VERMONT EDUCATION HEALTH INITIATIVE (VEHI)

HRA (Licensed)

Health Reimbursement Arrangement Summary

INTRODUCTION

VERMONT EDUCATION HEALTH INITIATIVE (VEHI)'s HRA (the "Plan") permits Eligible Employees be reimbursed for Eligible Medical Expenses. The HRA is funded solely through Employer Contribution Credits. The amount of the Employer Contribution Credits is stated in this summary. There are no Participant contributions.

This *Summary* describes the Plan. Through the Plan, you can receive tax-free reimbursement from the Company for uninsured Eligible Medical Expenses for yourself and eligible family members. Defined terms are capitalized. For a complete understanding of Plan terms, you should review the *Plan Document,* which can be requested from the Plan Administrator.

DETAILS REGARDING THE HRA BENEFIT

(a) Eligible Medical Expenses: To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Plan.

(b) Expenses cannot be reimbursed from any other source, including Tax Credits or Tax Deductions: Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud, and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

(c) Limitations for HSA and HRA Combination: You cannot participate in a general purpose HRA and remain eligible to participate in a Health Savings Account ("HSA"). If the Company sponsors an HSA Benefit and you elect to participate in both the HSA Benefit and the HRA, your HRA will reimburse only HSA-compatible medical expenses, including vision and dental (if applicable). You may also choose to participate in an HSA-Compatible HRA to maintain your eligibility and/or the eligibility of your spouse to participate in an HSA. You must, however, notify Further that you wish to participate in an HSA-Compatible HRA, and you will be required to complete and submit an election form.

ELIGIBLE EMPLOYEES

Only eligible employees may participate. An eligible employee may participate in the plan immediately after employment begins. You are eligible if you are:

- Employed by the company or a participating employer
- Enrolled under the Employer's Health Plan
- Satisfy eligibility requirement as stated in the "Eligibility" section of your medical SPD

- Not an Excluded Individual; and
- Satisfy any other eligibility requirements

You are a participant if you are an eligible employee, have enrolled in the Health Reimbursement Plan, and have not terminated participation.

Eligible employees do not include:

- Leased employees
- Independent contractors
- Employees subject to a collective bargaining agreement (except as specifically provided in the collective bargaining agreement)
- Interns
- Employees classified as temporary
- Employees covered by written agreements stating they are not eligible to participate in this Plan.

DEPENDENTS

(a) The HRA can reimburse medical expenses incurred for yourself or your Dependents.

(b) “Dependent” includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

ENROLLMENT

(a) **Initial Enrollment:** You must enroll within 30 days of becoming an Eligible Employee and satisfying the “Eligibility” section of your medical plan SPD.

(b) **HIPAA Special Enrollment.**

1. Special Enrollment Period due to Loss of Coverage. You and/or your eligible Dependents will be permitted to enroll in the Plan if:

    i. You and/or your Dependent had been covered under another group health plan or had an individual health policy at the time coverage under the Plan was initially offered;

ii. You and/or your Dependent lost that coverage as a result of a certain event, such as the loss of eligibility for coverage, expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or termination of Employer contributions towards such coverage; and

iii. You request enrollment for yourself or your Dependent within 31 days after the loss of the coverage.

2. Special Enrollment Period for newly acquired Dependent. If you get married and you request enrollment within 31 days after the date of the marriage, you will be permitted to enroll any and all of: (i) yourself; (ii) your spouse; and (iii) any new eligible Dependents acquired as a result of the marriage. The coverage will be effective as of the date of marriage. If you acquire a new child by birth, adoption or placement for adoption and you request enrollment within 31 days after the date of the birth, placement for adoption, or adoption, you will be permitted to enroll any and all of: (1) yourself; (2) your spouse; and (3) the Child. The coverage will be effective as of the date of the birth, placement for adoption or adoption.

(c) **Enrollment pursuant to a QMCSO:** A court or administrative agency may issue an order requiring you to provide health coverage for your child. If such an order is submitted to the Plan Administrator, the Plan Administrator will determine whether the order meets the requirements to be considered a Qualified Medical Child Support Order or “QMCSO.” If the order is a QMCSO, your child will be added to coverage. If you are not already covered under this Plan, you will also be added to coverage. The Plan Administrator will give you written notice if an order relating to coverage of your child is received and of the Plan Administrator’s decision as to whether the order is a QMCSO.

