**Important Notice Regarding Your Group Health Insurance Continuation Coverage Rights and Other Health Insurance Coverage Marketplace Alternatives**

*(Termination or Reduction in hours of Employment – 18 months) - Revised 12/2020*

To: **{Name of COBRA Qualified Beneficiary EE}** and **{Name of COBRA Qualified Beneficiary Spouse}** and all covered

dependents

**{Address of COBRA Qualified Beneficiary}**

RE: NOTICE OF RIGHT OF EACH COVERED INDIVIDUAL TO ELECT GROUP HEALTH PLAN CONTINUATION COVERAGE

Notification Date: **{Date of COBRA letter}**

Loss of Coverage Date: **{Date Coverage is canceled}**

This notice of rights to elect group health insurance continuation coverage applies individually to the following former plan participants: **{Name of COBRA Qualified Beneficiary EE}**, **{Name of COBRA Qualified Beneficiary Spouse}** and all dependent children. It is being provided to you at this time because you have recently, or you are about to, lose your group health insurance under **{Employer Name}**’s group plan. **This notice contains important information about your rights to continue coverage in the {Employer name} group health insurance plan(s), as well information on possible health insurance coverage alternatives through the Health Insurance Marketplace (**[**www.HealthCare.gov**](http://www.healthcare.gov/) **or 1-800-318-2596), Medicaid, or other employer group health plan(s). In this notice, the term “group health insurance” or “group health plan” refers to any {Employer Name} group insurance or coverage in which you were enrolled that provided you with health care, including medical, dental, vision, health flexible spending account (FSA), health reimbursement account (HRA), or any other plan providing medical care.** It is important that all covered individuals read this notice carefully before making a decision. If you choose to elect COBRA continuation coverage, you should use the election form attached to this Notice.

**ADDRESS CHANGES:** If there is a covered dependent whose legal residence is not yours, please provide us, in writing on the enclosed “COBRA Address Notification Form,” the appropriate address so a notice can be sent to them as well.

**QUESTIONS:** If you have any questions concerning information in this notice, or your rights to coverage, you should contact **{Employer contact}** at **{Employer contact phone number}**, **{Employer name}**, **{Employer Address}.** For questions regarding the availability of alternative coverages, visit www.Healthcare.gov or call 1-800-318-2596. These alternative plans may or may not cost less than health insurance continuation coverage with the plan administrator.

**Loss of health coverage and Qualifying Event:** Effective **{Date Coverage is canceled}**, **{Employer Name}** is terminating the group health insurance coverage provided to you, your spouse, and dependent child(ren), if any, because of your termination of employment or reduction in hours on **{Date of qualifying event}**. So any claims for services incurred after that date, including prescription drug charges, will be denied. Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, your termination of employment or reduction of hours is a **QUALIFYING EVENT** that will entitle you and your spouse and dependent child(ren), if any, to elect to continue your group health plan coverage until **{the date coverage will expire}**, which is 18 months from the date of your qualifying event. Coverage may continue for 29 months in the event of a disability (see below). This notice is designed to provide you with the following information:

* The right of each qualified beneficiary to continue the group health insurance plan or plans
* The duration of continuation coverage and when it can be canceled
* Exact procedures for electing to continue insurance
* How to pay your health insurance premiums
* Health insurance alternatives under the Health Insurance Marketplace, other potential coverage, and HIPAA special enrollments

**Individual Election Rights and Eligibility:**  Each individual referenced in this Notice is a “qualified beneficiary” and has independent election rights to continuation coverage. This means each individual can independently elect to continue coverage. For example, a spouse could elect continuation coverage even if the covered employee does not elect to continue coverage. Or a parent could elect to continue coverage on behalf of their dependent child who is losing coverage as a result of a qualifying event. Premium rates will be determined by the number of qualified beneficiaries electing to continue coverage. If elected, continuation coverage is available to qualified beneficiaries subject to their continued eligibility. **{Employer name}** reserves the right to verify eligibility and terminate continuation coverage back to the original continuation effective date, if it is determined you are ineligible or if coverage was obtained through a material misrepresentation of the facts.

