Wrap Summary Plan Description

Seattle Pacific University Health & Welfare Plan

Effective: January 1, 2019

Introduction

This Wrap Summary Plan Description ("Wrap SPD") is part of the Seattle Pacific University Health & Welfare Plan. The Employee Retirement Income Security Act of 1974 ("ERISA") requires that the Employer, as the sponsor of this Plan, provide you with information that describes the Plan and provisions that relate to your eligibility for benefits, the benefits that are available and reasons why your benefits may be limited or denied.

The Plan provides certain benefits each of which is called a "Benefit" in this Wrap SPD. These Benefits are listed in the Benefits Chart shown on Schedule A, attached at the conclusion of this document. The Benefits are described in more detail in separate Benefit Descriptions, Booklets, Certificates of Insurance, Evidences of Coverage, and/or similar documents (the "Benefit Descriptions"). These Benefit Descriptions are incorporated by reference into this Wrap SPD and are part of the Plan. The Benefit Descriptions may be provided to you along with this Wrap SPD or may be provided to you separately or at another time. Although separate all of these documents are considered to be the Summary Plan Description for this Plan.

Conflict between this Wrap SPD and the Benefit Descriptions
This document does not replace the provisions of any insurance policies that the Employer has purchased to provide benefits under the Plan or any other Benefit Descriptions. In the event of any difference between this Wrap SPD and the Benefit Descriptions, the terms of Benefit Descriptions will govern. However, where possible, this Wrap SPD is intended to supplement the provisions of the Benefit Descriptions.

General Information about the Plan

Type of Plan:	Employee welfare benefit plan
Plan Year:	January 1st to December 31st
Plan Number:	507
Plan Sponsor:	Seattle Pacific University 3307 Third Avenue West, Suite 302 Seattle, WA 98119-2846 (206) 281-2676
Plan Sponsor' s EIN:	91-0565553
Type of Administration:	Benefits are insured or self-funded as shown on the Benefits Chart attached hereto as Schedule A. Each Benefit is administered by the insurance carrier or claims administrator listed on the Benefits Chart.
Plan Funding:	Insurance premiums and benefits for Participants and Dependents are paid in part by the Plan Sponsor from its general assets, and in part by employees' pre-tax payroll deductions.
Plan Administrator:	Seattle Pacific University
Named Fiduciary:	Seattle Pacific University
Agent for Service of Legal Process:	Seattle Pacific University

Benefits

The Benefits offered under the Plan are listed and described on the most recent Schedule A, which is attached hereto and incorporated into this Wrap Summary Plan Description.

Eligibility and Participation

Employee Eligibility
In general, and in accordance with the Benefit Descriptions, an Eligible Employee means any of the following:

(a) All active, regular employees of Seattle Pacific University who regularly work a minimum nine-month work schedule and at least 20 hours per week.

(b) Retirees who were enrolled in the group's medical and dental plans prior to termination of employment may continue group medical and dental coverage as specified in the certificate.

(c) Any other employee who, when hired or following a measurement period, has been determined by the Employer to be classified as "full-time" pursuant to the requirements of the Affordable Care Act or other applicable law.

Waiting Periods
A "waiting period" is the period of time that elapses before coverage for an otherwise eligible individual becomes effective. Coverage for benefits under this Plan begins on the first day of the month coinciding with or following the first day of employment as an Eligible Employee.

Dependent Eligibility
Dependents are eligible to participate in the Plan to the extent that they are permitted to participate under the terms of each Benefit Description and only to the extent that the Benefit provides coverage for dependents. Generally and subject to the restrictions below and in the Benefit Descriptions, the following individuals may be enrolled in the Plan as Dependents:

(1) **Legal spouse.** The term "spouse" means the husband or wife of an Eligible Employee.

(2) **Children.** For medical and dental benefits, the children of an Eligible Employee are eligible for coverage until they reach the age of 26. Refer to the Benefit Descriptions for age limitations for other benefits.
The Plan also will extend benefits to dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of dependent children who are biological children of Participants.

(3) **Others.** For long-term care benefits, extended family between the ages of 18 and 80 may be covered in accordance with the terms of the Benefit Descriptions; for purposes of this paragraph, extended family refers to grandparents, in-laws, children and siblings.

