Allegiance℠
by Cigna Healthcare

Notice of Right to Elect COBRA Continuation of Flexible Spending Arrangement (FSA) Under Health Care FLEX Plan

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOU WILL LOSE YOUR RIGHT TO CONTINUE YOUR FSA UNDER COBRA.

Date of Notice _____* _____ __*__ Mailed __*__ Hand Delivered

TO: Qualified Beneficiary **FROM: Plan Administrator**

Name: _____* _____ Company: _____* _____

Address: _____* _____ Address: _____* _____

City, State, Zip: _____* _____ City, State, Zip: _____* _____

Entitlement to COBRA

EXAMPLE

Flex Cobra is only offered if there is a positive fund balance in the medical spending account. (not daycare)

The Plan Supervisor of the company's Health Care FLEX Plan was notified that your Health Care Flexible Spending Arrangement (FSA), under the Health Care FLEX Plan will terminate effective ____ ENTER TERM DATE ____ because of the following COBRA Qualifying Event:
_____ *Qualifying Event* ____NOTE TERMINATION _____

Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, this Qualifying Event may entitle you, to elect to continue the Health Care FSA under COBRA. The covered employee who was covered on the date of the Qualifying Event and who is eligible for COBRA is called a Qualified Beneficiary. Unless other arrangements are made with the Employer to pre-pay FSA contributions on a pre-tax basis from any severance pay or other compensation to which the employee is entitled, continuation of the FSA will be on an after-tax basis. The FSA can only be continued until the end of the Plan Year in which the Qualifying Event occurred, and continuation is subject to all eligibility requirements of the FSA and applicable law being satisfied.

In order to be eligible to continue the FSA, the Flexible Spending Account must have a positive balance on the date of the Qualifying Event.

CONTINUATION OF FSA BENEFITS UNDER COBRA IS SUBJECT TO YOUR ELIGIBILITY. THE PLAN ADMINISTRATOR RESERVES THE RIGHT TO TERMINATE YOUR COBRA FSA BENEFITS RETROACTIVELY IF YOU ARE DETERMINED TO BE INELIGIBLE.

How to Elect COBRA

- To continue an FSA under COBRA, the Qualified Beneficiary must complete and submit the attached election form to the Plan Supervisor by __* **60 DAYS FROM DATE OF NOTICE** *(sixty (60)* _ (sixty (60) days from the date of this notice). Please note, if you have elected a debit card it will not be reactivated upon COBRA election

The Flexible Spending Arrangement continued under COBRA will terminate no later than the end of the Plan Year during which the Qualifying Event occurred. Further, the total amount of funds available under the COBRA FSA cannot exceed the amount elected on the date of the Qualifying Event.

Payment of COBRA FSA Contribution

Any before-tax payroll deductions being made under a Compensation Reduction Agreement will cease if or when the employee's paychecks earned prior to the Qualifying Event cease. Unless other arrangements have been made to pre-pay COBRA FSA contributions on a pre-tax basis, contributions for continued FSA Benefits under COBRA must be paid on an after-tax basis directly to the Plan Supervisor. Within 45 days after the date that you elect COBRA Benefits, you must pay an initial contribution for COBRA FSA Benefits, which includes the required contribution for: . *Within 45 days after the date that you elect COBRA Benefits, you must pay an initial contribution for COBRA FSA Benefits, which includes the required contribution for:*

- The period of benefits from the date of your Qualifying Event to the date of your election, AND
- Any regularly scheduled monthly FSA contribution that becomes due between your election and the end of the 45-day period.

Your COBRA contribution for FSA Benefits is one-twelfth (1/12th) of the Participant's annual contribution election, plus any monthly administrative expense, plus two percent (2%) of the total of those costs.

Your FSA COBRA election is **$ 202.01**_____; FSA COBRA payments will be due for the months of __ **Nov** _____ thru ___**Dec** _____.

Once the Plan Supervisor receives the attached election form, you will be notified of the total FSA contribution amount due for your continued FSA Benefits. After the initial contribution for COBRA FSA Benefits, payments are due the first day of each month. A grace period of thirty (30) days from the first of each month will be allowed for payment.

