

CONTINUATION OF COVERAGE: EMPLOYEE NOTICE

VERY IMPORTANT ----- READ CAREFULLY

In this notice, the Employer is _____ . The plan is the group health insurance plan maintained and sponsored by the Employer. The Insurance Carrier is _____ . The Employer is the plan administrator.

A federal law called COBRA requires that most employers sponsoring group health insurance plans offer insured employees and their covered dependents the opportunity for a temporary continuation of health coverage at group rates in certain cases where coverage under the plan would otherwise end. This notice is intended to summarize for you and your covered dependents, your rights and obligations under the continuation of coverage provisions of COBRA. You should take the time to read this notice carefully. If you have any dependents covered by the plan, they should also read this notice, as each covered dependent has the right to accept or reject continuation coverage individually, if you do not elect coverage for them. *

If you are an employee insured by the plan, you have a right to choose this continuation coverage if you lose your group health insurance because of the termination of your employment (for reasons other than gross misconduct) or a reduction in the number of hours of your employment.

If you are the covered spouse of an employee insured by the plan, you have the right to choose continuation coverage if you lose health coverage because of:

- 1) The death of your spouse;
- 2) A termination of your spouse's employment (for reasons other than gross misconduct);
- 3) A reduction in your spouse's number of hours of employment;
- 4) Divorce or dissolution of your marriage; or
- 5) Your spouse's entitlement to Medicare benefits.

If you are the covered child of an employee insured by the plan, you have the right to choose continuation coverage if you lose health coverage because of: *

- 1) The death of your parent who is the insured employee;
- 2) The termination of your insured parent's employment (for reasons other than gross misconduct) or reduction in your insured parent's hours of employment;
- 3) Your parent, as the insured employee, becoming entitled to Medicare benefits; or
- 4) Your ceasing to be an "eligible dependent" under the terms of the plan.

Under COBRA, the employee or a covered family member must inform the Employer of a divorce/dissolution of marriage, or a child's ceasing to be an "eligible dependent" under the terms of the plan. **If the Employer is not informed within sixty (60) days after the date coverage would terminate because of these events, the covered spouse and/or children will lose their COBRA right to continue coverage under the plan.**

* In the case of a minor child, only the parent or guardian can accept or reject the continuation offer.

When the Employer becomes aware of, or is notified of, any of the above events, it will then notify you (or, if you are a dependent child, your parents or guardians) that you have the right to continuation of coverage. Under COBRA you will have sixty (60) days from the date of the employer's notification or the date coverage ended, whichever is later, in which to inform the Employer that you want continuation of coverage. **If you do not choose continuation of coverage within this sixty (60) day period, you will lose your right to continue coverage under the plan.**

If you choose continuation of coverage and so inform the Employer within the sixty (60) day period, it is required to give you coverage which, as of the time coverage is being provided, is the same as provided under the plan to active full-time employees and their covered dependents. If you lose group health insurance coverage because of termination of the insured employee's employment or a reduction in the employee's number of hours worked, you must be allowed to maintain continuation coverage for up to eighteen (18) months. * If coverage is lost due to other events (excluding the two (2) exceptions footnoted below), continuation coverage can be for up to thirty-six (36) months.

COBRA also provides that your continuation of coverage will end earlier for any of the following four (4) reasons:

- 1) The Employer no longer provides group health coverage to any of its employees;
- 2) The premium for your continuation of coverage is not paid;
- 3) You become covered under another plan as an employee or otherwise (and that plan has no pre-existing conditions limitation applicable to you); or
- 4) You are entitled to receive Medicare benefits.

You do not have to show that you are insurable to obtain continuation of coverage. However, under COBRA, the Employer may require you to pay the entire premium on a monthly basis for your continuation coverage (no employer contribution), plus a two (2) percent administrative fee. The law also says that within the one hundred eighty (180) day period prior to the end of the eighteen (18) or thirty-six (36) month continuation of coverage period described above, you must be allowed to enroll in any conversion health plan provided to other employees under the plan at that time.