The Employer reserves the right to request verification of Dependent status as necessary to determine eligibility for Plan coverage. Please see the Benefit Descriptions for additional eligibility information.

Enrollment
Any employee who is eligible to participate in this Plan and follows the election procedures required by the Employer and in the applicable Benefit Description will be considered a "Participant."

An employee's Spouse or Child who is eligible to participate in the Plan and who follows the required election procedures will be considered a "Dependent."

The Benefits also require an annual election. If a Participant changes his or her elections during an open enrollment period, any new or change in coverage will become effective on the first day of the plan year following the open enrollment period. Changes that occur outside the open enrollment period must be made in accordance with the election change procedures described by the Employer in the SPD, cafeteria plan documents, or similar document.

When Coverage Ends (Termination Date)

Unless otherwise provided in the individual Benefit Descriptions, coverage for Participants and Dependents described in this Plan will terminate at 11:59 p.m. on the last day of the month in which the Participant ceases to be an Eligible Employee as set forth in this Wrap SPD, except that medical coverage (including HRA and FSA) for Participants who have qualified as a full-time employee pursuant to the Affordable Care Act and who remain employed, will remain eligible throughout the last day of the stability period for which they have qualified.

Employees who are on vacation, are sick or are on a leave of absence will continue to be eligible for coverage as required by law and described in this Wrap SPD and the Benefit Descriptions. In certain circumstances, after coverage terminates a Participant and/or his or her dependents may be eligible for continued coverage and/or a conversion policy.

Dependent coverage will terminate upon termination of the employee's coverage, loss of eligibility for dependent coverage, or otherwise as described in the applicable Benefit Description.

If you or any Dependent makes a false representation to the Plan, the Employer, as Plan Administrator, has the right to permanently terminate coverage for the Participant and his or her Dependents. Fraudulent or intentional false representations may result in retroactive termination of coverage. False representation includes, but is not limited to, submitting falsified claims or covering an individual who is not eligible to participate in the Plan.

Special Enrollment Rights

In addition to the initial or annual election periods described above, an employee or dependent may enroll in medical coverage or change a medical coverage election if the individual has experienced a qualifying event as defined in the Benefit Descriptions. An individual seeking to enroll or change medical coverage due to a qualifying event must make the request:

- Within 60 days after termination of Medicaid or CHIP coverage due to loss of eligibility;
- Within 60 days after receiving notification that the employee or dependent has become eligible for premium assistance under Medicaid or CHIP;
- Within 30 days after losing other coverage or after a marriage, birth, adoption, or placement for adoption; or
- As otherwise provided in the Benefit Descriptions or required by law.

State laws may provide more generous special enrollment periods; refer to the Benefit Descriptions for more detailed information about special or late enrollment.

Qualified Medical Child Support Orders

An eligible dependent child may include a child for whom a Participant is required to provide coverage pursuant to a qualified medical child support order (QMCSO). A QMCSO is a court or administrative judgment, decree or order that is typically issued as part of a divorce or as part of a state child support order proceeding and that requires health plan coverage for an "alternate recipient" (meaning either a child of a participant or state or political subdivision acting on behalf of a child). The alternate recipient will be treated like any other plan participant.

Upon receipt of a child support order, the plan administrator will promptly send a written notice of receipt of the order to the participant and all alternate recipient children named in the order and their legal representatives.

If the plan administrator receives a National Medical Support Notice, it must notify the state agency whether coverage for the child is available under the plan and indicate the effective date of coverage (or any steps necessary to make the coverage effective, including copies of any forms that must be completed). The Plan Administrator will also send a description of the coverage.

After sending the notice of receipt, the plan administrator has the ultimate authority to determine whether or not the order meets the requirements of a QMCSO. Within 40 days after receiving the order, the Plan Administrator will notify the participant and the alternate recipients that either the order is a valid QMCSO or that the order is not a valid QMCSO. If an order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order.