(d) **Annual Open Enrollment:** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate, unless you experience a HIPAA special enrollment right. (See above.) The Open Enrollment Period for each Plan Year will be determined by the Plan Administrator.

(e) **Enrollment Procedure:** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.

(f) **HRA Election:** You must elect to participate in the HRA. This Plan is funded by Employer contributions. There are no Employee contributions. Maximum Employer Contribution Credits per Plan year:

Employee/Single: $2100

Employee + Child: $4200

Employee + Spouse: $4200

Employee + Children: $4200

Employee + Family: $4200

The Employer Contribution Credits will be added to a Participant's HRA in full on the first day of the Plan Year.

(g) **Mid-Year Enrollment:** If you enroll in the Plan during the year, the Employer Contribution Credits for that year will be added in full on the first day of your participation.

(h) **HRA Balance Carry Over from one year to the next*** There is no carryover permitted of the unused Employer Contribution Credits.

WHEN PARTICIPATION BEGINS

Your participation begins on the first day of the Plan Year. For Mid-year enrollment, you are enrolled the first day of the month following enrollment. Please refer to the "Eligibility" section of your medical plan SPD.

Coverage Change Process: The Plan Administrator will provide instructions for requesting a coverage change. The Plan Administrator will determine whether a coverage change is permitted.

ELECTION CHANGES DURING THE PLAN YEAR

(a) **Mid-Year Coverage Change Events:** If you change your medical coverage level (*e.g.*, single to family) mid-year, the amount of the Employer Contribution Credit for which you are eligible will be adjusted accordingly.

(b) **Time Limit for Making a Coverage Change:** To change your coverage level, you must request a coverage level change not later than 30 days after the event permitting the change (even if you are on leave at the time). You cannot change your coverage level more than 30 days after an event that permits the coverage level change.

(c) **Change in Level of Coverage:** In the event you change coverage options (e.g., single contract to family contract) during the plan year and the annual credit for your new coverage is a larger amount, then your account will be credited with the difference between the annual credit amount for your previous coverage and the annual credit

amount for your new coverage. This additional credit will be made effective on the effective date of your new coverage. The change in your full annual credit amount will be effective on the first day of the following plan year.

In the event you change coverage options (e.g., family contract to single contract) during the plan year and the annual credit for our new coverage is a smaller amount, then your account will not be impacted by this change (meaning the account will not be reduced to reflect the change in coverage) during the remainder of the current plan year. The change to your annual credit amount will be effective on the first day of the following plan year.

PARTICIPATION DURING A LEAVE OF ABSENCE

Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. Your leave must be approved by the Company.

You will be required to make your premium/contribution payments ("payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

(a) **Paid Leave of Absence:** Your HRA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.

(b) **Unpaid Leave of Absence:** Your right to continue HRA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your HRA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.

1. *FMLA Leave.*

    i. If you take FMLA Leave, your HRA coverage will continue unless you are required to have High Deductible Health Plan coverage and decide to terminate that coverage during your leave.

    ii. If your HRA coverage terminated, it will be reinstated on return from leave.

    iii. You will not be able to submit expenses you incurred during the leave for reimbursement for periods in which your HRA coverage was terminated.

2. *Military Leave.* If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your HRA coverage for up to 24 months during the military leave to the extent required by USERRA. USERRA continuation coverage information is provided in the "Other Legal Notices" section of this *Summary*. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Plan Administrator for more information.

3. *Other Types of Leave*. Contact the Plan Administrator for details. If your HRA coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. HRA COBRA rights are explained in the "Notice of COBRA Continuation Coverage Rights" section of this *Summary*. If you do not elect to continue your coverage through COBRA, you will not be eligible to recommence participation until the next Open Enrollment Period or you experience a HIPAA special enrollment right. (See the "Enrollment" section of this *Summary*).

(c) **Open Enrollment during your Leave:** If the Open Enrollment Period for the next Plan Year occurs during your leave <u>and your participation in the Plan continues</u>, you will be able to elect to participate in the Plan for the new Plan Year in the same manner as active Employees. If you do not elect HRA benefits, you will not be eligible to participate in the HRA in the new Plan Year, unless you experience a HIPAA special enrollment right.

