

SUMMARY PLAN DESCRIPTION

for the

FLEXIBLE BENEFITS PLAN

For The Employees of

CITY OF VANCOUVER

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Flex Claims Processed By:

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SUMMARY

**CITY OF VANCOUVER
FLEXIBLE BENEFITS PLAN**

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

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 SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

**I
ELIGIBILITY**

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan as of your date of hire with us. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the day you meet the eligibility requirements.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

**II
OPERATION**

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. Also, we will make additional Employer contributions to the Plan that you may use to increase the amounts used to pay benefits. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

**III
CONTRIBUTIONS**

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan after application of the Employer Contribution. These amounts will be deducted from your pay over the course of the year.

2. How much will the Employer contribute each year?

We may contribute a discretionary amount which we will determine prior to the beginning of each Plan Year. This contribution is to be used in the Health and/or Dependent Care Flexible Spending Accounts and will be made on a pro rata basis during the year. If you elect not to participate, the Employer will not contribute to the Plan on your behalf.

3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense

during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

4. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

5. When is the election period for our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 31 days after your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

7. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV BENEFITS

1. What benefits are available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Flexible Spending Account:

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

Drug costs, including "over-the-counter" drugs may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is \$5,000. In order to be reimbursed for a health care expense, you must submit to the

Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

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).

Dependent Care Flexible Spending Account:

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws:
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

Premium Expense Account:

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Dental insurance premiums.
- Cancer insurance premiums.
- Personal accident indemnity plan.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

V BENEFIT PAYMENTS

1. **When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. 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, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. **What happens if I don't spend all Plan contributions during the Plan Year?**

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which

benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. 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. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable. The City of Vancouver will allow you 31 days to reinstate your Health Flexible Spending Account and/or Dependent Care Flexible Spending Account 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.

4. 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 your Health Flexible Spending Account 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.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate. You must submit all claims within 90 days of termination of employment.

(c) You will still be able to request reimbursement from the balance remaining in your Health Flexible Spending Account at the time of termination of employment for qualifying medical expenses incurred prior to your termination date. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination of employment. However, you can

elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an additional amount (see COBRA Continuation of Coverage section for details) to provide this benefit. If you are eligible to continue participation in the Health Flexible Spending Account, your dependents may also have an independent right to elect COBRA continuation coverage (see COBRA Continuation of Coverage section for details).

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

7. May I withdraw any or all of the balance of my Health Flexible Spending Account for expenses other than qualified medical expenses?

No. The only exception to this rule is for Qualified Reservist Distributions as set forth in the Heroes Earnings Assistance and Relief Tax Act of 2008.

VI

HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

City of Vancouver Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your amended Plan become effective on January 1, 2009. Your Plan was originally effective on January 1, 1991.

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

2. Employer Information

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

City of Vancouver
610 Esther Street
Vancouver, Washington 98668
91-6001288

3. Plan Administrator Information

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

City of Vancouver
610 Esther Street
Vancouver, Washington 98668
360-619-1001

The 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. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

City of Vancouver
610 Esther Street
Vancouver, Washington 98668

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Allegiance Benefit Plan Management, Inc.
P.O. Box 4346
Missoula, Montana 59806

Website: www.allegianceflexadvantage.com
Phone: (877)424-3570
Fax: (877)424-3539

**IX
ADDITIONAL PLAN INFORMATION**

1. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health and Dependent Care Flexible Spending Accounts, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your claims within 90 days after your termination of employment.

Claims for benefits that are insured or self-funded will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a claim under this Plan is denied in whole or in part, you or your beneficiary will receive written notification from the Plan. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 180 days after denial, you or your authorized representative may submit a written request for reconsideration of the claim to the Administrator. The Plan Administrator will have a maximum of 60 days from the date the written appeal is received to make a final decision regarding the appeal. You may have additional rights for some reimbursement decisions to appeal to a Federal District Court with Jurisdiction, however, in order to do so you must first have exhausted all of your rights to appeal the claim to the Plan Administrator as stated above.

