

**Resolution No. 15-1059**

**A RESOLUTION APPROVING AND ADOPTING A HEALTH REIMBURSEMENT ARRANGEMENT WITH KABEL BUSINESS SERVICES AS THE THIRD-PARTY ADMINISTRATOR (TPA) AND AUTHORIZING THE CITY'S DESIGNATED PLAN ADMINISTRATOR TO SIGN ALL NECESSARY DOCUMENTS**

**WHEREAS**, the City of Windsor Heights desires to formalize its partially self-funded employee health insurance plan into a Health Reimbursement Arrangement; and

**WHEREAS**, the City has previously authorized Kabel Business Services to act on behalf of the City as its third-party administrator in administering a health reimbursement arrangement plan, flexible benefit (Section 125) plan and COBRA plan; and

**WHEREAS**, the form of Health Reimbursement Arrangement effective January 1, 2016, presented at this meeting is hereby approved and adopted and that the duly authorized agents of the City are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan; and

**WHEREAS**, the Administrator is instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the plan; and

**NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF WINDSOR HEIGHTS, STATE OF IOWA**, that the City Treasurer shall act as soon as possible to notify employees of the adoption of the Health Reimbursement Arrangement by delivering to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented at this meeting, which is hereby approved.

**BE IT FURTHER RESOLVED**, that the undersigned certifies that attached hereto as Exhibits A and B, respectively, are true copies of the Health Reimbursement Arrangement and Summary Plan Description approved and adopted in the foregoing resolution(s).

Passed and Approved this 19th day of October, 2015

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Diana Willits, Mayor

Attest: \_\_\_\_\_  
Brett Klein, City Administrator



ADOPTION AGREEMENT FOR HEALTH REIMBURSEMENT ARRANGEMENT

The undersigned Employer, by executing this Adoption Agreement, elects to adopt the accompanying Health Reimbursement Arrangement (the "Plan") by adopting said plan document in full. The Employer makes the following elections granted under the provisions of the plan.

- 1. Employer: City of Windsor Heights. (The Employer shall be the Plan Sponsor and Plan Administrator). Address: 1145 66th Street, #1 City: Windsor Heights State: IA Zip: 50324 Contact Person: Marcia Woodke Phone: 515-645-1281 Fax: 515-279-3604 E-Mail Address: mwoodke@windsorheights.org Business Type: C-Corp S-Corp Partnership Sole Prop. LLC Other City govt Federal I.D. Number 42-6004577

- 2. Effective Date. [X] This Health Reimbursement Arrangement shall be effective as of January 1, 2016. [ ] This amended Health Reimbursement Arrangement shall be effective as of [ ] If amended and restated, the Plan was originally effective on [ ]
3. Plan Year. The initial Plan Year shall begin on Jan. 1, 2016, and end on [ ] Future Plan Years will be based on a full twelve-month period beginning each [ ] and ending each [ ]
4. Excluded Employees. The following employees are excluded from the plan: [X] Employees not participating under Employer group health insurance plan. [ ] Part-time Employees expected to work less than [ ] hours per week. [ ] Commission Salespersons. [ ] Any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers unless the collective bargaining agreement requires the employee to be included within the Plan. [ ] Any Employee who is temporary or seasonal (working for the Employer less than 6 months of the year). [ ] Any Leased Employee. [ ] Nonresident Aliens [ ] Other [ ]

For purposes of determining continued eligibility under the Plan, Retirees [ ] shall [ ] shall not be eligible to continue participation in the Plan.

- 5. Plan Entry Date. Employees eligible to participate may become Participants: [X] Same as Employer's group health insurance plan. [ ] [ ] days after date of hire. [ ] Other [ ]

6. **Benefits.** The Plan shall reimburse Eligible Employees for the cost of Eligible Medical and Dental Expenses (as defined under Internal Revenue Code Section 213 and as further described below), subject to an annual limit of \$ \_\_\_\_\_ or amount specified in attachment A. Specific dollar amount per attachment A of this amount can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred).