Coverage will become effective for the eligible child(ren) on the first day of the month following the later of (1) the date of the Employer notification to the alternate recipient that the notice is a valid QMCSO; or (2) the date the Employer receives any required enrollment forms; or (3) the date specified in the QMCSO. If the Employee has not yet met the waiting period, coverage will not become effective until the end of the waiting period.

Funding and Administration

Funding
The Benefits will be funded as described in the Benefits Chart and in the Benefit Descriptions or other documents applicable to that Benefit, but generally, the cost will be paid in part by the Employer from its general assets and in part by employees' pre-tax contributions.

Benefits are provided through insurance policies purchased by the Employer or are self-funded by the Employer. The Employer is not an insurer of any benefit.

Administration
The administration of the Plan is under the supervision of the Employer as Plan Administrator. The principal duty of the Plan Administrator is to ensure that the Plan is operated in accordance with its terms and for the exclusive benefit of those persons who are entitled to participate in the Plan. Other responsibilities of the Plan Administrator include interpreting the Plan, determining eligibility for coverage under the Plan, approving benefits and the amount of benefit payments, gathering information necessary for administering the Plan, and maintaining all records of the Plan. The Plan Administrator may delegate any of these administrative duties to one or more other entities.

Payment of Claims

Claim Filing
Each insurance company or claims administrator will decide claims and make claim payments in accordance with its reasonable claims procedures, as required by federal and any applicable state laws. A complete description of the insurance company or claims administrator's claims procedures can be found in the Benefit Description or can be obtained from the applicable company. The procedures for filing claims, if required, are found in these procedures. If a claim is denied, in whole or in part, the Participant will receive a notice in writing setting forth the reason for the denial and other required information.

Benefit Denials
The procedures Participants are required to follow to file a complaint or grievance pertaining to denial of a claim for benefits or coverage are available to all Participants and beneficiaries, at no cost.

Refund of Overpayments
Whenever a payment has been made under any Benefit in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision ("Overpayment"), you or any Dependent must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of the Overpayment from another person or organization.

This includes any Overpayments resulting from retroactive awards received from any source including workers' compensation, fraud, or any error made in processing your claim.

In case of a recovery from an outside source, Overpayment recovery will not be more than the amount of the payment. This right to recovery or reimbursement exists regardless of the manner in which the recovery is structured or worded, and even if the Participant or Dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits, as permitted by law, or demanding an immediate refund of the Overpayment.

Subrogation

Because the Plan is entitled to reimbursement of medical expenses owed by a third party, the Plan has the right to seek repayment of these expenses from the responsible third party. This means that the plan is subrogated to any and all rights, recovery or causes of actions or claims that a Participant or Dependent may have against any third party.

The Plan may enforce its subrogation rights by requiring the Participant to assert a claim to any insurance or other benefits to which the Participant or a Dependent may be entitled.

Once a Participant or Dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) will be required to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or Dependent to any payment, amount or recovery from a third party.

Each Participant and Dependent consents and agrees that they will not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Continuation of Coverage during Leaves of Absence

General

In general, if an Employee goes on a leave of absence, the Employee, as well as the Employee's spouse and dependents, may continue coverage during the leave period if permitted by the Employer's policies regarding leaves of absence. Employees should refer to such policies and procedures for requirements relating to reinstatement, notice, and premium contributions.

Family and Medical Leave Act

This provision applies only for employees working for the Employer at a location that is subject to the FMLA and only during those years in which the Employer is required to comply with the Family and Medical Leave Act of 1993 (the "FMLA").

In general, a Participant who is an "eligible employee" under the FMLA is entitled to up to 12 workweeks of unpaid, job-protected leave per year for certain family and medical reasons. Participants should refer to the Employer's FMLA Policy for specific questions about eligibility for FMLA benefits.

The Employer will maintain group health insurance coverage, including family coverage, for a Participant on FMLA leave on the same terms as if the Participant continued to work. The Participant must follow the procedures set forth in the Employer's FMLA Policy to make arrangements for payment of any employee share of health insurance premiums during unpaid FMLA leave. Such payments may be made under any arrangement voluntarily agreed to by the employer and employee.

