

Model COBRA Continuation Coverage Election Notice (For use by single-employer group health plans)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

Date of notice: _____

Dear: _____

This notice has important information about your right to continue your health care coverage in the _____ (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on _____ due to (check appropriate box):

- | | | |
|--|---|---|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment | <input type="checkbox"/> Entitlement to Medicare |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation | <input type="checkbox"/> Loss of dependent child status |

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on (date) _____ and can last until (date) _____.

You may elect any of the following options for COBRA continuation coverage: _____
Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [enter name of party responsible for COBRA administration] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

How much does COBRA continuation coverage cost?

COBRA continuation coverage will cost: (enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.) _____

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication - and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't 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 questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact:

(name of party responsible for COBRA administration for the Plan, with telephone number and address) _____

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

COBRA Medical/Dental/Vision Benefits Election Form

Subject to the terms stated in your Summary Plan Description, COBRA medical, dental, or vision benefits may be available for you and/or your covered dependents. Please refer to the Summary Plan Description for terms and limitations. To apply for COBRA medical, dental, or vision benefits, please complete and return this form to your employer (or previous employer, in the event of termination of employment) or the employer's COBRA administrator.

Employer name _____

Group number _____

Employee information

Employee name _____

Social Security number _____

Phone _____

Street address _____

Apt / Suite / PO box number _____

City _____

State _____

Zip code _____

Dependent information

Dependent name _____

Social Security number _____

Qualifying Event

Check the qualifying event that applies to you and indicate the date of the qualifying event in the blank

- | | | | |
|--|---|--|------------------------------|
| <input type="radio"/> Termination | Last date employed _____ | <input type="radio"/> Marriage | Date of marriage _____ |
| <input type="radio"/> Medicare | Date covered by Medicare _____ | <input type="radio"/> Reduced Hours | Date hours reduced _____ |
| <input type="radio"/> Legal Separation | Date legal separation filed _____ | <input type="radio"/> Employee's Death | Date of death _____ |
| <input type="radio"/> Dependent Child | Date dependent child ceased
to be eligible dependent _____ | <input type="radio"/> Divorce | Date divorce effective _____ |
| | | <input type="radio"/> Reservist | Date of active duty _____ |

Employer complete premium due for coverages. Date form is given to insured _____

Medical

Dental

Vision

- | | | |
|--|--|--|
| <input type="radio"/> Individual only _____ /Month | <input type="radio"/> Individual only _____ /Month | <input type="radio"/> Individual only _____ /Month |
| <input type="radio"/> Individual and spouse _____ /Month | <input type="radio"/> Individual and spouse _____ /Month | <input type="radio"/> Individual and spouse _____ /Month |
| <input type="radio"/> Individual and child _____ /Month | <input type="radio"/> Individual and child _____ /Month | <input type="radio"/> Individual and child _____ /Month |
| <input type="radio"/> Family _____ /Month | <input type="radio"/> Family _____ /Month | <input type="radio"/> Family _____ /Month |

(Note: Rates are subject to any employer changes to plan.)

PREMIUMS MUST BE PAID TO THE EMPLOYER OR THE COBRA ADMINISTRATOR SELECTED BY YOUR EMPLOYER.

The initial premium is due within 45 days after the date COBRA is elected. Subsequent premiums are due monthly by the first of the month. Payment is considered timely if made within 31 days of the first of the month due date. Failure to submit a COBRA premium payment to the employer, or the employer's COBRA administrator, within the 31 day payment grace period will result in cancellation of coverage.

Signature of Person Electing or Waiving COBRA

- I elect COBRA
 I am waiving my right to COBRA

Employee signature _____ Date _____

Spouse signature _____ Date _____

Dependent signature _____ Date _____

(If Over Age 19)

SPOUSE AND DEPENDENT SIGNATURES ARE REQUIRED IF ANY DEPENDENT COVERAGE IS BEING WAIVED.

This form must be completed and returned within 60 days after or the later of: 1) the date that you would lose coverage, or 2) the date that you are sent notice of your right to elect COBRA. An election is considered to be made on the date that it is sent to your employer or plan sponsor. Failure to return this form within the specified time may result in the loss of COBRA privilege.

NOTE: If you are deemed Totally Disabled by the Social Security Administration prior to, or within 60 days of your COBRA election, you may be eligible to receive an additional 11 months of COBRA for you and your insured dependents. Please enclose your SSA Notice of Award with this application or within 60 days of receipt of your award notice.

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Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. 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.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due (due day for each monthly payment) _____ for that coverage period. 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 the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will or will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period [or enter longer period permitted by Plan] to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period.

If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. 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 don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to: (enter appropriate payment address) _____