Eligible Medical and Dental Expenses. The following categories of expenses qualify for reimbursement under the Plan:

- Comprehensive. All medical, dental and vision expenses not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), except as otherwise described as follows: \_\_\_\_\_
  - Deductible. Only those expenses that are covered under insurance, but subject to a deductible. Coverage will be provided for out-of-pocket costs.
    - Benefits under this Plan shall be paid BEFORE the employee is responsible for his portion of the deductible limit;
    - Benefits under this Plan shall be paid AFTER the employee's portion of the deductible limit is paid.
    - Coinsurance expenses will be included in this benefit.
  - Limited. Only those expenses that are not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), as further selected as follows:
    - Dental Expenses;
    - Vision Expenses;
    - Prescription Drugs;
    - Other: \_\_\_\_\_
  - Premium Only. Only the employee's applicable premium of the following employment-related insurance coverages (either employer-provided or individual employee purchased policies):
    - Health Insurance Premiums;
    - Dental Insurance Premiums;
    - Disability Insurance Premiums;
    - Long-term Care Insurance Premiums;
    - Other: \_\_\_\_\_
7. **Contributions.** Other than for Retiree/COBRA continuees, the employer shall make all contributions for this Plan.
8. **Order of Benefit Payments.** If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:
  - Eligible Medical and Dental Expenses must be paid under the Section 125 Plan before this Plan;
  - Eligible Medical and Dental Expenses must be paid under the Section 125 Plan after this Plan;
  - Applicable health insurance premiums are paid under this Plan before being paid under the Section 125 Plan.
9. **Accrual of Benefits:** The amount available for reimbursement to the employee will accrue in the following manner(s):
  - At the beginning of the plan year the full amount of the annual limit will be available for reimbursement.
    - If an employee becomes eligible during the plan year the annual limit will be prorated for the remainder of the year and that amount will be available for reimbursement.
    - The annual limit will be divided by 12 and be accrued monthly.
    - The annual limit will be divided by 4 and be accrued quarterly.

10. **Terminated employees shall:**

- cease to be a participant. They shall have 60 days from their termination date to submit bills for reimbursement for expenses incurred up to their termination date.
- continue to be a participant as long as funds remain in his/her account. The funds available for reimbursement will be the amount in the HRA account on the termination date.
- Other: \_\_\_\_\_  
\_\_\_\_\_

11. **For COBRA continuation of benefits the Qualified Employee must elect:**

- COBRA continuation for medical insurance and the HRA as a combined benefit.
- COBRA continuation for the HRA benefit as a stand alone benefit.

12. **Affiliated Employers.** The following Employers have adopted this Plan:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. **Authorized Signatures:**

Date \_\_\_\_\_

By  \_\_\_\_\_  
Employer Signature

Date \_\_\_\_\_

By \_\_\_\_\_  
Third Party Administrator Signature

# Attachment A

Employer: City of Windsor Heights

The annual limit for benefits shall be set as follows:

Employees with single coverage under the group health plan \$ 1250-union / 1400-non-union annual limit.

Employees with family coverage under the group health plan \$ \_\_\_\_\_ annual limit.

Other: \$ 2500 union  
2800 non-union

The following limit(s) are set for amounts that can be carried over and used in subsequent year(s).

Employees with single coverage under the group health plan \$ - 0 - maximum.

Employees with family coverage under the group health plan \$ - 0 - maximum.

Other:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X  
Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Administrator Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

**CERTIFICATE OF CORPORATE RESOLUTION**

The undersigned Secretary of \_\_\_\_\_ (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on \_\_\_\_\_, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of Health Reimbursement Arrangement effective \_\_\_\_\_, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Health Reimbursement Arrangement by delivering to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to this meeting, which form is hereby approved.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of the Health Reimbursement Arrangement and Summary Plan Description approved and adopted in the foregoing resolutions.

\_\_\_\_\_  
Secretary/Principal

Date: \_\_\_\_\_

**KABEL BUSINESS SERVICES**  
**HRA ADMINISTRATIVE SERVICES AGREEMENT**

This agreement specifies the services to be provided by Kabel Business Services to (Client) \_\_\_\_\_, regarding the administration of their Health Reimbursement Arrangement for the plan year beginning: (Date) \_\_\_\_\_.

**Administrator**

The Employer shall be the Plan Administrator and Kabel Business Services shall be engaged as a subcontractor in the performance of administrative services for the plan.

**Services to be provided by Kabel Business Services**

1. We will maintain the "Plan Document", keep it in compliance with all IRS regulations and prepare the Summary Plan Description.
2. We will prepare the annual 5500 tax return, if required and forward it to you for review and signature prior to the due date, which is seven months after the end of the plan year.
3. We will conduct the employee meetings to educate and answer any questions about the HRA, and provide all of the required documents.
4. We will perform the necessary highly compensated testing to insure compliance with the federal regulations.
5. We will review employee claims for reimbursement for compliance with the plan document and we will reimburse the employees **daily** for claims received.
6. We will prepare and furnish to the client, employee account statements two months prior to the end of the plan year.
7. We will be available to answer any questions the employees may have concerning the plan operation.
8. We will maintain a web site and voice response system that will allow the participants to check the status of their accounts 24 hours a day, seven days a week.