# Election Procedure: To protect your continuation rights, please follow the election procedure outlined below:

**Step 1:** To continue coverage you must complete the attached election form and return it to **{Employer Name}** by **{Date the election form is due},** which is 60 days from the later of the date of this notice or the date coverage ends. **Note: {Date the election form is due} is the last day to elect coverage.**

**Step 2:** Make a copy of the signed form(s) for your records.

**Step 3:** Mail the election form(s) to **{Employer contact}, {Employer Name}** at the address listed on the election form. While not required, it is recommended you obtain proof from the Post Office that you mailed the election form. Your election is deemed to have been made on the date the election form is sent to **{Employer Name}**. If the election form is not postmarked by **{Date the election form is due},** then rights to continuation coverage will end, as late elections will not be accepted.

**Step 4:** Call **{Employer contact}** within 10 days to ensure the election form has been received.

Should you have any questions concerning this notice or your notification obligations, please do not hesitate to call **{Employer Name} {Employer Phone Number}** Human Resources Department.

**Important Employee, Spouse, and Dependent 60-day Notification Requirement**

Under the group health plan rules and COBRA law, the employee, spouse, or family member has the responsibility to inform **{Employer Name}** group health plan administrator of a divorce, legal separation, or a child losing dependent status under **{Employer Name}** group health plan. Notification must be made within 60 days from the later of the date of the event or the date of group health plan coverage loss under the terms of the insurance contract because of the qualifying event.

**Notification Procedure:** Enclosed please find a **"Qualifying Event Notification Form"** which must be completed and submitted to Human Resources if one of the events described above occurs. Please make a copy for your records and mail the form, with required documentation (ex: divorce decree) attached, to the address listed on it. Document the date you mailed it. **{Employer contact}** within 10 days to ensure the form has been received.

If proper notification is not completed within the required 60-day notification period, then your right to continuation coverage will be forfeited. Carefully read the dependent eligibility rules contained in the summary plan description so you are all familiar with when a dependent ceases to be a dependent under the terms of the plan. Failure to remove an individual from the plan beyond the date he/she is eligible to participate may be considered insurance fraud on the part of the employee. **{Employer Name}** has the responsibility to notify the plan administrator of the employee's death, termination, reduction in hours of employment, or Medicare entitlement within 30 days of the qualifying event or the date coverage ends.

**No Health Coverage During Election Period and Retroactive Reinstatement of Group Health Insurance Coverage**

You will not be covered under the plan during the election period. If a health claim is submitted during this time, it will not be paid. However, if a COBRA election is made as just described and applicable premiums paid as detailed in the next paragraphs, then your coverage will be reactivated back to your loss of coverage date and pending claims will be released for payment. Keep in mind, however, that it may take a period of time for the paperwork to be processed by the insurance carrier and the coverage to be reactivated.

Should you receive medical services, including the purchase of prescription drugs, prior to reinstatement of your coverage, keep any medical payment receipts and, upon reinstatement, submit the claims for payment under the plan provisions. If a medical provider calls for verification of benefits, they will be told you currently do not have benefits, but upon election and payment of applicable premium, all valid claims will be released for payment.

**Consequences of Not Electing to Continue your Group Health Insurance (COBRA):**

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, Medicare, 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.

You have the right to request special enrollment in another employers group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your health insurance ends because of the qualifying event listed in this Notice. You will also have the same special enrollment right upon exhaustion of your continuation coverage if elected. 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.

**Medicare Eligible Individuals:**

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after your employment ends; or (2) the month after group health plan coverage based on current employment ends. If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

**Payment of Continued Coverage Premiums (COBRA):**

If you elect to continue your group health insurance coverage, a qualified beneficiary is responsible for the full applicable premium payment for the coverage plus a **{percent charged for admin}**% administration charge. The applicable premium includes both the employer’s and employee’s share of the total premium. Monthly premium amounts are fixed on a benefit plan year basis, so the possibility of a rate change in your premium could occur each **{first month of plan year}**.If the applicable premium is adjusted, you will be notified as soon as possible prior to the new premium rates going into effect. COBRA premium payments can be either hand delivered or mailed. If hand delivered, it must be delivered to the Human Resources Department. If mailed, document the date the premium is sent and call within 10 days to ensure payment has been received. Mail to the following address **{Employer Address}**. If premiums are not hand delivered or not postmarked if mailed within the required premium periods as described below, then COBRA rights and protections will be forfeited. Any person or entity can pay COBRA premiums for a qualified beneficiary; however, it is the qualified beneficiary’s responsibility to ensure that the payment is made on a timely basis. If a third party agrees to pay your premium, you should call each month to ensure that timely premium payment has been made. Your state may also have a premium payment program that may assist you with the payment of your premiums should you elect COBRA. **NO LATE PREMIUMS WILL BE ACCEPTED.**

# Initial Premium Payment

(if you are sending your payment *with* the election form, proceed to “Monthly Premium” section)

A qualified beneficiary has a maximum of 45 calendar days from the date of election (postmark date if mailed) to pay the initial premiums. First of all, this initial premium payment is for the retroactive coverage period from the date of loss of coverage to the date you elect continuation coverage. For example, if you lost health insurance on January 31, 2020 and elected COBRA coverage on March 1, 2020, you would have until April 15, 2020 to pay for the retroactive month of February.