**X
CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under the Health Flexible Spending

Account may have the right to elect to continue coverage under the Health Flexible Spending Account for the remainder of the Plan Year (called "COBRA continuation coverage"), where coverage under the Health Flexible Spending Account would otherwise end. This notice is intended to inform Plan participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended. This notice is intended to reflect the law and does not grant or take away any rights under the law. The law applies to employers who normally employ twenty (20) or more employees.

The Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Administrator to Plan participants who become Qualified Beneficiaries under COBRA. Whenever "Plan" is used in this section, it means the Health Flexible Spending Account.

COBRA Continuation Coverage is available to any Qualified Beneficiary* whose coverage would otherwise terminate due to a Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date coverage terminates.

*Qualified Beneficiary for the purposes of this section means an Employee, former Employee or Dependent or Spouse of an Employee or former Employee who is eligible to continue coverage in accordance with applicable provisions of federal COBRA law. "Qualified Beneficiary" will also include a child born to, adopted by or placed for adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

Qualifying Events:

Qualifying Events for former Employee participants, for purposes of this section, are the following events, if that event causes a loss of coverage under the Health Flexible Spending Account:

1. Termination (other than by reason of gross misconduct) of the former Employee participant's employment; or
2. Reduction in hours of the former Employee participant's employment.

Qualifying Events for the Spouse or Dependents of a former Employee participant, for purposes of this section, are the following events, if that event causes a loss of coverage under the Medical Reimbursement Plan:

1. Death of the former Employee;
2. Termination (other than by reason of gross misconduct) of the former Employee's employment;
3. Reduction in hours of the former Employee's employment;
4. Divorce or legal separation of the Spouse from the former Employee participant; or
5. Dependent child ceases eligibility as a Dependent.

Giving Notice of a Qualifying Event:

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only

after the Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Administrator) will notify the Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) termination of or reduction of hours of employment,
- (b) death of the employee,

NOTICE PROCEDURES:

Any notice you provide must be ***in writing***. You must mail, fax or hand-deliver your notice to the following address:

*City of Vancouver
610 Esther Street
Vancouver, WA 98668
360-619-1018*

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(s)** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(s) of the Qualified Beneficiary(s)**, 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**.

Notice of Election to Continue Coverage:

When the Administrator is notified of a Qualifying Event, the Administrator will notify the Qualified Beneficiary of the right to elect COBRA continuation coverage, if applicable. Notice of this right will be sent within fourteen (14) days after the Administrator receives notice of the Qualifying Event from the Employer or Employee.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notice from the Administrator, whichever is later, to elect to continue coverage. Failure to elect continuation coverage within that period will cause coverage to end.

Monthly Contribution Amounts:

A Qualified Beneficiary who elects to continue coverage must pay the full cost of COBRA continuation coverage. Monthly contribution amounts for COBRA continuation coverage must be paid in advance to the Administrator. The monthly payment for coverage will be an amount equal to one hundred and two percent (102%) of the former Employee participant's monthly contribution amount prior to the Qualifying Event.

Payment of any reimbursement requests submitted by a COBRA participant during the period of COBRA coverage will be contingent upon timely payment of the monthly contributions by the COBRA participant. Monthly contributions are due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Administrator.

When Cobra Continuation Coverage Ends:

COBRA Continuation Coverage under the Health Flexible Spending Account will cease at the end of the Plan Year for any COBRA participant.

Questions:

Any questions about COBRA Continuation Coverage may be directed to the Administrator or to the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) office. Addresses and phone numbers of these offices are available through the EBSA website of www.dol.gov/ebsa.

Address Changes:

COBRA participants should keep the Administrator informed of any changes in the family addresses and should also keep a copy, for his/her records, of any notices sent to the Administrator.

**XI
SUMMARY**

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.