Standard Operating Procedures

COBRA Notification

Background

The Consolidated Omnibus Budget Reconciliation Act ("COBRA" or "Act") was designed to provide "qualified beneficiaries" with a temporary extension of group health insurance benefits when their coverage is lost due to "qualifying events." The term "qualified beneficiary" refers to individuals who are covered under an employer's group health plan the day before a COBRA "qualifying event" takes place. Typically, a qualified beneficiary is the covered employee, covered spouse of the employee, or covered dependent child of the employee. "Qualifying events" under COBRA include: 1) voluntary termination; 2) involuntary termination (except where there is gross misconduct involved); 3) reduction of hours; 4) death of an employee; 5) employee's Medicare entitlement; 6) divorce or legal separation; 7) dependent child ceasing to be a dependent.

Under COBRA, qualified beneficiaries affected by voluntary and involuntary terminations, as well as reductions in hours, are entitled to 18 months of health insurance coverage continuation. For the remaining qualifying events, the affected individuals are entitled to 36 months of continuation coverage.

Disability Extends COBRA Coverage

COBRA coverage can be extended from 18 months to 29 months in the case of qualified beneficiaries who are disabled at the time of a termination or reduction in work hours. By extending the coverage up to 29 months, COBRA coverage may continue until the qualified beneficiary is entitled to Medicare benefits (due to the disability).

COBRA Notices

COBRA also requires employers to notify their employees of their rights under the law at various times during their employment. The following is a description of the process employers should undergo to give the notices required under COBRA (as well as a termination notice required under New York State law which works in conjunction with COBRA). Attached to this operating procedure are sample notice forms which you may use to satisfy your COBRA notification requirements

A. Initial Notification Procedure

The purpose of this notification is to acquaint employees, spouses, and their dependents (if covered) with the COBRA law, their notification obligations, and their possible rights to COBRA coverage in the future. Once a new employee has completed his or her health insurance application, mail the initial notification letter (Attachment No. 1) to all qualified beneficiaries. It is recommended that each and every COBRA notification be sent certified mail, return-receipt requested. That way, the employer will have evidence that the notification was sent and received.

B. Qualifying Event Notification Procedure

The purpose of the qualifying event notification is to inform each qualified beneficiary of their right to continue their group health insurance coverage under COBRA. Once it has been established that a qualifying event has occurred, employers should mail the qualifying event notification and election form (Attachment No. 2) to all qualified beneficiaries at their last known address within 14 days of the date on which company officials learned of the event. As with all COBRA notices, these should be mailed certified mail, return-receipt requested. ***PLEASE NOTE:*** If a participant applies for COBRA continuation coverage but the plan sponsor determines that he or she is not eligible for COBRA *(e.g.,* if there is no qualifying event), the participant must be notified of the determination within 14 days. The notice must explain why the individual is ineligible for COBRA. Group health plans and health insurance issuers are also required to furnish a certificate of coverage to an individual to provide documentation of the individual's prior creditable coverage. A certificate of creditable coverage: must be provided automatically by the plan or issuer when an individual either loses coverage under

the plan or becomes entitled to elect COBRA continuation coverage and when an individual's COBRA continuation coverage ceases; and must also be provided, if requested, before the individual loses coverage or within 24 months of losing coverage. (Attachment No. 3)

C. Extension Notification Procedure

The purpose of this notification is to inform qualified beneficiaries that they are eligible for an extension of their COBRA coverage. This extension can occur as a result of either a "secondary qualifying event" or due to the disability of a qualified beneficiary. A "secondary qualifying event" refers to a qualifying event which occurs during the 18-month continuation period (or in the case of a disability extension, during the 29-month continuation period) resulting from a termination (voluntary or involuntary) or reductions in hours. In other words, if during the 18-month continuation period following a termination, the former employee dies, his/her spouse and dependent children would be entitled to a total of 36 months of continuation coverage. The 36 months of coverage would be measured from the date of the first qualifying event. In the above example, the spouse and dependent children could elect to continue their coverage for up to 36 months from the date that the employee was terminated.

Qualified beneficiaries are eligible for a disability extension of up to 29 months of provided that the employer is given notice of the disability (from the Social Security Administration) before the expiration of the original COBRA period (18 months) and within 60 days of the disability determination.

