

**BLUFFTON PRECAST CONCRETE
BUILDERS EXCHANGE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION**

Bluffton Precast Concrete (the "Plan Sponsor") maintains the Bluffton Precast Concrete Builders Exchange Benefit Plan (the "Plan") for the exclusive benefit of the participants and their eligible dependents as defined by the underlying Benefit Booklet.

This information goes with your Benefit Booklet issued by Medical Mutual Services to give you important information about your benefits under the Plan. These documents, together, make up the "summary plan description" or "SPD" for the Plan, as required by ERISA.

1. Introduction

The Plan provides medical benefits. The Plan requires you to make an annual election to enroll for coverage and may require you to pay a portion of the premiums. The Plan is summarized in the attached Benefit Booklet issued by Medical Mutual Services.

This document and the Attachment constitute the SPD to the extent required by ERISA.

2. General Information About the Plan

Plan Name	Bluffton Precast Concrete Builders Exchange Benefit Plan
Type of Plan	Welfare plan providing medical benefits.
Plan Year	The plan year is January 1st – December 31st. The last day of the plan year is December 31st.
Plan Number	The plan number is 501.
Effective Date	The effective date of this SPD is 2017-03-01 The Plan was established 2017-03-01.
Funding Medium and Type of Plan Administration	The Plan is a self funded multiple employer welfare arrangement or MEWA as defined under Section 3(40)(A) of ERISA. The Plan is maintained in conjunction with the Builders Exchange Benefit Plan Trust (the "Trust").

Claims for benefits are sent to Medical Mutual Services and the claims are processed in accordance with the terms listed in the attached Benefit Booklet prepared by Medical Mutual Services. The Plan Sponsor, Medical Mutual Services and the Plan Administrator (defined below) are responsible for administering the Plan as outlined below.

The Plan Sponsor and employees both may contribute towards the cost of the coverage under the Plan. The Plan Sponsor's portion of the contributions is paid out of the Plan Sponsor's general assets. The employees' share of the contributions is made through employees' payroll deductions. Some of the employee deductions may be withheld on a pre-tax basis. The Plan Sponsor will provide the employees periodically a schedule of the amounts, if any; they must pay to participate in the Plan. The Plan Sponsor reserves the right, at any time, to modify the amount employees have to contribute to participate in the Plan.

Plan Sponsor	Bluffton Precast Concrete 8950 North Dixie Highway Bluffton, OH 45817 (419) 358-6946
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**Plan Sponsor's
Employer
Identification
Number** 34-0922004

**Claims
Administrator/
Insurance
Companies** Medical:
Medical Mutual Services
2060 E 9th St.
Cleveland, OH 44115
Customer Care: (800) 382-5729

Pharmacy Retail:
Express Scripts, Inc.
Attn. Commercial Claims
P.O. Box 2872
Clinton, Iowa 52733-2872
Fax (608) 741-5475
Customer Service Unit (800) 962-8192

Mail Order Pharmacy:
Express Scripts Home Delivery Service
PO Box 66772
St. Louis, Missouri 63166-6772
Fax: (866) 312-7456
(must come from physician)
Customer Service Unit (800) 962-8192

Plan Administrator Builders Exchange Benefit Plan Board of Trustees
9555 Rockside Rd.
Cleveland, OH 44125
Telephone (216) 393-6300

**COBRA
Administrator** Bluffton Precast Concrete
8950 North Dixie Highway
Bluffton, OH 45817
(419) 358-6946

Named Fiduciary Bluffton Precast Concrete
8950 North Dixie Highway
Bluffton, OH 45817
(419) 358-6946

**Agent for Service of
Legal Process** Builders Exchange Benefit Plan
9555 Rockside Rd.
Cleveland, OH 44125
Telephone (216) 393-6300
Attn: General Counsel

Service of legal process may be made upon the Plan Administrator at this address.

Trust Information Builders Exchange Benefit Plan Trust
9555 Rockside Rd.
Cleveland, OH 44125
Telephone (216) 393-6300

Trust Federal Identification Number is 47-2303889

Individual Trustees on January 1, 2017, are:
Gregg Mazurek, Russell O'Rorke, Jeff Molchan

Important Disclaimer Plan benefits are provided pursuant to the Benefit Booklet. If the terms of this document conflict with the terms of the Benefit Booklet, then the terms of the Benefit Booklet will control, rather than this document, unless otherwise required by law. This SPD (as well as the incorporated document) will be considered the plan document for any provision not addressed in the plan document.