Secondly, if you take full advantage of this 45-day premium payment period, additional prospective monthly premiums are due with this initial payment. This additional premium covers any monthly coverage period that falls after the date of election but within the 45-day time period. For example, if you pay for February on April 15th, but also need coverage for the month of March, your initial premium must cover that period as well. If you fail to make the premium payment for March, then your COBRA coverage would terminate at the end of February. You will not be allowed to pay for March and not February. This 45-day period is the maximum period in which to make initial premium payments. **If you make an initial payment prior to the end of this period, then the regular monthly due dates and grace periods will apply as described in the “Monthly Premium” section.** You are responsible for making sure the amount of your first payment is enough to cover this entire period. You may contact **{Employer contact}** to confirm the correct amount of your first payment.

**Benefits Verification:** If a medical provider (hospital, physician, pharmacy, etc.) requests verification of benefits during this period, they will be told that you have elected coverage but have yet to pay the premium and that no claims, including prescription drug charges, will be paid until the premium is paid.

# Monthly Premium

Once your initial premiums are paid, monthly premiums are due on the first of each month. You will have a maximum 30-day grace period following the due date in which to make these premium payments. For example, if you paid the initial premium for February and March on April 15th as described above, and you want health coverage for April, while the due date is April 1st, with the 30-day grace period you would have until May 1st to actually pay for April. May 1st is also the due date for May and you would now be in the regular monthly cycle. If applicable payment is not made within the grace period, then coverage will be canceled back to the end of the prior month. Once COBRA coverage is canceled you will not be reinstated. Partial payments will not be accepted. It is the qualified beneficiary’s responsibility to make these monthly payments as you will not receive a monthly billing or warning notices. Premium payments should be sent to: **{Employer Contact}, {Employer Name}, {Employer Address}.**

**Benefits Verification:** Any claims occurring during a future month will be held pending payment being made. If a medical provider requests verification of benefits during this period, they will be told that you are covered but that the monthly premium has not been paid, and coverage will be subject to retroactive cancellation.

If coverage is extended to 29 months due to Social Security disability (see below), premiums (can) equal 150% of the applicable premium during the extended 11-month coverage period. The current amount of this premium, the mailing address for payment, and the due date for payment are explained in the attached election form.

**Warning About Paying Near the End of the Grace Period:** If you wait until near the end of the grace period to mail your premium payment, you run the risk of not having sufficient time to correct errors, which may or may not be within your control (such as the Post Office postmarking your payment AFTER the last date to pay or the envelope is lost). Take all precautions when paying, *such as sending the form by certified mail or using a Certificate of Mailing*, as no late premiums are accepted.

# Continuation Coverage Options

Under the provisions of COBRA, each qualified beneficiary can elect to continue coverage. The applicable premiums will vary depending on the coverage’s elected. If you are covered by a region specific HMO and are moving outside of the HMO service area, additional rights may be available to you at the time of the event. Please call Human Resources for additional information. Once an election of continuation coverage is made, coverage may change in the future if modifications are made to the coverage provided to similarly situated active employees or if an open enrollment occurs. We will notify you should an open enrollment occur during your COBRA continuation coverage period. At that time, each qualified beneficiary will have independent election right to select any of the options or plans that are available to similarly situated non-COBRA participants.

Our records indicate on the day before the qualifying event, each qualified beneficiary was covered by **{name of health plan employee is covered by},** **{name of dental plan employee is covered by}, {name of vision plan employee is covered by}, {name of HRA plan}, {name of any other health coverage subject to COBRA employee is covered by}.** **{Our records also indicate you are a participant in the Medical FSA.}**  Each qualified beneficiary can elect to continue all the coverages, or any single coverage, or any combination of coverage. The applicable premium will depend on the coverage selected.

