the date benefits are terminated on account of your failure to return to work. (FMLA does not apply to all organizations and can differ between states. Please contact a company representative for further information on FMLA.)

COBRA TERMINATION - Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at anytime by notifying our office in advance. In addition, COBRA states that continuation coverage will

end for one or more of the following reasons:

1) The company terminates all of its health plans for similarly situated active employees;
2) COBRA premiums are not paid in a timely manner;
3) You and/or your covered dependents become covered under another group plan after electing continuation coverage and that plan does not exclude a pre-existing medical condition affecting you or your dependents;
4) You become entitled to Medicare (meaning enrolled in Parts A and/or B) after you have elected continuation coverage under COBRA;
5) You or a covered dependent are enrolled in a plan that requires you to live in the plan's "service area" or visit contracted providers and you move out of that service area. However, if another plan is available to similarly situated active employees who move from the service area, coverage under that plan will be offered to you;
6) You file fraudulent claims or engage in other activities for which a similarly situated active employee would be terminated "for cause;" or
7) A "disabled" participant is determined by Social Security to be no longer disabled during the eleven month extension. In that case, the entire family unit will be terminated from COBRA.

PREMIUM COSTS - The cost of continuation coverage will be determined at the time of the qualifying event. Your cost will be the amount the insurance company charges AI MANAGEMENT SERVICES INC (or if the plan is self insured, the cost of coverage as determined by the company) for similarly situated active employees under the plan plus a 2% administration fee. An employee who is deemed to be disabled and who elects the disability extension may be charged a 50% administration fee during the eleven month extension. (If the disabled employee does not elect the disability extension or terminates coverage before the extension would ordinarily end, his/her covered dependent's administration fee will be reduced to 2 %.) If the firm's premium increases or decreases, the COBRA participant's premiums will be adjusted accordingly. Premium rates for the plan are set for twelve month periods based upon the Plan Year.

If you elect to continue coverage under COBRA, you will be granted an initial forty-five day grace period to make your payment. Your first payment must include the premiums for coverage retroactively to the date you or your covered dependents would have lost coverage if you hadn't elected to continue coverage. Subsequent premium payments will have a thirty day grace period. If premiums are not received within the allotted grace period, COBRA coverage will be terminated back to the date for which premiums were applied. The company asks for full payment by the first of the month but will accept multiple payments (equaling the total monthly premium due) throughout the month of coverage.

COVERAGE UNDER COBRA - Once the Plan 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.

Since COBRA is a continuation of benefits, your benefits will remain the same as prior to the qualifying event. If the company elects to change plans and/or benefits, you will be eligible to enroll in the changed plan and will therefore receive the same benefits as a similarly situated active employee. If your plan has deductibles and coinsurance maximums, these amounts will be based upon expenses incurred prior to the qualifying event by only those family members electing to continue under the plan.

COBRA participants who move from the plan's service area may lose coverage under the group health plan (as would a similarly situated active employee). If the company offers a plan that would provide coverage in the new area, the COBRA participant will be offered the right to enroll in that plan.

OPEN ENROLLMENT - COBRA participants are offered the same rights as similarly situated active employees during open enrollment. They may change plans and add/delete eligible dependents. Although part of the family unit, dependents (other than newborn children and adopted children of the employee) added during open enrollment will not have the same COBRA rights as the initial qualified beneficiaries. The company's open enrollment may vary from year to year so feel free to contact the Plan Administrator for further information on open enrollment.

CONVERSION POLICIES - A conversion policy allows individuals covered under a group plan to convert their coverage to an individual policy without a lapse in coverage or a pre-existing condition limitation upon termination from the group plan. Not all group plans offer a conversion right. If you are enrolled in a plan that allows conversion, you will receive a notification explaining conversion privileges in the last 180 days of your COBRA term.

USERRA - Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights apply only to eligible employees and eligible dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

- The 24 month period beginning on the date that Uniformed Service leave commences; or
- The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage. Upon return to active employment, the employee's health coverage and that of the employee's eligible dependents will be reinstated. No exclusions or waiting periods may be imposed on the employee or the employee's eligible dependents. However, plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

TRADE ACT OF 2002 – On August 6, 2002, the Trade Act of 2002 was signed into law expanding the benefits available to workers displaced by import competition or shifts of production to other countries. The Trade Act of 1974 initially offered benefits (known as "trade adjustment assistance") which expired September 30, 2001. The Trade Act of 2002 extended this period to September 30, 2007 and offers qualified workers a tax credit of up to 65% of COBRA health insurance premiums for both them and their family.

To be eligible for the tax credit, you must be currently receiving trade adjustment assistance or considered an "eligible Pension Benefit Guaranty Corporation (PBGC) pension recipient," paying premiums for qualified health insurance, not receiving other coverage and not in prison. The law also creates a second "election period" for individuals not electing COBRA coverage upon their loss of employment if they are within the six months immediately after their group health plan coverage ended. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) - The scope of HIPAA is to eliminate barriers for individuals (mainly people with pre-existing medical conditions that would have difficulty obtaining immediate coverage) who lose coverage and want to find a replacement plan. The law limits a plan's "pre-existing condition limitation time frame" to twelve months for newly enrolling individuals and provides credit for prior medical coverage, including COBRA continuation coverage. When you terminate from a group medical plan, you will receive a Certificate of Coverage that illustrates your prior coverage. This certificate should be shown to a new employer to receive one month credit for every month of prior coverage. If there is a break in coverage greater than sixty-three days, the new employer does not have to provide any prior coverage credit. (Individuals receiving trade adjustment assistance and who enroll in COBRA during the "second election period" shall receive creditable coverage even with a break in coverage larger than sixty-three days.)

In addition, if you elect COBRA and keep your coverage for the maximum continuation period available to you, you may be eligible for coverage under an individual plan (through an insurer of your choice) on a guaranteed issue basis without any pre-existing condition limitations.

PLAN ADMINISTRATOR - The Plan Administrator is your contact as it relates to COBRA and your continuation coverage. If you have any questions regarding this notification or your continuation coverage, you may review your Plan's Summary Plan Document or contact the Plan Administrator. It is your responsibility to notify the Plan Administrator of any qualifying events and when you have a change of address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

AIMS
1206 N Lincoln St Suite 200
Spokane, WA 99201-2559
(800) 274-5309

aimstpa@aiin.net

FURTHER INFORMATION AVAILABLE - For further information concerning your Plan or your COBRA continuation coverage rights, you may contact the insurance carrier(s) identified below. For information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Plan Contacts:
If you have Medical Coverage:

Regence BlueShield
Customer Service
Phone: 1 (888) 370-6156 (TTY: 711)
1800 Ninth Avenue
Seattle, WA 98101 www.Regence.com

Asuris Northwest Health
Customer Service
Phone: 1 (888) 370-6156 (TTY: 711)
528 E. Spokane Falls Blvd., Suite 301 Spokane, WA 99202 www.Asuris.com

If you have Dental Coverage:
Delta Dental of Washington Customer Service
P: 800.554.1907
9706 4th Avenue NE Seattle, WA 98115 www.deltadentalwa.com

If you have Vision Coverage:
Vision Service Plan Customer Service
P: 800.877.7195
600 University St, Ste 2004
Seattle, WA 98101 www.vsp.com