TOWN OF EAST MONTPELIER, VT
HRA PLAN

SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2019

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HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this Summary Plan Description (SPD). We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

This SPD describes the current provisions of the plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this Summary Plan Description change, we will notify you.

Read this SPD carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan as of the first of the month after beginning employment and are working 24 or more hours per week, having enrolled in the Employer's Group Medical Plan and completed the HRA Election Form.

2. When is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the same date as the Employer's group medical plan.

3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are not participants in our group medical plan.

-- Part-time employees working, or expected to work, less than 24 hours a week.

II
BENEFITS

1. What Benefits Are Available?

Coverage Category	Employer Reimbursement of BCBSVT Eligible Expenses at 100% to a maximum of*:
Single	$2,750
2 Person/Family	$5,500

*Debit Cards will be issued for prescription expenses.

The plan allows you to be reimbursed for any eligible BC/BS expenses you have to meet under your employer sponsored group medical plan, which are incurred by you or your dependents subject to the chart above.

A "Take Care" debit card will be issued to the Participant for prescriptions. If extra card(s) are needed, it is the Participant's responsibility to order them.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for.

Expenses should first be submitted for reimbursement under your HRA Plan, and any applicable balance can be submitted under any eligible reimbursement accounts.

Any amounts reimbursed to you under the HRA Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including reimbursement accounts.

You may submit expenses for yourself, your spouse or your dependents. You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. Debit and Credit Cards

You will be issued a debit and/or credit (stored value) cards ("cards") by the Administrator and the Plan for payment of prescription expense purchases subject to the following terms:

You may only use these card(s) for prescription drug expenses. You must also certify that any prescription drug expense(s) paid with the card(s) have not already been reimbursed by any other plan covering health benefits and that you will not seek reimbursement from any other plan covering health benefits.

You will be issued your card(s) upon your Effective Date of Participation and they will be reissued for each Plan Year that you remain a Participant in the Health Reimbursement Arrangement. Cards will be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Reimbursement Arrangement.

The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth by the Administrator.

The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

You may only use your card(s) for Prescription Expense purchases at these providers, only for the following:

(1) Purchase of prescription drugs

a) Will I be required to substantiate expenses that I use my debit card for?

There are certain expenses, when paid for with your card(s), which will need to be substantiated in order for the expenses to be a qualified expense. Please note that this is an IRS requirement. When substantiation is required, you must submit your receipts for the claim, describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43, Notice 2006-69, and any subsequent guidance. You have 60 days from the date the card is swiped to submit to submit your receipts for substantiation. If you do not submit within the 60 day time period, your card(s) will be shut off. All charges shall be conditional pending confirmation and substantiation.

b) What if I use my card for a non-eligible expense?

If your purchase is later determined by the Administrator to not qualify as an eligible Prescription Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

(5) A fee may be charged if used for ineligible expenses.

3. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each calendar year. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

4. When Will I Receive Payments From the Plan?

During the course of the Coverage Period, payments shall be made directly to the medical provider via the Third Party Claims Administrator as claims are reported from a download from BC/BS. In the event that the Third Party Claims Administrator no longer receives claims information from BC/BS, you may

submit requests for reimbursement of expenses you have incurred. If you did not use your debit card for prescriptions, you may submit requests for reimbursement. However, you must make your requests for reimbursements no later than 90 days after the end of each year (December 31). The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator, proof of the expenses that you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes.

5. What Happens If I Terminate Employment?

If your employment is terminated during the Coverage Period for any reason, you shall continue to be eligible for reimbursement of any remaining balances for eligible expenses incurred through the end of the month in which you terminate, if you are not subject to COBRA. Requests for reimbursement must be made no later than 90 days after Plan Year ends.

6. Can I Opt Out of the Plan?

Yes you can, once a year, opt out of the Plan and receive no further reimbursement.

7. Family and Medical Leave Act (FMLA)

If your plan is subject to FMLA and you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to “catch up” your payments when you return.

8. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

9. Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

10. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

11. HIPAA Privacy Procedures

Use and Disclosure of Protected Health Information (PHI)

Protected health information ("PHI") is individually identifiable information created or received by the Plan about an individual's past, present or future physical or mental health condition, including information relating to the provision of and payment for health care services. The Plan will use PHI in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in more detail at 45 C.F.R. Part 160 and Part 164 (the "HIPAA Privacy Regulations"). Specifically, the Plan will use and disclose PHI for purposes related to payment for health care and for health care operations.

Payment for Health Care includes those activities defined in the HIPAA Privacy Regulations, including without limitation:

-- determination of eligibility and coverage;

-- coordination and determination of benefits;

-- adjudication of benefit claims;

-- establishing employee contributions;

-- claims management, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments; and

-- reimbursement to the plan.

Health Care Operations includes those activities defined in the HIPAA Privacy Regulations, including without limitation:

-- quality assessment;

-- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

-- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan;

-- resolution of internal grievances; and

-- due diligence in connection with the sale or transfer of assets to a potential successor in

interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

When the Plan uses or discloses PHI, or when it requests such information from other entities, it will undertake reasonable efforts to limit the use or disclosure to the minimum amount necessary to accomplish the intended purpose. This "minimum necessary" standard does not apply to: disclosures to health care providers for treatment, disclosures to the individual, disclosures based on a written authorization, disclosures required for a government compliance audit, or disclosures required by law.

Disclosures by the Plan to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor, Town of East Montpelier, VT, only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the provisions of this section and that the Plan Sponsor agrees to comply with these provisions.