(d) **Making Election Changes on return from Leave:** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another event for which a mid-year change is permitted.

<u>OBTAINING REIMBURSEMENTS</u>

(a) **Amount available for reimbursement:** The amount available for reimbursement is limited to the balance in your HRA at the time that you submit a claim.

(b) **Expense must be eligible for reimbursement under this Plan:** Only Health Plan Eligible Medical and Prescription Expenses will be reimbursed. **The Plan pays 100% of Eligible Health Plan Medical and Prescription Expenses and pharmacy expenses that qualify as Eligible Medical Expenses.**

(c) **Expense must have been incurred during your Period of Coverage:** You may only use your HRA to pay for Eligible Medical Expenses that you incurred while covered under the Plan. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.

(d) **Expense cannot be reimbursed out of other accounts:** The HRA cannot be used to reimburse expenses that are reimbursed from any other Account, including a Medical FSA.

(e) **Coordination with Other Health Care Accounts:** If you participate in the Company's Medical FSA Benefit and an HRA, your claims will be paid from your HRA first. If you participate in the Company's HSA Benefit, the HRA will only reimburse HSA-compatible expenses as provided in the HRA benefit summary.

(f) **Claim submission requirements must be satisfied.** You may submit a completed claim form and independent third-party documentation of the claim to the Administrator. You may also submit your claim Online by signing into the Member Online Service Center via www.HelloFurther.com. If your Company implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the HRA Plan, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional. You will still have to submit supporting documents. You will receive more information from the Company about what you must do to obtain reimbursement if such a system is implemented.

1. *Claims must be submitted during the Plan's Claims Submission Period.* **Further must receive all claims for reimbursement in our office no later than 3 months after the plan year end date to be reimbursed. For employees that have terminated during the plan year and if the employee has elected COBRA (if available), claims must be received 3 months from earlier of the end of the plan year or termination of the COBRA election.**

2. **For employees that have been terminated and they have not elected COBRA (if available) claims must be received in our office 3 months from their termination date.**

3. *Documentation must be provided.* To receive reimbursement for Eligible Medical Expenses, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill, receipt or an Explanation of Benefits) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.

4. *Claims cannot be reimbursed by Health Insurance.* You cannot request reimbursement of an expense that has been or will be reimbursed by health insurance.

5. *Limitation on reimbursement of claims incurred one year from Employer Contribution Credits for a subsequent Plan Year:* Employer Contribution Credits for a Plan Year cannot be used to reimburse claims incurred in a prior Plan Year.

(g) **Method of Reimbursement:** The Claims Administrator will reimburse Eligible Medical Expenses through a check or, if you so choose, direct deposit. Reimbursements will be issued as scheduled by the Claims Administrator.

(h) **Recovery of improper Reimbursements:** You will be required to repay the Plan for reimbursements the Claims Administrator determines to have been improper. The Claims Administrator may use one or more of the following recovery methods: (i) your repaying the amount to your HRA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursements to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

CLAIMS AND APPEAL PROCEDURE

(a) **Initial determination on claim for Reimbursement.**

1. *Time Period.* The Claims Administrator will make its decision on the claim within 30 days after receipt of the claim. The 30-day period for the initial determination may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Administrator; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Administrator expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

2. *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notice of the denial to you, which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) **Appeal Rights and Procedures.**

1. *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your

receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.

2. *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

3. *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who was consulted in connection with the initial adverse determination nor a subordinate of such individual.

4. *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of the decision on appeal in writing within 60 days after the Claims Administrator received your appeal. The notice will include the reason for the decision.

    i. *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through Further. If you are not satisfied with our decision, you may elect to further appeal to Further by sending a letter within 30 days or the later of your run out end date requesting our Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

    ii. *External Review Process.* If you still disagree with the Claims Administrator's decision, you have the right to an external review of the Claims Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA Plan's eligibility requirements. Your external appeal must be

filed with the Claims Administrator within four (4) months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether the adverse benefit determination qualifies for external review. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT

(a) **When Participation ends:** Your participation in the Plan will end as of the date of your termination of employment with the Company.