3. Eligibility and Participation Requirements

Eligibility and Participation An eligible employee with respect to the Plan will be any common-law employee of the Plan Sponsor who is eligible to participate in and receive benefits under the Plan. To determine whether you or your family members are eligible to participate in the Plan please read the eligibility information contained within the Benefit Booklet. A summary of this information is set forth below.

Summary of Eligibility and Participation Provisions An eligible employee is an individual who works a normal work week of thirty (30) hours or more. New eligible employees will become effective on 90 days of employment..

Eligible employee does not include a temporary or substitute employee, or seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

The Plan may require that you make an annual election to enroll for coverage. If you are an eligible employee, you may begin participating in the Plan upon your election to participate in accordance with the Plan's terms and conditions. You must consult the eligibility requirements and enrollment procedures listed in Benefit Booklet for additional information to fully determine all of the participation requirements.

Termination of Participation Your participation and the participation of your eligible family members in the Plan will terminate on the same day you terminate employment with the Plan Sponsor. However, Plan benefits may continue until the end of the month in which your employment terminates or beyond that date if applicable. Coverage also may terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims, or for any other reason as set forth in the certificate of insurance, benefit booklets, benefit summaries, or other governing documents for the component benefit program. You should consult the applicable Attachments for specific termination events and information.

**Continuation
Coverage Under
COBRA and
USERRA**

Any mention of COBRA rights within this document as well as the Model Notice and Notice of Qualifying event form are only applicable if the Plan Sponsor is subject to COBRA. As a general rule, COBRA applies to employers with 20 or more employees. You should contact the Plan Sponsor to determine if this Plan is, in fact, subject to COBRA. This document does not guarantee rights under COBRA.

If eligible coverage for you or your eligible family members ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child’s ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You must notify your COBRA Administrator should a qualifying event occur i.e. divorce, separation, birth or adoption of a child or when a child ceases to be a dependent under the terms of the Plans. We have provided a Notice of Qualifying Event Form on the last page of this document for you to notify the COBRA Administrator should you have a qualifying event.

If you have any questions about your COBRA rights, please read the attached Benefit Booklet. Please contact the COBRA Administrator if you need another copy. There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could 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 costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options through a Health Insurance Marketplace visit www.healthcare.gov.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the attached Benefit Booklet. You and your family also may be entitled to continue coverage under state law.

4. Summary of Plan Benefits

**Benefits and
Contributions**

The Plan provides benefits to you and your eligible dependents as defined by the Benefit Booklet.

The cost of Plan benefits will be funded in part by Plan Sponsor contributions and in part by employee payroll withholdings. Some of the employee deductions may be withheld on a pre-tax basis. The Plan Sponsor will make its contributions, out of the Plan Sponsor’s general assets, in an amount that (in the Plan Sponsor’s sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee contributions. The Plan Sponsor will pay its contribution and your contributions to the Trust periodically as soon as administratively possible.

The Plan will, within three months from date of receipt, return any refunds from an insurance Plan Sponsor with those participants entitled to a portion of those refunds. The Plan Sponsor will bear its incidental costs of administering the Plan.

Qualified Medical Child Support Orders

With respect to the medical benefits, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage 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 normal 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 the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

5. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

Medical Mutual Services is responsible for (a) determining eligibility for and the amount of any Plan benefits; and (b) prescribing claims procedures to be followed and the claims forms to be used by employees.

The Trust will hold all Plan assets and all Plan benefits will be paid from Trust assets . The Trust also insures benefits over a certain level through the purchase of stop loss insurance coverage pursuant to a reinsurance agreement between the Trust and The Health Plan of Upper Ohio Valley, Inc.. The Plan is subject to oversight and regulation by the Ohio Department of Insurance. However, Plan benefits are not covered under the Ohio Life & Health Insurance Guaranty Association.

Questions

If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of any benefit, please contact your Human Resources Manager. If you have any question regarding your eligibility for, or the amount of, any benefit payable under the Plan, please contact Medical Mutual Services.