**Responsibilities of the Employer**

1. Plan Documents. Secure legal review of the HRA Plan Documents and amendments and Summary Plan Description from Employer's legal counsel.
2. Enrollment. Provide a listing of participants, names, addresses, social security number and contribution amounts.
3. Employer Contributions. We will write check on our bank account and bill the employer at the end of the month for any checks written during the month. (One month's deposit may be required depending on payments made by Kabel.)
4. Fee Payments. Kabel Business Services will bill you monthly for the administrative fees.
5. Eligibility Changes. Notify Kabel Business Services of any changes in employee eligibility at least 5 business days prior to the employer contribution date effected by the change. Kabel Business Services must be notified by email or fax on our HRA Change Form.
6. Highly Compensated Employees. Annually provide an updated list of all highly compensated individuals to be used in our testing.
7. Discriminatory Plans. Initiate any action required in the event the plan(s) become discriminatory.
8. Reports and Data. All reports and data remain the property of the Employer. Kabel Business Services will provide the Employer all data, upon request, in the electronic or printed format used by Kabel Business Services in its administrative procedure.

Kabel Business Services will bill you monthly for the administrative fees.

**Authorized Signature:**

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Employer Signature

**City of Windsor Heights**  
**HEALTH REIMBURSEMENT ARRANGEMENT**  
**SUMMARY PLAN DESCRIPTION INSERT**

**PLAN INTENT**

The employer named below establishes this plan with the intention that this Summary Plan Description Insert will satisfy the Summary Plan Description requirements of ERISA. If you have any questions, please contact the company contact person listed below.

The employer named below establishes this plan with the intention of maintaining such plan for an indefinite period of time and for the exclusive benefit of its employees. The purpose of the Plan is to provide a source of funds to reimburse you or your dependents that are covered under the Plan for some or all of the uninsured medical expenses you incur in the course of each year while you are employed with the Company and the Plan remains in effect.

**EMPLOYER - SPONSOR**

Employer - Plan Sponsor	City of Windsor Heights
Federal Tax ID Number	42-6004577
Mailing Address	1145 66 <sup>th</sup> Street, #1
City, State, ZIP	Windsor Heights, IA 50324

Plan Administrator	Sponsoring Employer
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Company Contact Person	Marcia Woodke
Mailing Address	1145 66 <sup>th</sup> Street, #1
City, State, ZIP	Windsor Heights, IA 50324

**Plan Information**

Name of Plan:	City of Windsor Heights HRA Plan
Plan Number:	535
Plan Year End:	December 31 <sup>st</sup>

Plan Service Provider:	Kabel Business Services
Address:	1454 30th Street, Suite 105 West Des Moines, Iowa 50266
Phone Number:	515-224-9400

The appointed Plan Service Provider in conjunction with the Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

**Eligibility Requirements**

**Existing Employees-** If you are in the Employer's employment on the Plan's effective date, you shall be eligible to become a participant on the Plan's effective date, subject to the exclusions noted below.

**New Employees-** If your employment by the Employer begins after the Plan's effective date, your service period requirements for eligibility are incorporated by reference from the terms of the underlying benefit policies subject to the exclusions noted below.

**Re-employment of Former Employees-** A re-employed former employee shall be treated the same as a new employee in determining eligibility.

**Age requirement-** There will be no maximum age requirement for participation in the Plan.

Employees excluded from this classification group are those individual employees who fall into one or more of the following categories:

- Employees not eligible under Employer group health insurance plan  
 Part-time Employees expected to work less than \_\_\_\_\_ hours per week.

- Commission Salespersons.
- Any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers unless the collective bargaining agreement requires the employee to be included within the Plan.
- Any Employee who is temporary or seasonal (working for the Employer less than 6 months of the year)
- Any Leased Employee.
- Nonresident Aliens
- Other \_\_\_\_\_

Termination of Participation- You will automatically cease to be a participant on the earliest of the following dates. (Terminated employees have 60 days from their termination date to submit a claim):

- a. Your death;
- b. The date you terminate your employment;
- c. The date you fail to meet the eligibility requirements;
- d. The date the Plan terminates;
- e. The date the administrator determines you made fraudulent or improper use of any Plan, certificate, or identification.