**Length of Continued Coverage Period**

If you, or any of your covered family members, elect coverage it will last for as long as 18 months beginning on the date of your Qualifying Event. Exception: If you are participating in a Medical FSA at the time of the qualifying event, you will only be allowed to continue participation until the end of the current plan year in which the qualifying event occurs. The 18-month period may be extended for the following reasons:

1. **Disability Determination:** If the Social Security Administration determines that you, your spouse, or dependent child(ren), if any, were disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of COBRA coverage, the 18-month period may be extended for an additional 11 months to a maximum of 29 months from the date of the Qualifying event for all individuals covered under continuation coverage. If a newborn or adopted child is added to a covered employee’s COBRA coverage, then the 60-day disability window for the newborn or adopted child is measured from the date of the birth or the date of adoption. It is the qualified beneficiary’s responsibility to obtain the disability determination from the Social Security Administration and provide a copy of the determination to **{Employer Name}** within 60 days of a disability determination and before the end of the original 18-month period. If you are a covered dependent already has a SSA Disability determination before the date of the qualifying Event, notice must be made to Human Resources within 60 days of the date of the qualifying event. This notification must be done according to the notification procedure shown below. This notice can be made by any of the qualified beneficiaries. If these time frames are not complied with, then the additional 11-month extension of COBRA coverage will not be provided.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, the other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable premium rate may be raised to 150% of the rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the **{enter either 100% or 102% for cost of coverage}** level. It is also the qualified beneficiary’s responsibility to notify **{Employer Name}** within 30 days of when a final determination has been made that they are no longer disabled.

* **Special Medicare Entitlement Rule For Dependents Only:** If you become entitled to Medicare benefits prior to the date of your 18-month qualifying event, then your dependent qualified beneficiaries are eligible for 18 months of continuation coverage, or 36 months measured from the date of the Medicare entitlement, whichever is greater. For example, if you become entitled to Medicare eight (7) months prior to the date on which your employment terminates, your dependent qualified beneficiaries will be offered 29 months of continuation coverage (36 - 7 = 29). You, however, will only be offered 18 months. If this is the case, please contact Human Resources immediately so a correct determination can be made regarding the length of continuation coverage.

1. **Secondary Event - Death of employee, divorce, legal separation, and change in dependent status:** If these events occur during the original 18 (or the above mentioned 29) month period of coverage, the period of coverage for your spouse and dependent child(ren), if any, may be extended for an additional 18 months, resulting in a total of 36 months of coverage from the date of the original qualifying event. Note that to receive this extension, you and/or your spouse and dependent child(ren) must notify the plan administrator in writing within 60 days of the occurrence of these events and within the original 18 month continuation timeline. This notification must be done according to the notification procedure shown below. In no circumstance, however, will continuation coverage last beyond three years from the date of the original COBRA qualifying event. A reduction in hours followed by a termination of employment is not considered a second event for COBRA purposes. . 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.
2. **Secondary Event - Medicare entitlement of employee:** If you become entitled to Medicare after your qualifying event, but within 18 months or your qualifying event, your spouse and dependent child(ren), if any, may receive an additional 18 months of coverage. Medicare entitlement can only be a second event if it would have caused you or your dependents to lose coverage under the plan if the first qualifying event had not occurred. This is a rare possibility given that the Medicare Secondary Payer rules prevent most employers for denying coverage to employees who become entitled to Medicare.

🖊N**otification Procedure:** Enclosed please find a “**Qualifying Event Notification Form**” which must be completed and submitted to Human Resources if one of the secondary events described above occurs. Please make a copy for your records and mail the form, with required documentation attached (ex: divorce decree), to the address listed on it. Document the date you mailed it. Call **{Employer Contact**} within 10 days to ensure the form has been received.

For more information about extending the length of COBRA continuation coverage visit <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf>.

**New Dependents**

If during the 18 months or 29 months, if applicable, of COBRA coverage, a qualified beneficiary acquires new dependents (such as through marriage), new dependents may be added to the coverage according to the rules of the plan. However, new dependents do not gain the status of a qualified beneficiary and will lose coverage if the qualified beneficiary who added them to the plan loses coverage.

An exception to this is if a child is born to or placed for adoption with the covered employee qualified beneficiary. If the newborn or adopted child is added to the covered employee’s COBRA continuation coverage, then unlike a new spouse, the newborn or adopted child will gain the rights of all other “qualified beneficiaries”. The addition of a newborn or adopted child does not extend the 18 or 29-month coverage period. Plan procedures for adding new dependents can be found in the Summary Plan Description. Premium rates will be adjusted at that time to the applicable rate.

In addition, should an open enrollment period occur during your continuation period, we will notify you of that right as well. Each qualified beneficiary will have independent election rights to select any of the options or plans that are available for similarly situated non-COBRA participants.