6. Circumstances That May Affect Benefits

**Denial, Recovery,
or Loss of Benefits**

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4.

Your benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied under a certain benefit program if you have a preexisting condition and incur costs within the exclusionary period. In addition, certain benefits may be rescinded for fraud or an intentional misrepresentation of material fact. You should consult the Benefit Booklet for additional information.

7. Amendment or Termination of the Plan

**Amendment or
Termination**

The Plan may be amended or terminated at any time a written instrument duly adopted by the Plan Administrator or any of its delegates.

8. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Plan Sponsor to the effect that you will be employed for any specific period of time.

9. Claims Procedures

**Claims for Benefits/
Insured Benefit**

For purposes of determining the amount of, and entitlement to, Plan benefits, Medical Mutual Services is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to Plan benefits. To obtain Plan benefits, you must follow the claims procedures under the Plan, which may require you to complete, sign, and submit a written claim on the form provided by Medical Mutual Services. In that case, the form is available from Medical Mutual Services.

Medical Mutual Services will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. Medical Mutual Services has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If Medical Mutual Services denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to Medical Mutual Services for a review of the denied claim. Medical Mutual Services will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

See the attached Benefit Booklet for more information about how to file a claim and for details regarding Medical Mutual Services claims procedures.

10. Statement of ERISA Rights

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

You may be able to continue health care coverage for yourself or your eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per 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, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 9), you may file suit in a state or federal court.

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.

**Assistance With
Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Note that a premium only plan is not covered by ERISA and this Statement of the ERISA Rights does not apply to any premium only plan.

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Bluffton Precast Concrete GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS **

Introduction

You're getting this notice because you recently gained coverage under a group health plan(s) (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the COBRA Administrator.

You may have other options available to you 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.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Please note that all notifications to the COBRA Administrator must be in writing. See the last page of this document for the Notice of Qualifying Event Form.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or

- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 must notify the COBRA Administrator within 60 days after the qualifying event occurs. You must complete the Notice of Qualifying Event Form found on the last page of this document. The form must then be provided to COBRA Administrator at the address listed below.

How is COBRA continuation coverage provided?

Once the COBRA Administrator receives 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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. *Please note; special rules apply to the Health Flexible Spending Account Benefit plan with regard to COBRA coverage periods.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must complete the attached form and send it to the COBRA Administrator using the address listed below.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the COBRA Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator at the following address:

MyCafeteria Plan
432 East Pearl Street
Miamisburg, Ohio 45342

Bluffton Precast Concrete **NOTICE OF QUALIFYING EVENT FORM**

Bluffton Precast Concrete provides you and your family valuable benefits in the form of health coverage. As the attached Notice explains, COBRA permits certain individuals to continue their coverage under the Plans under certain circumstances when that coverage would otherwise end. One of the requirements under COBRA is that you or any member of your family must notify the COBRA Administrator if one of the following events occurs:

- You (the employee) become divorced or legally separated;
- A child is born or adopted;
- A child ceases to be a dependent under the terms of the Plans; or
- If anyone on COBRA becomes married, divorced or acquires a child
- A person is determined to be disabled and becomes entitled to Medicare

It is imperative you complete and return this form to the COBRA Administrator within sixty (60) days if there is a change in marital status or a child loses dependency status. You must complete and return this notice of Qualifying Event to the COBRA Administrator within thirty (30) days if a child is born or adopted. Failure to complete and return this form to the COBRA Administrator in a timely manner will result in the forfeiture of valuable benefits.

Please complete the following information:

Employee's Name and Address _____ Today's Date _____
_Bluffton Precast Concrete_____

_\$EmployerAdress_____ Your Telephone Number _____
_Bluffton, OH 45817_____

Please check the appropriate items:

- I have obtained a divorce or legal separation.
- A child has been born or adopted.
- A child no longer qualifies as a dependent.
- Received notice from Medicare regarding eligibility for disability benefits.

Date of Event: _____

This form must be completed and mailed, via first class mail, to the following address within sixty (60) days (thirty (30) days if a child is born or adopted) of the date the above event occurred:

COBRA Administrator
MyCafeteria Plan
432 East Pearl Street
Miamisburg, Ohio 45342

05/24/16