(b) **Medical Expenses incurred after Termination:** Medical expenses incurred after the date of your termination of employment will be eligible for reimbursement if you elect to continue your participation in the HRA through COBRA. Please refer to the "Notice of COBRA Continuation Rights" section of this *Summary.*

The HRA balance is forfeited unless you elect COBRA.

(c) **Amounts remaining after Termination:** Any amounts remaining in an Account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited unless you elect COBRA.

(d) **Re-employment by a Participating Employer:** A Participant who terminates employment and is re-employed by a Participating Employer as an Eligible Employee within the same Plan Year will be provided the same HRA Balance that he or she had at termination, less any reimbursements made after termination, or, if he or she elected COBRA, the most recent COBRA HRA balance.

OTHER REASONS FOR TERMINATION OF PARTICIPATION

(a) Your participation in this Plan can also end if:

1. you no longer qualify as an Eligible Employee;

2. your Employer stops participating in this Plan;

3. you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;

4. the Company terminates the Plan; or

5. if the certifications you made to participate are no longer accurate.

(b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

NOTICE OF COBRA CONTINUATION COVERAGE

(a) **Continuation:** You or your covered Dependents may continue this coverage if coverage ends due to any of the qualifying events listed below. You and your eligible Dependents must be covered under this Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.

(b) **Qualifying Events:** If you are the Employee and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

- Reduction in the hours of your employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment).

If you are the spouse of a covered Employee, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the Employee.
- A termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment with the Employer.
- Entering of decree in the event of a divorce or legal separation from the Employee. (Also, if the Employee eliminates coverage for his or her spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the later divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then continuation coverage may be available for the period after the divorce).
- The Employee becomes enrolled in Medicare.

In the case of a Dependent child of a covered Employee, the Dependent child has the right

to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the Employee.
- The termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment with the Employer.
- Parents' divorce or legal separation.
- The Employee becomes enrolled in Medicare.
- The Dependent ceases to be a "Dependent child" under the Plan.

(c) **Your notice of obligations:** You and your Dependents must notify the Employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legal separation.
- A Dependent child no longer meets the Plan's eligibility requirements.

Note: Refer to "Disability Extensions" in "Extension of Maximum Coverage Periods" below for three (3) additional notification requirements.

If you or your Dependents fail to provide this notice during this 60-day notice period, any Dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your Dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your Dependents will be required to reimburse the Plan for any claims paid.

When you notify the Employer that a divorce or a loss of Dependent status will cause a loss of coverage, then the Employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the Employer of a qualifying event or disability determination and the Employer determines that there is no extension available, the Employer will provide an explanation as to why you or your Dependents are not entitled to elect continuation coverage.

(d) **Employer's and Plan Administrator's Notice Obligations.** The Employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the Employee. This 30-day notice to the Plan Administrator is not often used because usually the Plan Administrator is the Employer. After plan administrators are put on notice of the qualifying event, they have 14 days to send the qualifying event notice. The qualified beneficiaries must be allowed 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later. The Employer will also notify you and your Dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in

a loss of coverage: the Employee's termination of employment (other than for gross misconduct), reduction in hours, death, or the Employee's becoming enrolled in Medicare.

(e) **Election Procedures:** You and your Dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your Dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.

You or your Dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse may not decline coverage for the other spouse and a parent cannot decline coverage for a non-minor Dependent child eligible for coverage. In addition, a Dependent may elect continuation coverage even if the covered Employee does not elect continuation coverage.

You and your Dependents may elect continuation coverage even if covered under another Employer-sponsored group health plan or enrolled in Medicare.

(f) **How to Elect:** Contact the Employer to determine how to elect continuation coverage.

(g) **Type of Coverage:** Ordinarily, the continuation coverage that is offered will be the same coverage that you or your Dependent had on the day before the qualifying event. Therefore, anyone who is not covered under the Plan on the day before the qualifying event generally is not entitled to continuation coverage. (Exceptions: 1) If coverage was eliminated in anticipation of a qualifying event such as divorce and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse had lost coverage earlier. The ex-spouse must notify the Employer within 60 days after the later divorce and establish that the coverage was eliminated earlier in anticipation of divorce; and 2) A child born to or placed for adoption with the covered Employee during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period).