****CALCULATE MONTHLY CONTRIBUTIONS PLUS REGULAR ADMIN FEE PLUS 2% OF THE TOTAL COSTS***

IF YOU FAIL TO PAY THE INITIAL FSA COBRA CONTRIBUTION WITHIN 45 DAYS FROM THE DATE OF YOUR ELECTION, YOUR FSA WILL TERMINATE AND COBRA CONTINUATION OF THE FSA WILL NOT BE AVAILABLE. REQUESTS FOR REIMBURSEMENT FOR SERVICES INCURRED AFTER THE DATE OF THE QUALIFYING EVENT WILL NOT BE PAID UNTIL THE PLAN RECEIVES THE REQUIRED COBRA ELECTION FORMS AND CONTRIBUTION.

How Long COBRA Lasts with Regard to Flexible Spending Arrangements

If you elect to continue the Health Care FSA under COBRA, continuation will last, at the latest, until the end of the Health Care FSA Plan Year in which the Qualifying Event occurred, as long as all required contributions are made when due.

Early Termination of COBRA Benefits

COBRA Benefits may terminate early if:

- The required FSA contribution is not paid when due, or
- All of the company's FSA plans are terminated.

TO BE SURE THAT YOU RECEIVE THE NECESSARY INFORMATION CONCERNING YOUR RIGHTS, YOU SHOULD KEEP BOTH THE EMPLOYER AND THE PLAN SUPERVISOR INFORMED OF ANY ADDRESS CHANGES. THIS NOTICE IS A SUMMARY OF YOUR COBRA RIGHTS ONLY WITH REGARD TO YOUR FSA. FOR ANSWERS TO SPECIFIC QUESTIONS, PLEASE CONTACT THE PLAN SUPERVISOR AT THE TELEPHONE NUMBER SHOWN ON THE ELECTION FORM OR CONTACT THE PLAN ADMINISTRATOR.

COBRA Election Agreement
for Health Care Flexible Spending Arrangement (FSA)

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF NOTICE SHOWN BELOW, YOU WILL LOSE YOUR RIGHT TO CONTINUE YOUR FSA UNDER COBRA.

Date of Notice _____* _____ _____ Mailed _____ Hand Delivered

Qualified Beneficiary Information (If applying separately, each Qualified Beneficiary must complete a form)

Name: _____ Social Security Number: _____
Last First Middle

Home Address: Street City State Zip

Date of Birth: / /

Employer Name: _____ *_____

Qualifying Event: _____ **TERMINATION** Date of Qualifying Event: _____ **TERM DATE**_____

I have read this form and the attached Notice of Right to Elect COBRA Continuation of Flexible Spending Arrangement (FSA). I understand that the Qualifying Event shown above will result in the loss of my Health Care FSA unless I elect to continue the FSA under COBRA. I understand that if I elect to continue my FSA and have not made arrangements with the Employer to pre-pay contributions on a pre-tax basis, contributions made for COBRA continuation will be on an after-tax basis, and if I fail to pay any FSA contributions on time, as described in the Notice of Right to Elect COBRA Continuation of Flexible Spending Arrangement (FSA), my FSA will terminate. I understand that continuation of my FSA under COBRA is provided subject to my continued eligibility and that the Plan Administrator reserves the right to terminate my COBRA retroactively if I am determined to be ineligible. This notice also discusses other health coverage alternatives that may be available to you through the Health Insurance Marketplace. There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you would be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket cost will be before you make a decision to enroll. For more information about health insurance options through the Health Insurance Marketplace, please visit www.healthcare.gov.

I understand my rights to continue my FSA under COBRA based on the Qualifying Event stated above and would like to take the action indicated below (Please check only ONE of the following):

_____ **I elect to continue my Health Care Flexible Spending Arrangement on an after-tax basis.**

_____ **I am waiving my rights to continue my Health Care Flexible Spending Arrangement under COBRA.**

Signature: _____ **Date:** _____

Name (please print): _____ **Telephone:** _____

Send form to the Plan Supervisor: ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
P. O. BOX 4346
MISSOULA, MT 59806 **CHANGE TO YOUR CO**

Inquiries should be directed to the Plan Supervisor noted below, or to the Plan Administrator:
ENTER YOUR ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC
YOUR INFO OR OURS 1-406-721-2222 or 1-877-424-3570

FOR OFFICE USE ONLY:
Received by the Plan Supervisor _____ Date: _____
This is what the employee sends back to elect cobra. PLEASE SEND A COPY TO ABPM WHEN ELECTED