COBRA provides that all types of extension coverage may be cut short for any of the following reasons (***PLEASE NOTE:*** If COBRA coverage terminates prior to the end of the applicable coverage period *(e.g*., due to nonpayment of premiums), the plan administrator must, as soon as possible, provide a notice informing the participant why the coverage is being terminated and describing alternative coverage, if any, that is available under the health plan or applicable law (such as an option to convert to an individual policy):

1. The company no longer provides group health insurance benefits to any of its employees;

2. The monthly premium for the extension coverage was not paid (***PLEASE NOTE*:** There is a requirement under the COBRA rules to accept payment something less than full payment of the premium. While the exact percentage is not defined in the rules, it is recommended that if a qualified beneficiary tenders at least 50% of the premium payment, that it be accepted. Anything less than that amount should be returned with a notification that the premium is insufficient. If the qualified beneficiary tenders such a payment, the individual will have an additional month to make up the difference between the actual premium payment and the amount paid.)

3. The individual becomes covered under a group health plan after electing COBRA coverage.

4. The individual becomes entitled to Medicare after electing COBRA coverage.

5. There has been a determination by the Social Security Administration that the individual is no longer disabled. The COBRA coverage terminates on the first day of the month, 30 days after the individual is deemed no longer disabled.

Once it has been established that a qualified beneficiary and/or family member is eligible for COBRA extension, mail them the COBRA extension notification document (Attachment No. 4), certified mail, return-receipt requested.

D. Conversion Notification Procedures

Once COBRA coverage comes to an end, covered individuals have the right to convert the COBRA coverage to an individual policy. This is known as "COBRA conversion." The company is required to notify all qualified beneficiaries of their right to elect a conversion option within 180 days prior to the expiration of the COBRA coverage. At that time, complete the COBRA conversion notification document (Attachment No. 5) and mail it to the covered individuals, certified mail, return-receipt requested.

Attachment No. 1

INITIAL NOTIFICATION HEALTH INSURANCE CONTINUATION COVERAGE
*** VERY IMPORTANT NOTICE ***

To: _____and/or Spouse/Dependents, if any
Date:
Address:
From:

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was signed into law (Public Law 99-272, Title X). Under COBRA, most employers sponsoring group health plans must offer covered workers and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the COBRA law. You, your spouse and your family (if applicable) should take the time to read this notice carefully.

As an employee of _____ (the "Employer") covered by the group health plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are a retired employee of the employer covered by the group health plan, you have the right to choose this continuation coverage if you lose your group health coverage because of a bankruptcy proceeding in a case under Title XI of the Bankruptcy Code with respect to the Employer.

If you are a spouse of an employee covered by the Employer's group health plan, you have the right to choose this continuation coverage for yourself if you lose group health coverage under the plan for any of the following five reasons:

(1) The death of your spouse;
(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
(3) Divorce or legal separation from your spouse;
(4) Employee's Medicare Entitlement; or
(5) If your spouse is retired, a Title XI bankruptcy proceeding commences involving the Employer.

In the case of a dependent child of an employee covered by the Employer's group health plan, he or she has the right to continuation coverage if group health coverage under the plan is lost for any of the following six reasons:

(1) The death of a parent;
(2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;
(3) Parents' divorce or legal separation;
(4) Employee's Medicare Entitlement; or
(5) The dependent ceases to be a "dependent child" under the provisions of the plan; or
(6) If a parent is retired, a Title XI bankruptcy proceeding commences involving the Employer.

In the case of a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage, the covered employee has the right to elect continuation coverage on behalf of such child in accordance with the notice requirements set forth below.

If there is a choice among types of coverage under the group health plan, each of you who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect continuation coverage even if the employee does not. Also, a spouse and/or dependent child may elect a different coverage from the coverage elected by the employee.

Under COBRA, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under any group health plan or the birth or adoption of a child including during a period of COBRA continuation coverage. Such notice must be made within 60 days of the event or the date on which coverage would be lost because of the event, whichever is later. In addition, if an employee or family member suffers a disability (as defined in the Social Security Act), the Plan Administrator must be notified with a Certificate of Disability within in 60 days of the disability determination and prior to the end of the initial 18-month continuation period. Likewise, if a determination is made that a disability no

longer exists, the administrator must be notified of this within 30 days. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or entitlement to Medicare.

When the Plan Administrator is notified that one of the above named events has happened, the Plan Administrator will, in turn, notify you that you have the right to choose continuation coverage. Under the COBRA law, you have at least 60 days from the date you would lose coverage or from the date notice was sent, whichever is later to inform the Plan Administrator that you want continuation coverage. If you participated in an HMO and you use the services of the facility during the election period, this use can be treated as a constructive election of COBRA continuation coverage. In such a case, you are obligated to pay the appropriate charge for the coverage.

