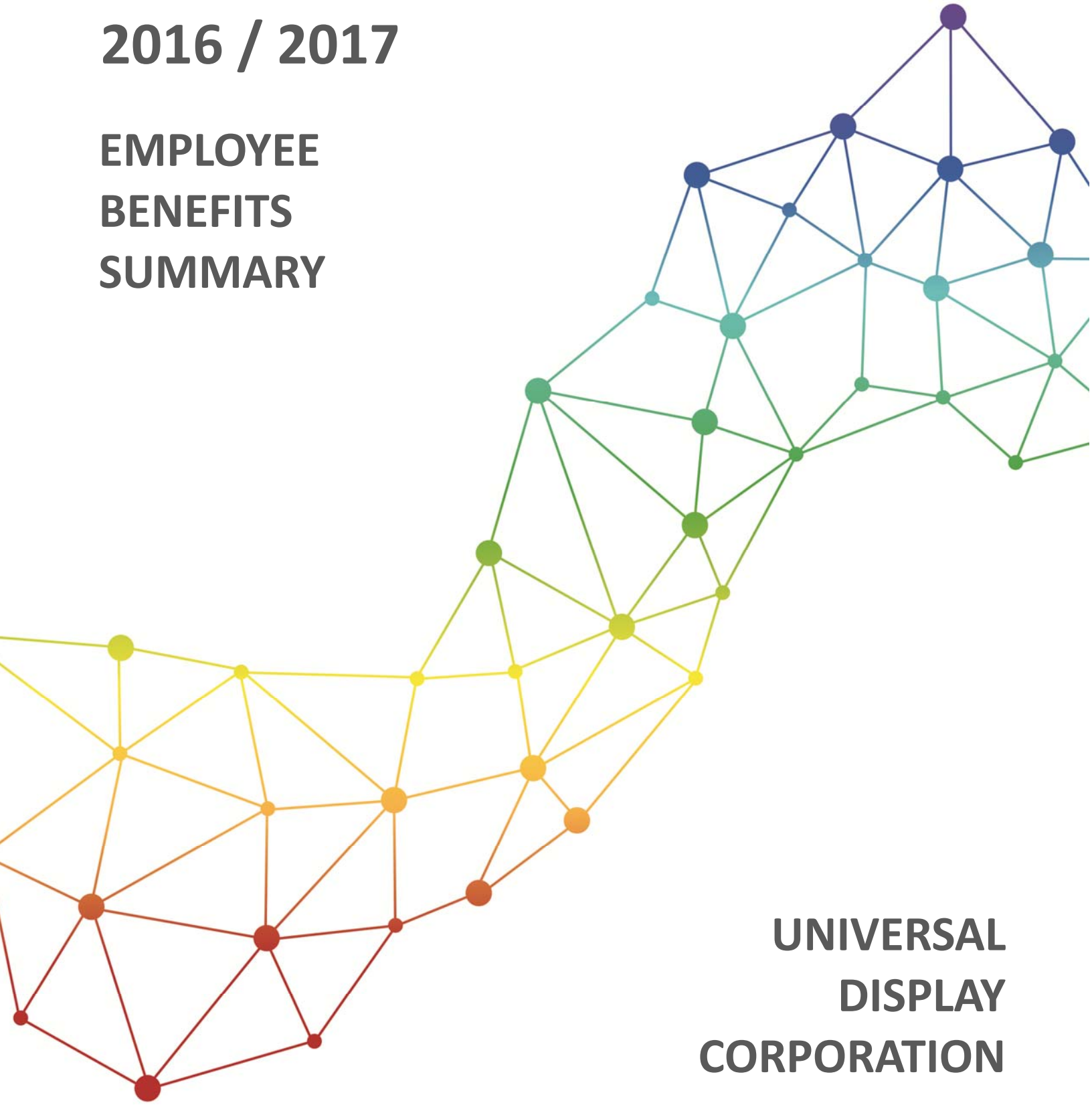
2016 / 2017

EMPLOYEE BENEFITS SUMMARY



UNIVERSAL DISPLAY CORPORATION

COLOR IS UNIVERSAL

— Enrollment Guidelines —

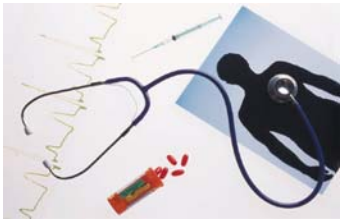
Who is Eligible:

As an UDC full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. The following family members are eligible for medical, dental coverage:

- Your legal spouse
- Dependent children until age 26
- Dependent children in NJ (Medical Only) have the option to stay covered after 26 at a discounted rate until age 31

Enrollment Rules:

Once you make your annual elections during open enrollment, you cannot make changes to your medical, dental, and Flexible Spending Account coverage until the next annual enrollment unless you experience a qualified change in status. A qualified change in status would be birth of a child, marriage, divorce, loss or gain of other coverage or death of a dependent. If you experience one of these life events during the year, you can make applicable changes to your benefits within 30 days of the event. You must notify HR in writing during this 30 day window in order to make any changes. If you fail to notify HR in the time frame outlined, you will not be able to make any changes until the next open enrollment period.