The Plan Sponsor agrees to:

-- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

-- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

-- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

-- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

-- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

-- make PHI available to an individual in accordance with HIPAA's access requirements;

-- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

-- make available the information required to provide an accounting of disclosures;

-- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

-- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Disclosures by Others to the Plan Sponsor

For purposes of conducting operations on behalf of the Plan, the Plan Sponsor shall be entitled to receive PHI from:

-- the Plan;

-- any business associate of the Plan;

-- any person or entity that contracts with the Plan, the Plan Sponsor, or a business associate of the Plan, to provide services to or on behalf of the Plan;

-- any health insurer, health insurance company, HMO or health clearinghouse that provides services to or on behalf of the Plan;

-- any individual with authority to direct the disclosure of PHI related to any Plan participant.

Adequate Separation Between the Plan and the Plan Sponsor Must be Maintained

In accordance with HIPAA, only C. Bruce Johnson, as designated by the Town of East Montpelier, VT may be given access to PHI. This employee may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

If the individual designated by the Town of East Montpelier, VT does not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

12. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth above.

III
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information

Town of East Montpelier, VT HRA Plan is the name of the Plan.

Your Employer has assigned Plan Number 510 to your Plan.

The provisions of your Plan become effective on 1/1/2019.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on 1/1 and ends on 12/31.

2. Employer Information

Your Employer's name, address, and identification number are:

Physical:
Town of East Montpelier, VT
40 Kelton Road
East Montpelier, VT 05651
03-6000456

Mailing:
Town of East Montpelier, VT
PO Box 157
East Montpelier, VT 05651
03-6000456

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

There are no other employers who have adopted the provisions of the Plan as of the date of this document.

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Physical:
Town of East Montpelier, VT
40 Kelton Road
East Montpelier, VT 05651
(802) 223-3313

Mailing:
Town of East Montpelier
PO Box 157
East Montpelier, VT 05651
(802) 223-3313

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Third Party Claims Administrator Information

The name, address and business telephone number of the Third Party Claims Administrator are:

Northeast Benefits Management, LLC
PO Box 2363
South Burlington, VT 05407-2363
Telephone: (802) 865-0239

Claims eFax: (802) 304-1009 (Burlington exchange)
Scan and email: info@nbmus.com

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

5. Service of Legal Process

The Employer is the Plan's agent for service of legal process.

6. Type of Administration

The Plan is a Health Reimbursement Arrangement and the claims administration is provided through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

IV
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) Examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, 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 copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) Continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

If your claim for a 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.

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.

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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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 medical child support order, you may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent the Plan Participant from obtaining a benefit or from exercising your rights under ERISA.

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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. How to Submit a Claim

In the event that the Third Party Administrator no longer receives claims information via download from BC/BS, or you do not use your debit card for prescriptions, you may submit a claim for reimbursement.

When you have a Claim to submit for payment, you must:

(1) Obtain and complete a claim form from your Employer OR log onto your account (www.nbmus.com) and create a claim.

(2) Attach the Explanation of Benefit(s) from BC/BS for medical expenses. The amount(s) must be eligible BC/BS expenses for which you are requesting reimbursement.

(3) If requesting reimbursement for a prescription, you need to submit a prescription receipt generated by the pharmacy in order to be reimbursed.

(4) To submit your claim for reimbursement either;

A. Submit electronically, by following the instructions to upload your receipts or
B. Print, Scan or Fax to:

Mail: Northeast Benefits Management, LLC
PO Box 2363
South Burlington, VT 05407-2363

Scan and email: info@nbmus.com
eFax: (802) 304-1009 (Burlington)

(5) Claims may be submitted using our apps for iPhone and Android. They are free, just search for "MyFlexonline" at the iTunes App Store or Google Play. To log in, use the same ID and password as you do for the MyFlexOnline website.

** Please reference your Users Guide for Employees for further instructions.

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether Claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by Participant	45 days
Review of Claim denial	60 days

The Plan Administrator will provide written or electronic notification of any Claim denial. The

notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the Claim determination;

(2) was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;

(4) or constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was

submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

V
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Arrangement will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Arrangement would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. The Arrangement itself can provide group health benefits and may also be used to provide health benefits through insurance. Whenever "Arrangement" is used in this section, it means any of the health benefits under this Plan.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage**.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

2. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under the Arrangement by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then

the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Arrangement as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Arrangement due to his or her performance of services for the employer sponsoring the Arrangement. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Arrangement's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Arrangement under the same terms and conditions

as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Arrangement occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Arrangement that results from the occurrence of one of the events listed above is a loss of coverage.

If your plan is subject to FMLA, the taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Arrangement provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Arrangement during the FMLA leave.

4. What Factors Should Be Considered When Determining to Elect COBRA Continuation Coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

(a) **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

(b) **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

(c) **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

(d) **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

(e) **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing

COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

(f) **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

(g) **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the Procedure for Obtaining COBRA Continuation Coverage?

The Arrangement has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Arrangement. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

7. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Arrangement will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The

Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare,

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Physical:
Town of East Montpelier, VT
40 Kelton Road
East Montpelier, VT 05651

Mailing:
Town of East Montpelier, VT
PO Box 157
East Montpelier, VT 05651

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Arrangement with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Arrangement can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Arrangement terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Arrangement solely because of the individual's relationship to a Qualified Beneficiary, if the Arrangement's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Arrangement is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under What Circumstances Can the Maximum Coverage Period Be Expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

13. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

14. Does the Arrangement Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Arrangement, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Arrangement Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The health coverage is also permitted to allow for payment at other intervals.

16. What is Timely Payment for Payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Arrangement by a later date is also considered Timely Payment if either under the terms of the Arrangement, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Arrangement does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to those providing coverage.

If Timely Payment is made to the Arrangement in an amount that is not significantly less than the amount the Arrangement requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Arrangement's requirement for the amount to be paid, unless the Arrangement notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.