Qualified beneficiaries must be provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active Employees or their Dependents, then continuation coverage will be modified in the same way. (Examples: 1) If the Employer offers an Open Enrollment Period that allows active Employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation should be allowed to switch plans as well; and 2) If active Employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation should also be afforded this same right).

(h) **Maximum Coverage Periods:** The maximum duration for continuation coverage is described below. Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of Continuation Coverage before the end of the Maximum Coverage Period." In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

1. *18 Months.* If you or your Dependent loses coverage due to the Employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

2. *36 Months*. If a Dependent loses coverage because of the Employee's death, divorce, legal separation, the Employee became enrolled in Medicare or because of a loss of Dependent status under the Plan, and then the maximum coverage period (for spouse and Dependent child) is three (3) years from the date of the qualifying event.

(i) **Extension of Maximum Coverage Periods:** Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

1. The general rule is that the maximum coverage period runs from the date of the triggering (qualifying) event, even if the actual loss of coverage per the terms of the Plan does not occur until later. The Employer has 30 days from the date of the triggering event to notify the Plan Administrator of the qualifying event.

2. *Extended Notice Rule*: Under the extended notice rule, the maximum coverage period runs from the date that a qualified beneficiary's loss of coverage occurs (rather than the triggering event), if the Employer also sends its notice of the qualifying event to the Plan Administrator within 30 days after the loss of coverage instead of 30 days after the occurrence of the triggering event. Use of this delayed commencement of coverage period coupled with the extension of the Employer's notice period has the effect of extending the maximum coverage period.

   i. This extension is applicable only when loss of coverage is due to termination of employment, reduction of hours, death of the Employee, or the Employee's Medicare enrollment, and the extension applies to all qualified beneficiaries.

   ii. Example: The triggering event, termination of employment, occurs on January 5. The loss of coverage under the terms of the Plan, however, does not occur until January 31. Under the Extended Notice Rule, the Employer must notify the Plan Administrator of the qualifying event within 30 days after coverage is lost and the maximum coverage period begins when coverage is lost, January 31).

3. *Disability Extension*: This extension is applicable when the qualifying event is the Employee's termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your Dependent who is a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

   Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the Social Security Administration disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the qualifying event (the Employee's termination of employment or reduction of hours); 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

   Notice Obligation: The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the Employee's termination of employment or reduction of hours.)

   Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the formerly disabled qualified beneficiary is no longer disabled; or 2) the end of the coverage period that applies without regard to the disability extension.

4. *Multiple Qualifying Events*: This extension is applicable when the qualifying event is the Employee's termination of employment or reduction of hours (each of which triggers an 18-month maximum coverage period) is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the Employee, divorce, legal separation, the Employee becoming enrolled in Medicare or a Dependent child losing Dependent status). The extension applies to the Employee's Dependents that are qualified beneficiaries.

   If a second qualifying event occurs within an 18-month or 29-month coverage period that gives rise to a 36-month maximum coverage period for the Dependent, then the maximum coverage period (for the Dependent) becomes three (3) years

from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of continuation coverage will occur.

5. *Pre-Termination or Pre-Reduction Medicare Enrollment*: This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the Employee's Medicare enrollment. The extension applies to the Employee's Dependents who are qualified beneficiaries. If the qualifying event occurs within 18 months after the Employee becomes enrolled in Medicare, regardless of whether the Employee's Medicare enrollment is a qualifying event (causing a loss of coverage under the group Plan), the maximum period of continuation for the Employee's Dependents who are qualified beneficiaries is three (3) years from the date the Employee became enrolled in Medicare. (Example: Employee becomes enrolled in Medicare on January 1. Triggering/qualifying event, Employee's termination of employment or reduction of hours is May 15. The Employee is entitled to 18 months of continuation from the date coverage is lost. The Employee's Dependents are entitled to 36 months of continuation from the date the Employee is enrolled in Medicare.) If the qualifying event (Employee's termination of employment or reduction of hours) is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.

6. *Employer's Bankruptcy*: The bankruptcy rule technically is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the Employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and Dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the Plan, then that surviving spouse is entitled to coverage for life.