**Early Termination of Continuation Coverage**

We may cancel your continuation coverage prior to the expirations of the applicable 18, 29, or 36 month time period if any of the following things occur:

1. If the required premium payment is not paid when due.
2. If a qualified beneficiary becomes, after the date of election, entitled to Medicare.
3. If **{Employer Name}** ceases to provide any group health insurance plan to any of its employees.
4. If a qualified beneficiary notifies **{Employer Name}** they wish to cancel continuation coverage.
5. If the qualified beneficiary becomes, after the date of election, covered by another group health insurance plan
6. If coverage is extended to 29 months due to disability and a determination is made that a qualified beneficiary is no longer disabled. The qualified beneficiary must notify **{Employer Name}** of any final determination that he/she is no longer disabled within 30 days of such determination.
7. For cause, on the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA participants.

## Conversion

At the end of the 18 (29 or 36) months of continuation coverage, a qualified beneficiary may be allowed to enroll in an individual conversion health plan if one is available from the insurance carrier, or as required by applicable state law. If so, **{Employer Name}** will notify you of the availability in writing approximately 30 days prior to the continuation coverage expiration date. In addition, upon exhaustion of your health insurance continuation coverage, you will be able to purchase health insurance coverage through the Health Insurance Marketplace with no pre-existing condition limitations or exclusions. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

**Alternative Health Insurance Plan Options Through the Health Insurance Marketplace, Medicaid, Or Other Employer Sponsored Health Plans.**

Besides electing and paying for continuation coverage with the plan administrator, there are other health insurance options available through the **Health Insurance Marketplace, Medicaid or other group health plan coverage (such as a spouse’s plan) through what is called a “special enrollment period**. The Marketplace offers "one-stop shopping" where you can see what your premium, deductibles, and out-of-pocket costs will be for a variety of individual health plans before you make a decision to enroll. Secondly, you could be eligible for a 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. Being eligible for continuation coverage (COBRA) does not limit your eligibility for coverage or for a tax credit through the Marketplace. Depending upon the health plan purchased through the **Marketplace**, the insurance may cost less or more that continuation coverage with the plan administrator.

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.

**Special Enrollment Opportunity For Another Employer Group Health Plan:** Additionally, you may qualify for a special enrollment opportunity for another employer's group health plan for which you are eligible (such as a spouse’s plan), if you request enrollment within 30 days of your loss of coverage date. If another employer group health plan is available, please contact them directly for their special enrollment procedures. If a qualified beneficiary chooses to elect continuation coverage instead of enrolling in another group health plan for which you’re eligible, you will have another opportunity to enroll in the other group health plan within 30 days of exhaustion of your continuation coverage.

**Enrolling for Individual Health Insurance Through the Marketplace**

You have a maximum period of 60 days from the date your lost your group health insurance to enroll in coverage through the Marketplace online at www.HealthCare.gov or by calling 1-800-318-2596. Just like health insurance continuation coverage, if you fail to enroll in coverage during this 60 day window, then your rights to enroll will cease at that time. You will then in general have to wait until the next Marketplace open enrollment period.

**Special Enrollment Outside of Open Enrollment:** If you elect continuation coverage or fail to enroll in a health plan during the initial 60 day eligibility period, you may have the opportunity to enroll prior to the next Marketplace open enrollment period if you experience a "special enrollment period" or what some call a "life event" such as getting married, having a baby or adopting a child. In addition, if you elect and then exhaust your health insurance continuation coverage through the plan administrator, you would then also be eligible to enroll in a plan through the Marketplace. If your continuation coverage is canceled as a result of a failure to pay the required premiums, that is not a special enrollment and you could end up without insurance.

**Some Factors To Consider When Choosing Health Insurance Coverage Options**

When considering your health insurance options, such as continuation coverage with the plan administrator, purchasing a plan through the Marketplace, or enrolling in another employer's group health plan, you should compare and choose the option that is best for you. Here are a few things to consider when making your decision because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

**Premiums:** If you elect to continue your health insurance with the plan administrator, as described earlier in the notice, the premium will equal **{Enter 100% or 102%}** of the full premium (or up to 150% for a disability extension). Other plan options such as through the Marketplace or with a spouse's plan may be more or less expensive.