— Medical Insurance —

Horizon Blue Cross Blue Shield of New Jersey

Below is a summary of the medical plan offered through **Horizon.** A detailed plan design is available in the HR department.

Plan Features	Direct Access EO
	In-Network Services
Referrals Required	No
Deductible[1] Coinsurance Payment Limit[2]	$500 / $1,000 90% $3,000 / $6,000
Preventive Care	100% No Deductible
Office Visit Primary Care Physician Specialist	 $25 Copay $50 Copay
Emergency Room	$100 Copay then 10% No Deductible
Inpatient Hospitalization	90% After Deductible
Outpatient Surgery	90% After Deductible
Durable Medical Equipment	50% After Deductible
Outpatient Lab[3]	100% in Office or Participating Facility 90% After Deductible in Outpatient Facility
Outpatient X-Ray	100% Office 90% After Deductible in Outpatient Facility
MRI, CT, Pet Scan	100% Office 90% After Deductible in Outpatient Facility
Mental Health/Substance Abuse Inpatient Outpatient	 90% After Deductible $50 Copay
Prescription Coverage Generic Preferred Brand Non-Preferred Brand Mail Order (up to 90 day supply)	 $15 Copay $35 Copay $50 Copay $30 / $70 / $100
	Out-of-Network Services
Deductible[1] Coinsurance Out-of-Pocket Maximum	$2,000 / $4,000 70% $7,000 / $14,000

[1]Deductible is applied on a calendar year basis. The deductible is not pro-rated and must be met in full each calendar year.

[2]Payment Limit is applied on a calendar year basis. Pharmacy expenses do apply toward the Payment Limit

[3]Check for your local in network provider to receive highest level of benefits.

The information in this Benefit Summary is presented for illustrative purpose. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Summary, contact Human Resources.

— Health Reimbursement Arrangement—

The Health Reimbursement Arrangement (HRA) plan is an employer-provided benefit that is made available as part of the medical insurance coverage. It allows you to seek reimbursement for qualified unreimbursed medical, dental, and vision expenses such as deductibles, copays, and coinsurance. Your HRA benefits can be used for claims incurred by your dependents even if they are not enrolled in the medical plan. Over-the-counter (OTC) health products may be eligible provided a script is issued and provided to eFlex as documentation.

If you are also enrolled in the Healthcare FSA, the FSA funds will be used first. HRA funds (and FSA funds, if enrolled) can be accessed by submitting receipts for reimbursement or through the convenience of a Debit Card. Your card may be used at doctors' and dentists' offices, and pharmacies. This means you won't have to wait for reimbursement for most expenses. Even when using the card, though, you should retain all receipts, as you may be required to submit a receipt to Eflex to validate that your expenses qualify. You will need to pay out of pocket for over-the-counter medications and submit a claim form along with your script to eFlex for reimbursement.

Below is a summary of the HRA benefits provided depending on your medical enrollment coverage level.

Coverage Level	Annual HRA Benefit
Single	$600
Employee + Child(ren)	$900
Employee + Spouse	$900
Family	$1,200

If you terminate your employment, you have 90 days to spend down your HRA account balance. It can be used for the same expenses as when you were an active employee. Due to ACA changes, funds cannot be used to pay COBRA premium.

***Annual Rollover Notice: You have 30 days following the end of each plan year (until September 30th) to submit a paper claim for any service that was incurred between September 1st and August 31st of that plan year. This 30 day period is called the Run Out period. Any balance left over from the previous plan year will not be available until the Run Out period is closed and reconciled (approximately October 15th).**

It is your responsibility to ensure that proper documentation is provided to eFlex and maintained with your annual tax records in the event of an IRS audit. UDC is not responsible for any expenses paid without full supporting documentation.
Documentation for eligible **HRA and FSA** expenses, required by the IRS, includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)
- Name of the merchant/provider

A carrier Explanation of Benefits (EOB) would be considered sufficient documentation for any expense processed by an insurance carrier.

