

NOTICE OF CONTINUATION RIGHT – COBRA  
\*VERY IMPORTANT NOTICE\*

(This form is to be filled in by the employer, and this notice and accompanying Continuation of Coverage forms are to be given to the employee or dependent.)

Date: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Group Policy Number: \_\_\_\_\_

Employee or Dependent Name: \_\_\_\_\_

Termination Date or Qualifying Event Date: \_\_\_\_\_

Monthly Premium for Continuing Employee and/or Dependent: \_\_\_\_\_

Plan Administrator: \_\_\_\_\_

Plan Administrator's Address: Street \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**This notice contains important information about your right to continue your health care coverage in the Group Health Plan provided by the Employer listed above.** Both you and your spouse should take time to read this notice carefully.

Under certain circumstances, you have the right to continue your health insurance beyond the date that it would normally end. The health insurance coverage that can be continued is the same coverage that is provided to insureds whose coverage has not ended. However, any weekly income benefits for total disability cannot be continued. If you are eligible for COBRA continuation coverage and do not elect to continue coverage, your coverage under the Plan will end on \_\_\_\_\_ *(date)*.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. If you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with February 28, 2010, you may be eligible for the temporary premium reduction for up to 15 months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the Continuation Coverage Premium Assistance Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

If you qualify as an "Assistance Eligible Individual" your premium cost will be \$\_\_\_\_\_ for up to 15 months. You do not have to send any payment with the Election Form.

## CONTINUATION RIGHTS

1. An insured's health insurance can be continued for a maximum period of 18 months, if it is ending because:
  - a. the insured employee's employment terminated for reasons other than gross misconduct; or
  - b. the insured employee had his hours reduced.

If an insured does not wish to continue coverage for himself, his covered spouse and/or children may elect to continue the coverage on their own for a maximum period of 18 months.

2. An insured's health insurance may be extended beyond the 18 month continuation period, to a maximum period of 29 months, for himself and/or his insured dependents, if:
  - a. his insurance is ending because of one of the reasons listed above; and
  - b. he qualifies as disabled for Social Security purposes at the time his employment ends or at any time during the first 60 days of COBRA continuation; and
  - c. he notifies the plan administrator of a determination of total disability by the Social Security Administration within 60 days of the determination, but before the end of the first 18 months of continuation.

However, an insured's extended continuation will end the premium due date that is at least 30 days after a final determination under the Social Security Act that he is no longer disabled. The coverage extension is available to the disabled insured and the insured's nondisabled dependents who are eligible for COBRA continuation. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18 month period.

3. An insured dependent's health insurance can be continued for a maximum period of 36 months, if his insurance is ending because:
  - a. the insured employee dies;
  - b. a divorce or legal separation has occurred;
  - c. the insured dependent child no longer meets the policy's definition of a dependent child;
  - d. the insured employee became covered by Medicare.
4. An insured dependent's health coverage can be continued for at least 36 months from the date the insured employee became covered by Medicare, if the employee's insurance ends for any of the above listed reasons.
5. An insured can continue his insurance for 36 months if:
  - a. he has lost coverage or had his coverage substantially reduced within one year before or after the date his employer began proceedings in a Ch. 11 bankruptcy proceeding; and
  - b. he retired after the Ch. 11 bankruptcy proceeding; or
  - c. he is an insured dependent of a retiree who died after a Ch. 11 bankruptcy proceeding.
6. An insured can continue his insurance for his lifetime, if:
  - a. he has lost coverage or had his insurance substantially reduced within one year before or after his employer began proceedings in a Ch. 11 bankruptcy case; and
  - b. he is a retiree who retired before the Ch. 11 bankruptcy proceeding; or
  - c. he is a widow or widower of a retiree who died before the bankruptcy proceeding.

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.

1. You can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage. Election of continuation coverage may help prevent such a gap.
2. You will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you.
3. 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.

## **COST TO CONTINUE COVERAGE**

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 (or, in the case of an extension of continuation coverage due to a disability, 150 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. The required payment for each continuation coverage period is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with February 28, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the Continuation Coverage Premium Assistance Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

## **YOUR RESPONSIBILITIES**

1. You must notify the plan administrator if you want to continue coverage. You must notify them within 60 days after the date a qualifying event occurs, or within 60 days after you were provided notification of this right to continue, whichever is the longer period of time. You must notify them in writing by using the COBRA Continuation of Coverage Election form they provided to you.
2. You must notify the plan administrator if any of the following events occur:
  - a. a divorce or legal separation;
  - b. an insured child no longer meets the policy's definition of an insured dependent child.

This notice must be given to the plan administrator within 60 days of the occurrence of one of these events.

3. If you decide to continue coverage, your first premium payment is due 45 days following the date you return the election form. If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.
4. Coverage is provided only when the full premium for the applicable period is received. You must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the plan administrator. Coverage is not in force for any period for which premium is not paid. If the applicable payment is not received within 30 days of the date the premium is due, you will lose all rights to continuation coverage under the plan.
5. Inform the plan administrator of any changes in your address and the addresses of family members.
6. Keep a copy, for your records, of any notices you send to the Plan Administrator.

## **INSUREDS WHO CANNOT CONTINUE**

An insured cannot continue this coverage if at the time of his termination, he is:

1. covered by Medicare;
2. covered by another group health plan. However, if the other group health plan contains a pre-existing condition limitation that prevents him from obtaining full coverage under the plan, then he can continue under this plan; or
3. a non-resident alien with no earned income from sources within the United States, or the dependent of such person.

## **TERMINATION**

Continued coverage will end on the earliest of the following dates:

1. the date that the maximum continuation period has been exhausted;
2. the date the employer ceases to maintain any group health plan for any employee;
3. the date the insured is covered by another group health plan which does not include a pre-existing condition clause;
4. the date the insured becomes covered by Medicare;
5. the date any premium that is due is not paid within the time allowed.

An insured's continuation will terminate anytime this policy is terminated.

**RIGHTS FOLLOWING COBRA CONTINUATION**

You may be able to convert your insurance to an individual conversion policy if your continuation is ending because your insurance has been continued for the maximum period allowed by law. Your conversion rights are outlined under the provision regarding conversion of health benefits in your certificate of insurance. Please refer to your certificate of insurance for more information regarding your conversion rights.

**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 is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact the plan administrator.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). State and local government employees should contact HHS-CMS at [www.cms.hhs.gov/COBRAContinuationofCov/](http://www.cms.hhs.gov/COBRAContinuationofCov/) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).