COBRA does not apply to employers who normally employ fewer than twenty (20) employees, unless the Employer obtains health insurance coverage through an association in which at least one member employs more than 20 employees. If you have any questions about COBRA, contact the Employer. **Also, if you, as an employee, change marital status or you or your covered spouse move, notify the Employer.**

* There are two (2) other exceptions:

1. If you are a covered employee or dependent who is "disabled" (as defined by the Social Security Administration) at the time the employee terminates employment or reduces work hours, or within the first sixty (60) days following loss of health coverage, then your continuation coverage will be extended to twenty-nine (29) months, provided you notify the Employer about your "disability" within the first eighteen (18) months of continuation coverage.
2. An employee's entitlement to Medicare is an event that terminates continuation coverage. In such case, and only if you are a covered dependent, you may elect to extend medical coverage for a total of thirty-six (36) months (which includes the eighteen (18) month continuation period in which you have been covered).

INSURANCE TERMINATION/CONTINUATION REQUEST (COBRA) ELECTION FORM

Date: _____

Insured Employee: _____ Employer Group No.: _____

Employer: _____ Address: _____

City/State/Zip Code: _____

The group insurance for:

_____ employee

_____ spouse of the employee

_____ child(ren) of the employee

ended or will end on _____ because of (whichever is checked):

- employee's termination of employment on _____ .
- employee's reduction in work hours on _____ .
- employee's Medicare entitlement on _____ .
- employee's divorce or dissolution of marriage on _____ .
- child's ceasing to be eligible dependent on _____ .
- employee's death on _____ .

The persons named above for whom group insurance ends may **each** elect to continue all, or a portion of, their **existing** group health insurance coverage, as follows:

1. Medical coverage only (includes supplemental prescription drug benefits if applicable);
or
2. Medical **and** Dental/Vision coverage (if applicable).

In order to continue coverage, **each** person named above must:

1. **Indicate on the next page**, the coverage or coverages he or she wants;
2. **Pay all appropriate amounts** in the manner prescribed under **THE SCHEDULED PREMIUM PAYMENT** (see back); **and**
3. **Mail or deliver this completed form** to the above Employer within **sixty (60) days** after the later of:
 - (a) the date of this form (shown at the top); or
 - (b) the date regular group insurance ends.

If this form is not mailed or delivered back to the Employer within the appropriate sixty (60) days, then the person(s) named above will have lost the right to continue coverage. Read the enclosed CONTINUATION OF COVERAGE NOTICE for full details.

CIRCLE CHOICES BELOW, COMPLETE AND SIGN

NO I do not want COBRA-required group health continuation coverage. (**Each person** rejecting coverage must sign below. Parents or guardians must sign for minor children).

Signature

Date

Signature

Date

YES Continue COBRA-required group health coverage as follows (**complete 1, 2 & 3 below**).

1. Continue group **medical** coverage (includes supplemental prescription drug benefits if also covered) for eligible persons named here. **If no one wants such coverage, write "none"**.

2. Continue group **dental** coverage for eligible persons named here. **If no one wants such coverage, write "none"**.

3. Are any persons to be continued already covered by another group health plan or Medicare? **If "yes", name person(s) and date(s) such coverage began** (otherwise write "none").

I/We, the undersigned, understand that my preceding answers are a basis for any COBRA-continued coverage, and that an incorrect answer voids such coverage. (**Each person** wanting some form of continued coverage must sign below. Parents/guardians to sign for minor children.)

Signature

Mailing Date

Signature

Mailing Date

THE SCHEDULED PREMIUM PAYMENT

The scheduled payment amount of \$ _____ is for **all** persons losing coverage as named on the previous page and for **all** forms of health coverage (major medical, supplemental prescription drug, dental, and/or vision, as applicable) that those persons last had under this group plan. If the continued coverage desired does not include **all** these persons and previous forms of coverage, contact the Employer for the correct **scheduled payment amount**.

The scheduled payment amount is payable to the Employer on or before the **monthly due date, which is the _____** of each month. Initially, however, the person(s) electing COBRA continuation can make their first payment for such coverage within forty-five (45) days after sending or delivering this form back to the employer.

This first payment must include any back-payment for health insurance from the date regular group insurance ended. (See date shown on the prior page.) To determine the first payment (including any back-payment) multiply the **scheduled payment amount** by the number of **monthly due dates** that occur between the date regular group insurance ended and the date the first payment is received by the employer.