Continuation of benefits after termination- Your employer has elected to allow you to use accrued benefits in the Plan after your termination date. No further benefits will accrue, but you still can file claims and be reimbursed up to the amount remaining in your account.

Continuation of benefits after retirement- Your employer has elected to allow you to use accrued benefits in the Plan after your termination date. No further benefits will accrue, but you still can file claims and be reimbursed up to the amount remaining in your account.

Service period requirements for eligibility are incorporated by reference from the terms of the Plan Document.

The entry date is the date when an employee meeting the eligibility requirements will be able to begin participation in the Plan. This will mean the date eligibility requirements are met.

### Benefits

The plan shall reimburse Eligible Employees for the cost of Eligible Medical, Vision, and Dental Expenses (as defined under Internal Revenue Code Section 213 and as described further below). None of the amount provided by the employer can be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred. Employer dollars may be allocated by expense category.

**Benefits:**

Comprehensive. All medical, vision, and dental expenses not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), except otherwise described as follows: \_\_\_\_\_

- Deductibles and Co Insurance. Only those expenses that are covered under insurance, but subject to a deductible.
  - Benefits under this Plan shall be paid BEFORE the employee is responsible for his portion of the deductible limit.
  - Benefits under this Plan shall be paid AFTER the employee's portion of the deductible limit is paid.
  - Coinsurance expenses will be included in this benefit.

Limited. Only those expenses that are not otherwise covered by insurance specifically identified as follows:  
\_\_\_\_\_

Premium Only. Only the employee's applicable premium of the employer provided health and health related insurance policies.

**Order of Benefit Payments:** If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:

If the employer offers a Section 125 Cafeteria Plan Eligible medical, dental, and vision expenses must be paid under the Section 125 Plan before this Plan.

If the employer offers a Section 125 Cafeteria Plan Eligible medical, dental, and vision expenses must be paid under the Section 125 Plan after this Plan.

Applicable health insurance premiums are paid under this Plan before being paid under the Section 125 Plan.

**Accrual of Benefits:** The amount available for reimbursement to the employee will accrue in the following manner(s):

At the beginning of the plan year the full amount of the annual limit will be available for reimbursement.

If an employee becomes eligible during the plan year the annual limit will be prorated for the remainder of the year and that amount will be available for reimbursement.

The annual limit will be divided by 12 and be accrued monthly.

Other: \_\_\_\_\_

### **Health Reimbursement Arrangement Allocations**

For each Plan Year the employer will determine the amount that will be contributed for each employee based upon the criteria established by the employer for each Plan Year. Benefits will accrue as determined by the employer.

### **Termination**

Plan Termination- The Plan or any portion of the Plan shall be subject to termination at any time by the Employer. Upon termination of the Plan, the Administrator may continue the Plan in order to pay balances.

### **Claims**

When to File- Claims should be filed as soon as you or your dependents incur eligible expenses.

How to File- The "Request for Reimbursement" form should be completed and signed. This form must be completed for all claims submitted. The completed forms should then be sent to the Plan Service Provider for processing.

Notice of Claim- You should file a claim only on forms provided for such purpose.

Forms- Upon request, the Administrator will provide you with the necessary forms.

Processing the Request- Your "Request for Reimbursement" form will be processed by the Plan Administrator. Determination of expense and eligibility and fund's availability based on your account balances, will then be made.

Information for Claim- Prior to making any payment of benefits hereunder, the Plan Administrator may require you to provide information and complete the appropriate documents or forms necessary for the proper administration of a claim.

Claims Procedure- The Plan Administrator shall make all determination as to the right of any person to benefit under the Plan.

Payment- After reviewing the request, the Administrator shall issue a benefit check, if appropriate, to you.

Denied Claim- You will be notified in writing by the Plan's Administrator within 30 days of the date you submitted your claim if the claim is denied. If you do not receive notification of the denial of a claim within the 30 day period, then if the claim is not otherwise paid, it will be deemed denied. The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180 day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information.

Coordination of Benefits- It is your responsibility to make certain that claimed expenses have not been previously reimbursed by another benefit plan and will not be claimed as a tax deduction.

Eligible Expenses- Expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.

### **COBRA COVERAGE**

If you, your spouse, or dependents are eligible for COBRA continuation coverage, you must elect COBRA continuation coverage for your employer sponsored group health insurance in order to be eligible to elect COBRA continuation coverage for your Health Reimbursement Arrangement Plan. You cannot elect COBRA continuation coverage for this Plan as a stand alone benefit.