The Employer's obligation to maintain health benefits under the FMLA stops if and when the Participant informs the Employer of an intent not to return to work at the end of the leave period, or if the Participant fails to return to work when the FMLA leave entitlement is exhausted. The Employer's obligation also stops if the Participant's premium payment is more than 30 days late and the Employer has given the Participant written notice at least 15 days in advance advising that coverage will cease if payment is not received.

Continuation of Coverage under State Family and Medical Leave Laws or Similar State Laws
To the extent this Plan is required to comply with state or local family and medical leave laws or ordinances that are more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such law or ordinance and with the Family and Medical Leave Act.

Non-FMLA Leaves of Absence
If a Participant goes on a leave of absence that is not subject to the FMLA or for benefits that are not subject to the FMLA, the Participant will be permitted to continue coverage in accordance with the Employer's policies relating to non-FMLA leaves of absence.

Military Leaves of Absence
Participants 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, as amended ("USERRA"). These rights apply only to Participants and Dependents covered under the Plan before leaving for military service. "Military Service" means the armed forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the Commissioned Corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active or inactive duty, whether or not in training, full-time National Guard duty, a period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties; a period for which you are absent from your job for the purpose of performing certain funereal honors duty; and certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, the Participant may elect to continue coverage under USERRA for up to 24 months from the date leave for Uniformed Service began. This USERRA continuation coverage will end earlier if one of the following events takes place:

(1) The Participant or a Dependent fails to make a premium payment within the required time;
(2) The Participant fails to report to work or to apply for reemployment within the time period required by USERRA following the completion of Service; or
(3) The Participant loses rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, the contribution amount will be the same as for active Participants. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage provided under any state law requiring continuation of coverage.

If coverage under the Plan terminated because of Service in the Uniformed Services, coverage will be reinstated on the first day of return to employment if the Participant is released under honorable conditions and returns to work within the time period required by USERRA.

Continuation of Coverage after Termination

General

If a Participant or Dependent is a "qualified beneficiary" and loses medical coverage because of a life event known as a "qualifying event," then the qualified beneficiary may have the right to purchase continued coverage for a temporary period of time. Qualifying events include termination of employment (other than for gross misconduct), reduction in hours, divorce, death, a child ceasing to meet the definition of dependent, or the Participant's or spouse's eligibility for Medicare (Part A, Part B or both).

Qualified Beneficiaries

A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse, or an employee's dependent child. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

Notice of Qualifying Event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has received *timely* notification that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the Participant in Medicare, the Employer must notify the Plan Administrator of the qualifying event within 31 days after the qualifying event or the loss of coverage. For other qualifying events, such as divorce or legal separation, or the dependent child's loss of eligibility for coverage as a dependent, the Participant or dependent must notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the loss of coverage. Notice must be provided as required by the initial COBRA notice which has been delivered by the Employer or the Employer's COBRA Administrator. If these procedures are not followed or if the notice is not provided within the 60-day notice period, any beneficiary who loses coverage WILL NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

COBRA Elections

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage by the specified deadline, coverage will begin on the date of the qualifying event.

Duration of Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, enrollment of the Participant in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months. When the qualifying event is the end of employment or reduction in the Participant's hours of employment, COBRA continuation coverage lasts for up to 18 months.

There are three ways in which this 18-month period can be extended:

(1) If the qualified beneficiary covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the Plan Administrator is notified by providing a copy of the determination letter within 60 days after the date of the determination, but before the end of the 18-month continuation period, the qualified beneficiary can receive up to an additional 11 months of coverage for a total of 29 months.

(2) If any qualified beneficiary experiences another qualifying event while receiving COBRA continuation coverage (such as death of the Participant or divorce), the beneficiary can get additional months or COBRA continuation coverage, up to a maximum of 36 months.

(3) If a qualifying event that is termination of employment or reduction of hours occurs within 18 months after the Participant becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the Participant became entitled to Medicare (but the Participant's maximum coverage period will be 18 months).

Additional Information
For additional information about COBRA continuation rights and for any questions about COBRA, please read the General COBRA Notice, a copy of which has been provided to each Participant and his/her covered spouse. Participants can contact the Plan Administrator for another copy.