— Dental Insurance —

UNITED CONCORDIA

You will make the most of your annual maximum by seeking dental services through a participating United Concordia PPO dentist. PPO dentists are obligated to accept the negotiated network fee, so they can only bill you the applicable percentage allowed for the services provided. A non-participating dentist can balance bill you for the difference between what they are reimbursed from United Concordia and their total fee, costing you more out of pocket. Balance billing is the difference between the dentist's charge and what United Concordia deems usual, customary and reasonable.

Benefit Highlights	United Concordia PPO Dentist	Non-participating Dentist*
Calendar Year Maximum Deductible	$2,000 $25 / $75	$2,000 $25 / $75
Diagnostic & Preventive Exam & Cleaning X-Rays, Fluoride, Sealants	100%	100%*
Basic Fillings, Simple Extraction, General Anesthesia, Periodontics, Periodontic Surgery, Space Maintainers Endodontics, Repairs and Adjustments	100%	80%*
Major Implants, Crowns, Bridges, Dentures	60%	50%*
Orthodontia (to age 19) Lifetime Maximum	50% $2,000	50% $2,000

Sample Claim Savings	United Concordia PPO Network	Non-Participating Dentist*
Charge for a crown	$1,800	
Dentist will accept as payment in full	$1,200	$1,800
Service Covered at	60%	50%*
Reasonable and Customary Charge	N/A	$1,250
Patient Share	$480	$625
Insurance Pays	$720	$625
Patient Balance Billing	$0	$550
Patient Total Responsibility	$480	$1,175**

*United Concordia will pay a percentage of the usual, customary and reasonable charge (UCR), and you are subject to balance billing.

**United Concordia paid 50% of the UCR ($1,250) = $625. Patient paid 50% of UCR ($625) + difference between $1,800 and UCR of $1,250 ($550) = $1,175.

Visit United Concordia's website at www.Unitedconcorida.com to locate a participating dentist in your area, using the Alliance network.

— Life and Disability Insurance —

Basic Life & AD&D Insurance
UDC provides full-time employees with life and accidental death and dismemberment (AD&D) insurance, and pays the full cost of this benefit. This benefit is based on a multiple of the employee's salary. Contact Human Resources for additional details or to update your beneficiary information.

Short and Long Term Disability Income Benefits
UDC provides full-time employees with short and long-term disability income benefits, and pays the full cost of this coverage. In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term or long-term disability benefits if you are receiving workers' compensation benefits.

	Short-Term Disability Reliance Standard	Long-Term Disability Prudential
Benefits Begin	8th Day	181st Day
Benefits Payable	Up to 26 Weeks	Up to 65 or Social Security Normal Retirement Age if disabled prior to age 60
Percentage of Income Replaced	66.66% of Base Monthly Earnings	60% of Base Monthly Earnings
Maximum Benefit	$2,000 per week*	$10,000 per month

*Benefit amount will be reduced by any amount received from NJ State disability.

— Flexible Spending Accounts (FSA) —

Flexible Spending Accounts (FSA) - FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Plan Carefully: Unused balances up to $500 in your Health Care FSA will be rolled over at the end of the plan year. Balances in your Health Care FSA above $500 will be forfeited. The Dependent Care FSA remains a "Use It or Lose It" fund. Any unused monies in your Dependent Care FSA at the end of the year will be forfeited.

The plan year is January 1 through December 31. Qualified expenses must be incurred during the plan year. Expenses are considered incurred when the service is performed. Once you make your election, you cannot change the contribution amount unless you experience a qualified life event change. There are two unique FSA options:

Health Care FSA - This program allows UDC employees to pay with pre-tax dollars for certain IRS-approved medical care expenses not covered by your insurance plan. You do not need to be enrolled in the medical plan to enroll in this benefit. **The annual maximum you may contribute is $2,550.** This maximum is based on IRS guidelines.

Eligible Expenses Include:

- Copays, Coinsurance, and Deductibles
- Hearing services, including: hearing aids and batteries
- Vision services, including: contact lenses, contact lens solution, eye exams and eye glasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Over-the-counter (OTC) medications provided you have a prescription

Please note: OTC rules changed January 1, 2011 as a result of Healthcare Reform. Only OTC medications accompanied by a prescription from your provider will be eligible for reimbursement. Your debit card will not work for these purchases.

Dependent Care FSA – The Dependent Care FSA allows UDC employees to use pre-tax dollars to pay for qualified dependent care, such as caring for children under the age of 13 or caring for elders (dependent on you for their daily care). **The annual maximum amount you may contribute is $5,000** (or $2,500 if married and filing separately) per calendar year.