### **Your Rights**

As a participant in the Company's Medical and Dental Expense Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations such as work-sites and union halls, all plan documents including insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report when such a report is required by law.

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 the 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 benefit from the plan or from exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 materials and pay you up to \$100 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 as above. 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 or if it finds your claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this part of the Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.

### **Incorporation By Reference**

The actual terms and the conditions of the separate benefits offered under this Health Reimbursement Arrangement are contained in separate, written document.

### **Attachment A**

**\* VERY IMPORTANT NOTICE \***  
**(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES)**  
**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

#### ***INTRODUCTION***

A federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

#### ***CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)***

If your employer is subject to COBRA, you, as an employee of that employer, have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

#### **Qualifying Events**

1. Termination of employment (for reasons other than gross misconduct)
2. Involuntary termination of employee
3. Reduction in hours of employment.

#### ***CONTINUATION COVERAGE FOR SPOUSE OF EMPLOYEE***

As a spouse of a covered employee, you have the right to continue coverage under your current health plan(s) if your coverage is lost due to any of the following qualifying events:

#### **Qualifying Events**

1. A termination of your spouse's employment (for reasons other than gross misconduct).
2. Reduction in your spouse's hours of employment.
3. The death of your spouse.
4. Divorce or legal separation from your spouse.
5. Your spouse becomes entitled to Medicare.

#### ***CONTINUATION COVERAGE FOR DEPENDENT OF EMPLOYEE***

As a dependent child of a covered employee, you have the right to continue your current coverage if your coverage is lost due to any of the following qualifying events:

#### **Qualifying Events**

1. The termination of an employee parent's employment (for reasons other than gross misconduct).
2. Reduction in an employee parent's hours of employment with his/her current employer.
3. The death of your employee parent.
4. Parent's divorce or legal separation.
5. Employee parent becoming entitled to Medicare.

You cease to be a "dependent child" under the current health plan(s).

#### ***NOTIFICATION AND PREMIUMS***

Under this law, it is your responsibility to inform us of a divorce, legal separation, or a child losing dependent status under the plan(s) within 60 days of the occurrence of the event. You must also notify us within 60 days of receiving a disability determination letter from the Social Security Administration. Upon the occurrence of a qualifying event, you will be notified of your right to continue coverage under your current health plan(s). If you elect continuation coverage you must do so, in writing, within 60 days from the later of the notice or the date of the qualifying event/loss of coverage.

The recipient of coverage may have to pay part or all of the cost of coverage, which cannot exceed 102 percent of the cost under the group plan. If, during the continuation period, rates change for the employer group, persons under COBRA are subject to that increase.

You will have a 45-day period from the date you elect continuation coverage to pay the initial premium. This premium must include the entire amount due from the date you would have lost coverage to the date of the election. Thereafter, you will be given a grace period of not less than 30 days to pay premiums.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members.

You do not have to show that you are insurable to choose continuation coverage.

If you do not choose continuation coverage, your group health coverage will end as of the date of the qualifying event.

If a qualified beneficiary dies or becomes incapacitated during the election period, he or she may not be able to elect coverage timely. A legally-appointed guardian can make the election and act for the qualified beneficiary. However, there may not be adequate time during the 60-day election period. Therefore, the election period can be extended until a legally-appointed guardian is designated. This extension of the time period is referred to as "tolling".

### ***TERMINATION OF RIGHTS***

If you do choose continuation coverage, the law provides that coverage may be terminated for any of the following reasons:

1. Your employer terminates all group health coverage provided to its employees.
2. The premium for your continuation coverage is not paid in full the time prescribed under the Notifications and Premiums section of this notice.
3. You are or become covered under another group health plan other than the plan of the employer providing continuation as long as no exclusionary period will be imposed on a preexisting condition.
4. You are or become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payor, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

### ***ADDITIONAL INFORMATION***

If you have questions about your right to continue coverage under your current health plan(s), please contact your Plan Administrator.

If you change your address, marital status, or become entitled to Medicare or another group health plan while you are covered under the plan, please notify your Plan Administrator.

### **Qualified Beneficiaries**

The term Qualified Beneficiary (Q.B.) refers to individuals who are covered under the employee's group health plan the day before a COBRA qualifying event takes place. According to the COBRA statutes, a Qualified Beneficiary is the covered employee, covered spouse of the employee, covered dependent child of the employee **OR** any child born to, or placed for adoption with the covered employee during the period of continuation coverage.