Election Changes

An employee or Participant may change his or her election during a Plan Year only if the employee or Participant has the right to a special enrollment (as described above) or if an event occurs for which a change is permitted by the Employer and is in accordance with the provisions of the Employer's cafeteria or Section 125 plan documents, if applicable.

Amendment and Termination of the Plan

The Plan Sponsor has the right to amend or terminate the Plan at any time for any reason and without notice. No person has any vested rights to benefits under this Plan. The insurance companies that provide benefits under the Plan may make changes to the Plan either as required by law, as requested by the Employer, or in their own discretion.

General Notices

Benefits after Childbirth (NMHPA)
Group health plans may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third-party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA prevents discrimination by group health plans and insurance companies based on genetic information. Generally, this Plan and the insurance companies from which it has purchased coverage are not permitted to:

- Use genetic information to discriminate with respect to premiums or contributions;
- Request or require Participants and/or their Dependents to undergo genetic testing (except in specifically permitted situations);
- Collect genetic information for underwriting purposes or prior to enrollment under the Plan;
- Use genetic information to determine eligibility for coverage.

Genetic information includes any information about (i) an individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual.

Women's Health & Cancer Rights Act (WHCRA)
If the Participant or Dependent have had or are going to have a mastectomy, the individual may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances shown in the Benefit Description will apply.

Additional Information

Compliance with State and Federal Mandates
With respect to the Benefits and as applicable, the Plan will comply with the requirements of all applicable laws. If for some reason the information presented in this Wrap SPD differs from the actual requirements of any law, the Plan reserves the right to administer the Plan in accordance with those requirements.

No Contract of Employment
Nothing in this Plan shall be construed as a contract of employment between the employer and any employee or Participant, or as a guarantee of any employee or Participant to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

Additional Information contained in Benefit Descriptions
The following additional information about the Benefits is included in the Benefit Descriptions for the benefit (if applicable):

- Any additional procedures for enrolling in the Plan;
- A summary of benefits, though this may be provided as a separate document;
- A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of your contributions, if any, to the premium payment will be provided to you by the Employer;
- A description of any annual or lifetime caps or other limits on benefits;
- Whether and under what circumstances preventive services are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers (if any). If there is a network, the Benefit Description will contain a general description of the provider network and you will receive access, without charge, to a list of providers in the network from the carrier or administrator;
- Whether and under what circumstances coverage is provided for any out-of- network services;
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any services requiring preauthorization or utilization review as a condition to obtaining a benefit service;
- A summary of the claim procedures. However, if the claims procedures are not included in the Benefit Description, a copy will be provided to you automatically, without charge from the insurance carrier or administrator;
- Provisions describing the coordination of benefits with the benefits provided under another similar plan in which you or another plan participant are enrolled;
- Any subrogation or reimbursement rights that prevent duplicate payments for your health care; and
- Any other benefit limitations and exclusions.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants are entitled to:

Receive Information about the Plan and its Benefits
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), if any, 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The administrator may make a reasonable charge for the copies.

The plan administrator may be required by law to furnish each participant with a copy of a summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself and/or your 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.

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 welfare 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 an employee welfare benefit or exercising your rights under ERISA.

Enforce Participant's Rights
If your claim for an employee 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 $149 per 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 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.

SCHEDULE A

Benefits Chart

The following benefits are described in this Wrap SPD and are included in the Plan as ofJanuary 1, 2019.

Coverage	Plan Type	Funding	Carrier or Administrator
Medical	PPO	Self-funded	Cigna
Dental	PPO	Self-funded	Delta Dental of Washington
Vision	PPO	Self-funded	Vision Service Plan
Life	n/a	Insured	Cigna
Accidental Death	n/a	Insured	Cigna
Long Term Disability	n/a	Insured	Cigna
Employee Assistance Program	n/a	Insured	Cigna
Long Term Care	n/a	Insured	UnumProvident
Health Reimbursement Arrangement	n/a	Self-funded	Cigna
Health Flexible Spending Account	n/a	Self-funded	Benefit Administration Company
Wellness	n/a	Self-funded	Cigna

Please refer to the attached Benefit Descriptions for the address and phone number of the respective insurance carrier or claims administrator for each benefit.