If a Qualified Beneficiary becomes incapacitated during or prior to a period of time in which an action must be taken by the Qualified Beneficiary, the affected period of time is to be tolled until the person is no longer incapacitated; has a legal guardian appointed; or has an executor of the estate appointed, in the event the Qualified Beneficiary dies before becoming no longer incapacitated.

If you do not choose continuation coverage, your group health insurance will end as provided in the group health plan.

If you choose continuation coverage, the Employer is required to give you coverage that is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if coverage under the plan is modified for similarly situated employees or family members, your coverage will also be modified in the same manner.

COBRA requires that you be afforded the opportunity to maintain continuation coverage for 36 months (i.e., 3 years), unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18-month period may be extended to 36 months after the date of the termination of employment or reduction in hours if other events (divorce, legal separation, death, Medicare entitlement or the dependent child ceases to be a "dependent child" under the provisions of the plan) occur during that 18-month period.

The 18-month period may be extended for an additional 11 months (for a total of 29 months) if the employee or family member is determined to be disabled (under the rules for Social Security disability benefits) at the time of termination of employment or reduction in hours of employment or at any time during the first sixty (60) days of COBRA continuation coverage, and the Plan Administrator is notified of that determination within 60 days and prior to the end of the 18-month period. If an individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the 11-month disability extension. The affected individual also must notify the Plan Administrator within 30 days when it is determined (for purposes of Social Security disability benefits) that the individual is no longer disabled.

Under COBRA, you may have to pay all of the premium for your continuation coverage, plus (if opted by the Employer) an administrative fee (up to 2%; or in disability cases, the administrative fee may increase up to 50% after the initial 18-month period). If the qualifying event is a bankruptcy reorganization, coverage continues until the death of the covered employee or other qualified beneficiary, and if the covered employee dies, coverage continues for the surviving spouse or dependent child of the covered employee for 36 months after the covered employee's death. The term "qualified beneficiary" in this context includes a covered employee who retired on or before the date of the substantial elimination of coverage and any other individual who on the day before the commencement of the proceeding, is a beneficiary under the plan.

COBRA provides that your continuation coverage may be cut short of the full coverage period for any of the following reasons:

(1) The Employer no longer provides group health coverage to any of its employees;
(2) The premium for your continuation coverage is not paid on time;
(3) After electing COBRA coverage, you become covered under another group health plan that either (i) does not contain any provision restricting or limiting coverage of a "pre-existing medical condition" which may apply to you or (ii) whose limits or exclusions for pre-existing conditions do not apply to (or would be satisfied) by you under the provisions of the Health Insurance Portability and Accountability Act of 1996;
(4) You become entitled to Medicare after electing COBRA coverage;
(5) There has been a final determination that you are no longer disabled (in the case of qualification for an extra 11 months of continuation coverage based on disability at termination or within 60 days following termination).

You do not have to show that you are insurable to choose continuation coverage. However, under the COBRA law, you may have to pay all of the premium for your continuation coverage plus (if opted by the Employer) an administrative fee up to 2%; or in disability cases, the administrative fee may increase up to 50% after the initial 18-month period). The first premium payment

(retroactive premium) must be received by the Plan Administrator within 45 days of the date you sign the election form. The retroactive premium is the amount due from loss of coverage to date of election. Subsequently, premiums will be due and payable on a monthly basis. The premium is due on or before the 1st day of each month and you are allowed a 30-day grace period. The COBRA law also says that, at the end of the 18-, 29-, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan. Your carrier will send you conversion notification information to your last known address.
Please advise the Plan Administrator if the employee or family member has changed address. COBRA notices will be sent to the last known address. If you have any questions about the COBRA law, please contact the Plan Administrator.

Plan Administrator - _____ Address - _____
_____

Telephone- _____

Attachment No. 2

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[Enter date of notice]

Dear: *[Enter Name of Employee,*
Spouse, Dependent Children, as appropriate}

This notice contains important information about your right to continue your health care coverage in the *[enter name of group health plan]* (the Plan).

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage, you should contact *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]*.

