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Example:

	Using Dependent Care FSA Program	Not Using Dependent Care FSA Program
	_____	_____
Your Net Take Home Pay	\$42,750	\$42,000
Your Tax Savings	\$750	N/A

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Time Student

Full-

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COBRA

COBRA Continuation Coverage

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For the other Qualifying Events (e.g., your divorce or legal separation, or your Child's losing eligibility for coverage as a dependent Child), you must notify the COBRA Administrator within 60 days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the COBRA Administrator. Emailed notices or notices sent by facsimile will be considered written notices. Oral or voice-mailed notices will not be accepted.

Your notice must include: the name and contact information of the person giving notice, the name and address of the employee or former employee who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event (e.g., a copy of a judgment of divorce in the event of a divorce), and the names, addresses, and Social Security numbers of the Covered Dependents affected by the Qualifying Event. Failure to notify the COBRA Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

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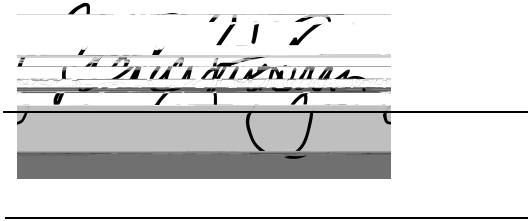
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APPENDIX A

PLAN DOCUMENTS CHART

Effective July 1, 2020

Benefit Program	Insurance Policy/Contract (if applicable)	Booklets
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APPENDIX B

BENEFIT PROGRAM INFORMATION CHART

Effective July 1, 2020

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Medical/Rx Program	Self-Funded	
Dental Program	Insured	

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Long-Term Disability Program	Insured	
Life /AD&D Insurance Program	Insured	
Group Travel Accident	Insured	
EAP	Self-Insured	
Pre-Tax Payment Program	N/A	
Dependent Care FSA Program	N/A	

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Health Care FSA Program	Self-Insured _____	
HSA Contributions Program	N/A _____ _____	
COBRA Administrator	N/A	