**Out-Of-Pocket Expenses:** Different plans require different deductibles, copays and out-of-pocket expenses as you use your benefits. Comparing these expenses is extremely important in making your health insurance decision. For example, one option may have lower monthly premium but have a high deductible and copayment amounts. Or, another plan may have a low monthly premium but you have already met your annual deductible and coinsurance maximums under your coverage with the plan administrator.

**Prescription Drug Benefits:** If you are 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. Confirm your current medications are covered by the other plan.

**Doctor's and Other Provider Networks:** If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. Verify your current health care providers participate in a new plan's network.

**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. Does the plan you are thinking of purchasing have a service or coverage area limitation?

**Severance Payments:** If you lost your job and are being offered a severance package from your former employer in which they have agreed to pay some or all of your continuation coverage payments for a period of time, be advised that when the payments end under the severance agreement that is NOT a special enrollment opportunity to purchase insurance in the Marketplace. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

The above list is not all inclusive but a few of the important considerations when making a decision to enroll and purchase a health insurance plan. Your decision should be made upon careful deliberation after reviewing all of the information available from the plan administrator, insurance professionals, the Department of Labor at 1-866-444-3272, or at www.HealthCare.gov or by calling them at 1-800-318-2596.

Notification of Address Change

To receive accurate and timely information regarding your continuation rights, please immediately notify {Employer Name}, in writing, of any change in address by completing the attached “COBRA Address Notification Form” and mailing it to the address below. You should keep a copy of the form for your records and call within 10 days to ensure that it has been received.

Questions

Remember, this notice is simply a summary of your potential options under COBRA and not a description of your actual group health benefits under the plan. For questions regarding your group health benefits, you should refer to your summary plan description or obtain a copy of the plan document from the plan administrator. If any covered individual does not understand any part of this summary notice or has questions regarding the information or your obligation, please contact:

**{Employer Contact Name}**

**{Employer Name}**

**{Employer Contact Phone Number}**

**{Employer 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.

**\*Please be sure to read and complete the enclosed election form\***

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***

Sincerely,

**{Employer Name}**

### **COBRA ADDRESS NOTIFCATION FORM**

If you have a dependent that is covered by the group health plan whose legal residence is not yours (dependent child covered by a court order, living with an ex-spouse, etc.), you are required to provide us with the proper address so an initial COBRA notice can be sent to them as well. This does not include a dependent child (whose legal residence is still yours), but is away at school. Should you have any questions, please call Human Resources immediately. Thank you for your assistance.

**This information must be provided to the Benefits Department upon commencement**

**of coverage under the group health plan.**

**Covered Dependent Address Information**:

|  |
| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

**Covered Dependent Address Information**:

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| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

**Covered Dependent Address Information**:

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| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

**Covered Dependent Address Information**:

|  |
| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

#### Qualifying Event Notification Form

*(To notify* ***{Employer Name}*** *of a qualifying event or Social Security Disability)*

**Attention Employee and/or Spouse and Dependent:**

This form is to be completed by a covered employee, spouse or dependent to report certain events to **{Employer Name}** as required under provisions of the federal Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA). Failure to complete and submit this form in a timely manner will result in a loss of health insurance continuation rights that are available under COBRA. Should you have any questions as to this form’s purpose or how to complete the form, please contact **{Employer Name}**

##### Instructions

Please complete the information requested and submit this form to **{Employer Name}.** **The notice must be received by the Plan Administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date that the qualified beneficiary would lose coverage on account of the qualifying event.**

|  |
| --- |
| Name of Company: **{Employer Name}** |
| Name of Covered Employee: |
| Name of Reportee: |
| Relationship to Employee: |

**Please Check One:**

** Death- as second event Date of event:\_\_\_\_\_\_\_\_\_\_** (attached copy of death certificate)

** Divorce: Is it a second event? Yes /No Date of event:\_\_\_\_\_\_\_\_\_\_** (attached signed copy of

divorce decree)

** Legal Separation: Is it a second event? Yes/No Date of event:\_\_\_\_\_\_\_\_\_\_\_\_** (attached signed

copy legal separation)

** Child Ceasing to be a dependent: Is it a second event? Yes/No Date of event:\_\_\_\_\_\_\_\_\_\_\_**

** Social Security Disability Date of Social Security disability:\_\_\_\_\_\_\_\_\_\_**

(enclose Social Security Disability determination which needs to be submitted within 60 days from

the date the determination is made and within the original 18 months or continuation coverage)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

signature of reportee Date

**Current Mailing Address of Qualified Beneficiary:**

**Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mail or hand deliver completed form to {Employer Name}, {Employer address}. Thank you.**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***