If you do not elect to continue your health care coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on *[enter date]* due to:

- ❑ End of employment
- ❑ Death of employee
- ❑ Enrollment in Medicare
- ❑ Reduction in hours of employment
- ❑ Divorce or legal separation
- ❑ Loss of dependent child status

Each of the following persons is entitled to elect to continue health care coverage under the Plan:

- ❑ Employee - *[enter name]*
- ❑ Spouse (or former spouse of employee) *[enter name]*
- ❑ Dependent children *[enter name(s)]*

Because of the event (checked above) that will end your coverage under the Plan, you *[and/or, as appropriate*, your spouse, and dependent children] are entitled to continue your health care coverage for up to _____months *[enter* 18 *or* 36 *months as appropriate]*. If you elect to continue your coverage under the Plan, your continuation coverage will begin on *[enter date]* and can last until *[enter date]*.

Your continuation coverage will cost: *[enter amount each qualified beneficiary would be required to pay for each option per month of coverage and any other permitted coverage periods.]*

IMPORTANT - To elect continuation coverage you MUST complete the enclosed "Election Form" and return it to us. You may mail it to the address shown on the Election Form *[or describe other acceptable means of submission].* The completed Election Form must be post-marked by *[enter date] [or received by [enter date] if submitted by other means].* If you do not submit a completed Election Form by this date, you will lose your right to elect continuation coverage. Important information about your rights is provided to you on the pages after the Election Form.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS.

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including *[add if applicable:* open enrollment .and] special enrollment rights. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from *[enter name, address and telephone number of appropriate party (Plan Administrator or other party)]*.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[If the maximum period of coverage of this notice is 18 *months, add the following three paragraphs:]*

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify *[enter name of COBRA administrator]* of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify *[enter name of COBRA administrator]* of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify *[enter name of COBRA administrator]* of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify *[enter name of COBRA administrator]* within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

[If employees might be eligible for trade adjustment assistance, the following information may be added: The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated *[if Plan permits, add:* unless you request that your continuation coverage begin only with the date of your Election Notice] up to the rime you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

[enter appropriate payment address]

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. *[Enter additional information on other due dates for payments if Plan permits other periodic payment schedules.]* Under the Plan, these periodic payments for continuation coverage are due on the *[enter due day for each month of coverage]. [If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before its due date,

your coverage under the Plan will continue for that coverage period without any break. The Plan *[select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

[enter appropriate payment address]

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days *[or enter longer period permitted by Plan]* to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. *[If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

[If Plan provides any election of other health coverage besides continuation coverage (such as alternative coverage in lieu of continuation coverage, individual conversion rights, etc.), enter description of all such coverages and explain how election of such other coverages would affect continuation coverage rights under the Plan. The following are two separate examples of such a description:]

Can you elect other health coverage besides continuation coverage?

Under the Plan, you have the right to elect alternative group health coverage for a period of six months at no cost to you instead of the continuation coverage described in this Notice. If you elect this six-month alternative coverage, you will lose all rights to the continuation coverage described in this Notice. You should also note that if you enroll in the alternative group health coverage you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact [*add appropriate contact information*] if you wish to elect alternative coverage.

–OR--

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical co those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan are available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from: [*Enter name, address and telephone number of appropriate party (plan administrator or other party)*].

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

COBRA CONTINUATION COVERAGE ELECTION FORM

[Name of Employee / Spouse / Dependent Children (as appropriate)]

IMPORTANT: This form must be completed and returned by mail [or *describe other means of submission and due date].* If mailed, it must be post-marked no later than *[enter date].* Send completed form to:

[Enter Name and Address]

I (We) elect to continue our coverage in the *[enter name of plan]* (the Plan) as indicated below:

Name.	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.			
b.			
c.			
d.			

Type of coverage elected (check only one):

- ❑ *[enter description of option]*
- ❑ *[enter description of option]*
- ❑ *[enter description of option]*

_____ _____
Signature Date

_____ _____
Print Name Relationship to individua1(s) listed above

_____ _____

_____

_____

_____ _____
Print Address Telephone number

Attachment No. 3

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

* IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____

2. Name of group health plan: _____

3. Name of participant: _____

4. Identification number of participant: _____

5. Name of any dependents to whom this certificate applies: _____

_____

_____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____

_____

_____

7. For further information, call: _____

8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ____ and skip lines 9 and 10.

