

## COBRA CONTINUATION COVERAGE ELECTION NOTICE

TO: \_\_\_\_\_ DATE: \_\_\_\_\_  
Beneficiaries

FROM: BOB KASPER

**This notice contains important information about your right to continue your health care coverage in our Company’s group health plan (the “Plan”).** Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on \_\_\_\_\_ due to *[check appropriate box]*:

Date

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

Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to \_\_\_ months *[enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]*:

- 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

If elected, COBRA continuation coverage will begin on \_\_\_\_\_ *[enter date]* and can last until \_\_\_\_\_ *[enter date]*.

AVAILABLE OPTIONS FOR COBRA CONTINUATION COVERAGE	MEDICAL INSURANCE PREMIUM PER MONTH	DENTAL INSURANCE PREMIUM PER MONTH
<input type="checkbox"/> Individual Coverage	\$	\$
<input type="checkbox"/> Two Person/Double Coverage	\$	\$
<input type="checkbox"/> Family Coverage	\$	\$

You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact Bob Kasper, Vice President, Informed Marketing Services, Inc., 500 Federal Street, Suite 201, Troy, New York, telephone number: (518) 687-6700.

## COBRA Continuation Coverage Election Form

**Instructions:** To elect COBRA continuation coverage, you **MUST** complete this Election Form and return it to us within 60 days of the date your insurance benefits terminate or the date you received this Election Notice, whichever occurs later. Copies of this form can be made if any qualified beneficiary chooses to individually elect or decline continuation coverage.

Send completed Election Form to: **Bob Kasper, Vice President, Informed Marketing Services, Inc., 500 Federal Street, Suite 201, Troy, New York 12180.**

This Election Form must be completed and returned in person or by mail by \_\_\_\_\_ [due date]. If mailed, it must be post-marked no later than \_\_\_\_\_ [enter date].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

### MEDICAL INSURANCE

Name of Medical Plan: CDPHP

- I am declining my (our) right to continue medical insurance coverage under the Plan.
  
- I (We) elect to continue my (our) medical insurance coverage under the Plan as indicated below:

Name of Each Qualified Beneficiary Electing Medical Continuation	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)

Type of medical insurance coverage elected: *Check only one.*

- Single
- Two Person/Double
- Family

**IMPORTANT**

I (we) understand that I (we) will not be eligible for COBRA continuation coverage if I (we) become covered under another group plan that does not impose any pre-existing condition exclusion for my or a family member's pre-existing condition or if I (we) become entitled to Medicare. I (we) agree to notify the organization immediately upon become covered by another group plan, enrolling in Medicare, or if I (we) no longer wish to continue COBRA coverage.

Signature of Employee or Person Electing Coverage:	Date:
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Print Name:	Relationship to Employee:
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Signature of Spouse*:	Date:
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*\*Required if employee had family coverage at the time of the qualifying event and the employee is now declining continuation coverage or is only electing single coverage.*

Street Address:

City:	State:	Zip Code:	Telephone Number:
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## **IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS**

### **What is COBRA 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 (or retired employee) covered under the group health plan, the covered employee’s spouse, and the 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.

### **How Long will COBRA Continuation Coverage Last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

### **Termination of COBRA Continuation Coverage**

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- 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).

## **How Can You Extend the Length of COBRA Continuation Coverage?**

If you elect COBRA continuation coverage and are entitled to a maximum of 18 months of coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Bob Kasper 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 determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.*] Each qualified beneficiary who has 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 the Plan of that fact within 30 days after 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 may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

## **How can you elect COBRA Continuation Coverage?**

To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

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 COBRA 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 (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 for each option is described in this notice.

### **When and How Must Payment for COBRA Continuation Coverage be Made?**

#### *First payment for continuation coverage*

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 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 in full not later than 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 Bob Kasper to confirm the correct amount of your first payment.

#### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. 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 on the 26<sup>th</sup> Day of The Preceding Month for that coverage period. *[If Plan offers other payment schedules, enter with appropriate 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 *[select one: 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 will 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. 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 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 under the Plan 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 fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Bob Kasper, Vice President  
Informed Marketing Services, Inc.  
500 Federal Street, Suite 201  
Troy, NY 12180

### **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 Bob Kasper, Vice President, Informed Marketing Services, Inc., 500 Federal Street, Suite 201, Troy, New York 12180 tel. (518) 687-6700, ext. 106.

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](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Keep Your Plan Informed of Address Changes**

In order to protect your and your family's rights, you should keep the Plan Administrator (Bob Kasper) informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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