Eligible Expenses include:

- The cost of child or adult dependent care either inside or outside the home
- The cost for an individual to provide care either in or out of his/her house
- Nursery schools and preschools (excluding kindergarten)

Transit – The Transit Account allow UDC employees to set aside pre-tax dollars to pay for work-related mass transit expenses. **The current maximum monthly pre-tax contribution is $255 a month for transportation ($3,060 annually).** This is subject to change annually.

Some eligible expenses include:

Transit passes, such as: tokens, passes, fare cards, and vouchers

You may obtain information regarding your FSA and HRA balance by calling Eflex at (877) 933-3539 or logging onto www.eflexgroup.com. Once you log onto the website go to the login section and select participant. You should monitor your accounts on a regular basis to ensure funds are being paid out of the desired account.

— Resources —

Benefit Hotline

When you contact the Benefit Hotline, you will be assisted by an Employee Benefit Specialist with extensive background in the insurance industry. The Hotline can be reached Monday through Friday from 9:00 a.m. – 5:00 p.m. They are available to assist you with services such as the following:

- General insurance education related to your UDC benefits
- Eligibility questions
- Claim issues
- Assistance with completing and understanding enrollment forms and much more – If you have a question about your benefits and don't know where to turn, call the Benefit Hotline and they will redirect you if necessary.

CBIZ Model Consulting

The Benefit Hotline toll-free number is (800) 442-1413.

Health Advocate

With Health Advocate, you will have your own Personal Health Advocate, a registered nurse, supported by a team of medical doctors and administrative experts. Your Personal Health Advocate can assist with the following:

- Finding the best doctors and hospitals
- Understanding Medicare & eldercare issues
- Scheduling timely appointments, especially with specialist
- Assist with the transfer of medical records
- Locate and research the newest treatments for a medical condition
- Assisting with insurance claims and billing issues

HealthAdvocate
Always at your side

Health Advocate's toll-free number is (866) 695-8622.

— 401K Retirement Plan —

The UDC 401(k) Retirement Plan provides the opportunity to save for retirement through tax-deferred and/or after tax (Roth) payroll deductions which you can invest in funds offered through Fidelity Investments. When you participate in the plan, you may contribute either a dollar amount or a percentage between 1% and 90% of your eligible pay up to current IRS limits. If you are age 50 or older and defer the maximum allowed under the plan, you may make additional salary deferral contributions "catch-up contributions" up to the IRS limit. The plan accepts rollovers from other qualified retirement plans.

The Company also makes a discretionary matching contribution to your account. The amount would be equal to a percentage determined annually by the Board of Directors. Currently, this Company match is equal to 50% up to the first 6% of the employee's deferral contribution.

You are eligible to participate in the plan the first of the quarter after completing 60 days of continuous service and are age 19 or older. When eligible, you make your withholding and fund elections by completing an online enrollment through Fidelity's online portal at www.NetBenefits.com. Your elections are effective and may be changed each quarter on any January 1, April 1, July 1, or October 1.

— Pay for Time Off—

- Paid Time Off (PTO) –Three (3) paid weeks of Paid Time Off per annum, accruing at a rate of 4.62 hours per pay period, with an increase of one (1) week (an additional 1.54 hours per pay period) after five (5) years of service. Up to two times your Paid Time Off can be carried over to the following year, for one (1) year. The maximum amount of Paid Time Off allowed at any time is two times earned Paid Time Off. Calculated based on anniversary date.
- Holiday pay – The Company observes up to seven (7) paid holidays per year.
- Floating holiday pay – Two (2) paid floating holidays per year.
- Sick pay – Five (5) paid sick days per year, accruing at a rate of 1.54 hours per pay period. Up to five (5) sick days can be carried over to each year. The maximum amount of sick time allowed at any time is two times earned sick time. Calculated based on anniversary date.

Federally Required Notices Related To Your Benefits Program

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov.hcpf/
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/id
Click on Health Care, then Medical Assistance
Phone: 800-657-3629

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid
Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

MONTANA – Medicaid

Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: http://health.utah.gov/medicaid CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistanc.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because you have other health/dental coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Non-Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or SCHIP.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, all your plan administrator at (609) 671-0980.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the 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 insurers 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 48 hours/96 hours.

Rights Under COBRA

As a UDC employee, you are eligible for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 as amended). This gives employees and their qualified beneficiaries the opportunity to continue health insurance coverage for specified periods of time under the Company's health plan when a "qualifying event" occurs. Some common qualifying events are resignation, termination of employment (other than for gross misconduct), or death of an employee; a reduction in an employee's hours or a leave of absence; an employee's divorce or legal separation; and a dependent child no longer meeting eligibility requirements. Under COBRA, the employee or beneficiary pays the full cost of coverage at the employer's group rates plus an administration fee.

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