9. Date waiting period or affiliation period (if any) began: _____

10. Date coverage began: _____

11. Date coverage ended: _____ (or check if coverage is continuing as of the date of this certificate: _____).

Attachment No. 4

COBRA EXTENSION NOTIFICATION

To:
Date:
Address:
From:

This is to inform you and/or your dependents that you are eligible for an extension of your COBRA continuation coverage benefits beginning _____ and terminating on _____because of the following: (all applicable events are marked with an "X")

Standard Secondary Event

_____Termination or _____Reduction of hours followed by:

_____ Death of the employee
_____ Medicare Entitlement
_____ Divorce or _____ Legal Separation
_____ Dependent Child Ceasing to be a Dependent

For any of the foregoing events, the 36 months of coverage will extend from the date of the original qualifying event.

Disability Extension

_____ Disability Extension

In order for the Qualified Beneficiary and/or family member to take advantage of the disability extension of COBRA coverage, the Notice of Disability (from the Social Security Administration) must be provided to the employer before the expiration of the original COBRA period and within 60 days of the disability determination.

COBRA provides that your extension coverage may be cut short of the full extension coverage period for any of the following reasons:

(1) Our company no longer provides group health insurance to any of its employees;

(2) The monthly premium for your extension coverage is not paid on time;

(3) After electing COBRA continuation coverage, you become covered under another group health plan that either (i) does not contain any provision restricting or limiting coverage of a "preexisting medical condition" which may apply to you or (ii) whose limits or exclusions for preexisting conditions do not apply to (or would be satisfied) by you under the provisions of the Health Insurance Portability and Accountability Act of 1996;

(4) After electing COBRA coverage, you become entitled to Medicare; or

(5) There has been a final determination that you are no longer disabled (in the case qualification for an extra 11 months of continuation coverage based on their disability at termination or within 60 days following termination). COBRA coverage terminates on the 1st of the month, 30 days after being deemed no longer disabled.

If you should decide to extend your COBRA coverage, your monthly premium will be $_____ and is due on the ____st/nd/rd/th of each month.

Attachment No. 5

COBRA CONVERSION NOTIFICATION

To:
Date:
Address:
From:

This is to inform you and/or your dependents that your COBRA coverage is coming to an end and you and/or your dependents have the right to elect an individual conversion policy. Your qualifying event was _____on _____with ____ months of coverage. Your COBRA coverage will expire on _____.

_____***(Health Insurance carrier, address, telephone number)*** will send you individual conversion option information to your last known address. The coverage they will offer you and/or your dependents is not always the same coverage that you had with COBRA coverage. Please notify your health insurance carrier directly at the above telephone number if you have any questions about the individual conversion option.

The COBRA law provides that your continuation coverage may be cut short of the full coverage period for any of the following reasons:

(1) The Employer no longer provides group health coverage to any of its employees;
(2) The premium for your continuation coverage is not paid on time;
(3) You become covered under another group health plan that either (i) does not contain any provision restricting or limiting coverage of a "preexisting medical condition" which may apply to you or (ii) whose limits or exclusions for pre-existing conditions do not apply to (or would be satisfied) by you under the provisions of the Health Insurance Portability and Accountability Act of 1996;
(4) You become entitled to Medicare; or
(5) There has been a final determination that you are no longer disabled (in the case of qualification for an extra 11 months of continuation coverage based on disability at termination or within 60 days following termination). COBRA coverage terminates on the 1st day of the month, 30 days after being deemed no longer disabled.

If one of the above occurs, and your COBRA coverage is terminated prior to the end of the maximum period you will be notified by (health insurance carrier) directly about an individual conversion option.

There are two different ways a qualified beneficiary can extend their COBRA coverage explained below:

(1) A Standard Secondary Event, termination or reduction of hours followed by death of the employee, Medicare entitlement, divorce or legal separation or a dependent child ceasing to be a dependent. In standard secondary events, the 36 months of coverage will extend from the date of the original qualifying event.

(2) Disability Extension - COBRA coverage can be extended from 18 months to 29 months in cases of Qualified Beneficiaries or their family members who are disabled (according to Title II or XVI of the Social Security Act) at the time of a termination or reduction in work hours or at any time during the first sixty (60) days of COBRA continuation coverage. By extending the coverage up to 29 months, coverage may continue until the Qualified Beneficiary is entitled to Medicare benefits due to the disability. In order for the Qualified Beneficiary or family members to take advantage of the 29-month disability extension, the Notice of Disability (from the Social Security Administration) must be provided to the employer before the expiration of the 18-month COBRA period and within 60 days of the disability determination. COBRA coverage terminates on the 1st of the month, 30 days after being deemed no longer disabled.

If you have experienced one of the above events during your COBRA coverage, please contact the Plan Administrator as you may have COBRA extension privileges.