(j) **Termination of Continuation Coverage before the end of Maximum Coverage Period:** Continuation coverage of the Employee and Dependents will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

- The Employer no longer provides group health coverage to any of its Employees.
- The premium for the qualified beneficiary’s continuation coverage is not paid when due. Charges for continuation can be up to the group rate plus a two (2)

percent administration fee. In the event of a disability, the charges for continuation can be up to the group rate plus a 50% administration fee for months 19-29. All charges are paid directly to the Employer.

- After electing continuation, you or your Dependents become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable preexisting condition exclusions or limitations, then your continuation coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note: An exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the new group health plan.)
- You or your Dependent became entitled to a 29-month maximum coverage period due to the disability of a qualified beneficiary, but then the Social Security Administration makes the final determination that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Dependents who have coverage under the Plan for a reason other than the continuation coverage requirements of federal law.
- Voluntarily dropping your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the Plan Administrator. The notice will contain the reason continuation coverage has been terminated; the date of the termination, and any rights to elect alternative coverage that may be available.

(k) **Children born to or placed for adoption with the covered employee during Continuation Period.** A child born to, adopted by or placed for adoption with a covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered Employee is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption, or placement for adoption and it lasts for as long as continuation coverage lasts for other family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

(l) **Open Enrollment Rights and Special Enrollment Rights:** Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly situated active Employees to change their coverage options or to add or eliminate coverage for Dependents at Open Enrollment. Special enrollment rights will apply to those who have elected continuation. Except for certain children described above, Dependents who are enrolled in a special enrollment period or Open Enrollment Period do not become

qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as Dependents.

(m) **Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes:** If your or your Dependent's address changes, you must notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important continuation notices and other information). Also, if your marital status changes or if a Dependent ceases to be a Dependent eligible for coverage under the terms of the Plan, you or your Dependent must notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled Employee or family member is no longer disabled.

(n) **Special Second Election Period:** Special continuation rights apply to certain Employees who are eligible for the health coverage tax credit. These Employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible Employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

(o) **Questions:** If you have general questions about continuation of coverage, please call the telephone number on the back of your identification card for assistance.

(p) **Overview:** The following chart is an overview of the information outlined in the previous sections. For more details, refer to the previous sections.

Qualifying Event/ Extension	Who May Continue	Maximum Continuation Period
• Employment ends (for reasons other than gross misconduct) • Reduction in hours of employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and Dependents	Earlier of: 1. 18 months; or 2. Enrollment date in other group coverage.
• Divorce or legal separation	Former spouse and any Dependent children who lose coverage	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Death of Employee	Surviving spouse and Dependent children	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end if the Employee had lived.
• Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Dependents lose eligibility due to the Employee's enrollment in Medicare	All Dependents	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Retirees of the Employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree Dependents	Lifetime continuation Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: • Disability, as determined by the Social Security Administration, of Employee or Dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the Employee leaves employment; or 2. Date disability ends; or 3. Date coverage would otherwise end.

OTHER LEGAL NOTICES.

(a) **Uniformed Services Employment and Reemployment Rights Act (USERRA) Continuation Coverage:** If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible Dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible Dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. Your eligible Dependents do not have independent election rights for USERRA continuation coverage so you must elect to continue coverage for USERRA coverage to be provided beyond any COBRA coverage period. You will be required to pay for USERRA continuation coverage.

(b) **HIPAA Privacy Rule Notice of Privacy Practices:** The Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices* (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

(c) **Company's Right to Terminate or Amend the Plan.** The Company reserves the right to amend or terminate the Plan at any time and without notice.

(d) **No Guarantee of Employment:** Participation in this Plan is not a guarantee of employment.

(e) **Plan Administrator's Discretion:** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

PLAN SPECIFICATIONS

Employer, Plan Sponsor and Plan Administrator:

VERMONT EDUCATION HEALTH INITIATIVE (VEHI)
52 Pike Dr
Berlin, VT 05602

Telephone: 802-223-5040

Health Plan Coverage:

You are required to enroll in the VERMONT EDUCATION HEALTH INITIATIVE (VEHI) Health Plan coverage to be eligible to participate in the HRA.

For details regarding the Health Plan Coverage, review the summary for that plan.

Claims Administrator:

Further
3535 Blue Cross Road
Eagan, MN 55122-1154
651-662-5065 or 800-859-2144
www.HelloFurther.com

Plan Year:

January 1 through December 31