LHK Initial Rights Notice

You are receiving this notice because you have recently become covered under one or more of the group health plans sponsored by LHK Partners, Inc.. LHK Partners, Inc. has retained Benefit Design Specialists, Inc. to provide assistance with their COBRA responsibilities. One of our tasks is to provide you with important information about your right to COBRA continuation of coverage under one or more of the group health plans named above. The information is intended to educate you about your COBRA rights and obligations in the event that you or one of your dependents loses coverage under one or more the plans. For simplicity, the remainder of this notice will refer to the above plans collectively as the "Plan".

While no action or response is required unless you or your dependent actually have a loss of coverage under our health plan(s), both you and your spouse should read the information carefully, and keep it with your records. If you experience a loss of coverage in the future, please refer to this overview for guidance about your rights and responsibilities.

Note: This notice does not fully describe continuation coverage under COBRA or other rights under the Plan and a more complete description can be found by contacting the Plan Administrator (identified below) and/or referring to the applicable health plan Summary Plan Description. There is a more detailed description of your rights under COBRA and the coverage under the Plan(s) under which you have become covered in the applicable Summary Plan Description(s).

This Notice provides a brief overview of your rights and obligations under the current COBRA law. The Plan (as outlined below) offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

You may have other options available to you when you lose group health coverage. 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.

About the COBRA Law.

COBRA refers to a Federal law which applies to most employers who sponsor group health insurance plans for their employees and dependents. For COBRA purposes, a group health plan includes any major medical plan, dental plan, vision plan, health FSA, or any other employer sponsored group plan which provides medical care.

The law requires that employees and certain dependents (spouse and dependent children) who lose coverage under a group health plan must be given the opportunity to continue coverage on a temporary basis. The maximum length of time coverage may be continued depends upon the reason coverage is lost. An employee, spouse and/or dependent child who loses coverage as a result of a qualifying event is called a "Qualified Beneficiary".

COBRA Qualifying Events.

Listed below are "qualifying events" which result in the right to continue coverage under COBRA. Please note that the maximum period of time coverage can be continued depends on the type of qualifying event.

Eighteen (18) Month Maximum Continuation (experienced by a covered employee):

1.) Termination of Employment (for reasons other than "gross misconduct")
2.) Reduction of Work Hours

If you experience one of the events listed above, you and any other impacted qualified beneficiary will be notified of the right to elect continuation coverage.

Disability Extension to twenty-nine (29) months. This extension will apply when any Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time prior to

the end of the first sixty (60) days of COBRA coverage resulting from a termination of employment or reduction of work hours, and continues to be disabled at the end of the initial 18 month period of coverage.

For the disability extension to apply, you must provide a copy of the SSA Determination of Disability letter within the 18 month COBRA period but no later than 60 days after the latest of: (1) the date of the SSA Determination of disability; (2) the date on which the qualifying event occurs; or (3) the date on which the qualified beneficiary loses coverage.

Second Qualifying Event Extension to thirty-six (36) months. If a Qualified Beneficiary experiences an second qualifying event during the 18 or 29 month COBRA continuation coverage resulting from termination of employment or reduction of work hours, then the spouse and dependent children will qualify for an extension of COBRA continuation coverage of up to 36 months from the original qualifying event. A covered employee or qualified beneficiary must provide notice of the second qualifying event within 60 days of the event in order to qualify for the extension. Events eligible for the extension of coverage are those listed below (but only to the extent that they would have caused a loss of coverage under the Plan if it was the initial qualifying event):

Thirty Six (36) Month Maximum Continuation (experienced by a covered spouse or dependent child):

1) Death of an Employee
2) Divorce or legal separation
3) Dependent child no longer meets the Plan's definition of a "dependent

In addition, if you become entitled to Medicare and then experience a qualifying event or reduction in hours of employment within 18 months of the Medicare entitlement, the qualified beneficiary spouse and/or dependent children may elect to continue coverage for up to 36 months from the Medicare entitlement.

Your IMPORTANT Qualifying Event Notice Obligations.

