SUMMARY PLAN DESCRIPTION INFORMATION
for Plan Participants and Beneficiaries of the
TOURISM INDUSTRY HEALTH TRUST

This insert contains Summary Plan Description information for the programs and benefits provided to Plan Participants and Beneficiaries through the Tourism Industry Health Trust (the "Plan").

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 insert 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.

Plan Administrator.

The Plan is administered by the Business Health Trust (the Plan Administrator).

Plan Administrator's Discretion.

The Plan Administrator is the named fiduciary under the Plan. In exercising fiduciary responsibilities, the Plan Administrator will have discretionary authority (a) to determine whether and to what extent Participants and Beneficiaries are entitled to Plan benefits, and (b) to construe the Plan terms. The Plan Administrator will be deemed to have properly exercised such discretionary authority unless the Plan Administrator has abused its discretion hereunder by acting arbitrarily and capriciously.

Plan Sponsor.

The sponsor of this Plan is the tourism industry group. You may receive from the Plan Administrator, upon request, information as to whether your employer is a Participating Employer in the Plan 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 36-7481494. 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. In some cases your contract renewal year may not be the same as the Plan Year. The contract renewal year for some Participating Employers is July 1 through June 30 and for some Participating Employers is January 1 through December 31.

Type of Plan.

This is an 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 Tourism Industry Health Trust (the "Trust"). The Trust is a multiple employer welfare arrangement established and maintained by the Participating Employers. The primary function of the Trust is to act as the policyholder of the group policy issued by the insurance provider. The insurance provider is responsible for payment of claims according to the coverage levels described in the applicable booklet or benefits summary. Each eligible Employer shall pay the amount of contributions required to maintain coverage for the Employer's Participants. Depending on the program, contributions may be made either wholly or partially by your Employer, and either wholly or partially by the Participants.

Trustees.

The names and addresses of the Trustees of the Trust are available, upon request, from the Plan Administrator at:

Business Health Trust
c/o Vimly Benefits Solutions
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

Legal Service.

Legal process may be served upon the Plan Administrator at:

Business Health Trust
c/o Vimly Benefits Solutions
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

Eligibility.

To determine eligibility for participation for you and your Beneficiaries 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.

Termination of Participation.

Your eligibility for Plan benefits will terminate according to the terms in the booklet or benefits summary issued by the insurance provider.

If coverage for you or a Beneficiary ceases, you may be entitled to purchase up to three months of continuation coverage under the Plan. If coverage for you or a Beneficiary ceases because of certain qualifying events specified by federal law, then you or your Beneficiary may have the right to purchase continuing coverage for a period of time. Refer to your COBRA

notice previously provided to you or contact the Plan 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 Plan Administrator.

Claims Procedure.

You or your Beneficiary 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 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.

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 Beneficiary is eligible under this Plan, and which clearly specifies the following:

(i) 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.

(ii) 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.

(iii) 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 Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders ("QMCSO Procedures"). The Plan Administrator shall permit each alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order. A Participant or Beneficiary may obtain from the Plan Administrator, without charge, a copy of the Plan's QMCSO Procedures. The following QMCSO Procedures shall apply when any medical child support order is received by this Plan with respect to a Participant:

(i) The Plan Administrator shall promptly determine whether the order is a qualified medical child support order, as defined in Section 609(a)(2)(A) of ERISA. The Plan Administrator shall promptly notify the Participant and each alternate recipient of its decision.

(ii) An alternate recipient under a qualified medical child support order shall be considered a Beneficiary under the Plan.

(iii) Any payment for benefits made by this Plan pursuant to a medical child support order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient of the alternate recipient's custodial parent or legal guardian.

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, 2015, 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. 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 Trustees intend this Plan to be a continuing program but reserve the right to amend or terminate this Plan at any time and to terminate benefits thereunder.