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation, or your child no longer meets the Plan's definition of "dependent", then you, your spouse or dependent child must notify LHK Partners, Inc. of the loss. Written notice must be provided no later than sixty (60) days after the event or the date coverage terminates, which ever is later. It is mandatory that you use the enclosed notification form for this purpose. It can be mailed first class or faxed to LHK Partners, Inc. . A notification form is enclosed for this purpose. (Contact information is listed on the notification form and later in this document.) You may be required to provide additional information to support the qualifying event (e.g. a divorce decree, etc).

If LHK Partners, Inc. is provided timely notice of the divorce, legal separation, or a child's loss of dependent status, we will notify the affected Qualified Beneficiaries of the right to elect continuation coverage.

If LHK Partners, Inc. is not provided notice of the divorce, legal separation, or a child's loss of dependent status during this sixty (60) day period, COBRA continuation will not be offered. If any claims are mistakenly paid for expenses incurred after the divorce, legal separation, or a child's loss of dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If your spouse or dependent child loses coverage as a result of your death or your entitlement to Medicare, LHK Partners, Inc. will automatically notify your spouse, and dependent children of the right to elect continuation coverage.

Other Notification Requirements:

In order to protect your family's rights, you should notify the Plan Administrator, LHK Partners, Inc., immediately when the name or address changes for you or any covered dependent. For your records, you should also keep a copy of any notices you send to the Plan Administrator.

COBRA Continuation Coverage:

If you lose coverage as a result of one of the qualifying events listed above, you may elect to continue the same coverage that you had immediately preceding the qualifying event; however, that continuation coverage is subject to

changes made by the Employer to the same coverage maintained by similarly situated active employees. You have the same right to change your coverage that similarly situated active employees have (including any open enrollment rights to change coverage). Once you receive your election notice from the Plan Administrator, you have 60 days from the later of the date of the notice or the date coverage is lost as a result of the qualifying event to elect coverage. If you elect coverage you may be required to pay up to 102% of the applicable premium and possibly up to 150% of the applicable premium during a disability extension. The first premium is due 45 days after the date you make your election for coverage. All subsequent premiums are due the first day of the coverage period (with a 30 day grace period). Premiums are typically due on the first day of each month.

Other Coverage Options:
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through 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.

Plan Administrator.
LHK Partners, Inc. is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to:

LHK Partners, Inc.
Attn: Human Resource Administrator
2 Campus Blvd.
Newtown Square, PA 19073

For More Information.
If you have questions, or need additional information, you should contact the Plan Administrator, LHK Partners, Inc., or the service provider, Benefit Design Specialists, Inc. at:

Benefit Design Specialists, Inc.
600 Wilson Lane, Ste. 200
Mechanicsburg, PA 17055
Phone: (717) 766-8844
Fax: (855) 296-1027
Email: hy@bdsadmin.com

Employee / Qualified Beneficiary

Notice of Qualifying Event to Employer / Plan Administrator

Date: _____

Attn: **LHK Partners, Inc.**
Attn: HumanResources
2 Campus Blvd.
Newtown Square, PA 19073

From: _____

This is my notice to you that the changes and/or events checked below have taken place. I understand that I must provide this notice no later than 60 days after the event or 60 days after the loss of coverage as a result of the change/event, if later). I understand that this notification is required in order to protect COBRA rights for all covered individuals listed below.

- ☐ Divorce/Legal Separation or other termination of marriage on _____.
- ☐ Dependent Child turning Age _____ on _____ .
- ☐ Dependent Child is no longer a full time student as of _____.
- ☐ Other (please describe): _____

This change effects coverage under the following plans:

- ☐ Health Plan
- ☐ Dental Plan
- ☐ Medical Expense Reimbursement Plan
- ☐ Other: _____

This notice effects the following individuals (attach additional sheets if necessary):

Name:	
Social Security #:	Date of Birth:
Mailing Address:	
City, State, Zip:	
Name:	
Social Security #:	Date of Birth:
Mailing Address:	
City, State, Zip:	
Name:	
Social Security #:	Date of Birth:
Mailing Address:	
City, State, Zip:	

Signature: _____ Date of this Notice: _____

Printed Name: _____ Phone Number: (_____) _____ - _____

Address: _____City: _____ State: _____ Zip: _____