Notice of Employee's Rights to Continue Group Health Insurance Coverage under COBRA

On April 7, 1986, a federal law was enacted [Public Law 99-272, Title X] requiring that most employer sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health 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 law. Both you and your spouse should take the time to read this notice carefully.

As an *employee* covered by your employer's group health insurance plan, you have the right to choose continuation coverage for yourself if you lose group health coverage for either of the following reasons:

1. Termination of employment (for reasons other than gross misconduct on your part);
2. A reduction in hours of employment.

If you are a *spouse or any applicable dependent* of an employee covered by the employer's group health insurance plan, you have the right to choose continuation coverage for yourself if you lose group health insurance for any of the following reasons:

1. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
2. A reduction in hours worked by the covered employee;
3. Covered employee becomes entitled to Medicare and is terminating their employer-sponsored coverage;
4. Divorce or legal separation of the covered employee;
5. Death of the covered employee.

In the case of a *dependent child only (independent of any spouse)* of an employee covered by the employer's health insurance plan, he or she has the right to continuation coverage if dependent child status is lost under the plan rules.

Your responsibilities. Under the law, you and your family members have the responsibility to inform your employer of a divorce, legal separation, or child losing dependent status under the employer's health insurance plan. Your employer has the responsibility of notifying the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, your spouse, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

Once your employer is notified that one of these events has occurred, your employer will notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date your election notice is sent to you, whichever is later, to inform the Insurance Administrator that you wish to continue your coverage under COBRA. If you do not choose to continue your group health insurance coverage under COBRA, your coverage will end.

If you choose to continue your group health insurance coverage under COBRA, your employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated non-COBRA beneficiaries or family members. You must pay your employer up to 102% of the group rate for continuation coverage. The required premium includes the 2% of the group rate to cover administration costs.

Definition of Qualified Beneficiary. Individuals entitled COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse, and dependent children of a covered employee, and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as termination of employment, or a divorce from, or death of, the covered employee). HIPPA changes this requirement so that a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary. A COBRA enrollee who gets married is eligible to enroll their spouse under COBRA continuation coverage as well.

Termination of Continuation Coverage. However, the law also provides that your continuation coverage may be

terminated for any of the following five reasons:

1. Your 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 by another group plan, unless the plan contains any exclusions or limitations with respect to any preexisting condition you or your covered dependents may have; see *Duration of COBRA Continuation*, below;
4. You become entitled to Medicare.

Duration of COBRA Continuation. As a qualified beneficiary, you are entitled up to a 36 month benefit for health coverage or up to an 18 month benefit for dental coverage. Under the COBRA rules there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One of these situations is where the qualified beneficiary obtains coverage under another group health plan; see number 3 above. Under current law, if the other group health plan limits or excludes coverage for any preexisting condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPPA limits the circumstances in which plans can apply exclusions for the preexisting conditions. HIPPA makes a coordinating change to the New York COBRA rules so that if a group health plan limits or excludes benefits for preexisting conditions, but because of the new HIPPA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing COBRA continuation coverage can stop making the COBRA continuation coverage available. The HIPPA rules limiting the applicability of exclusions for preexisting conditions become effective in plan years beginning on or after July 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements).

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law says that at the end of the 36-month COBRA continuation coverage period, you must be allowed to enroll in an individual conversion plan provided under your employer.

If you have any questions regarding the information listed above, please contact your employer or the Plan Administrator, Conference Associates, Inc. (or Elite Programs, Inc. *as administrators for NYSBG association health plans*):

CAI/ELITE PROGRAMS CORPORATE HEADQUARTERS
180 East Main Street
Suite 205
Patchogue, New York, 11772
1-800-427-5358
Fax: (631) 654-0840

Also, if you have changed marital status, or you or your spouse have changed address; please notify your employer or Plan Administrator at the address above.

Acknowledgment/Election of New York State Continuation/COBRA Right

Employers's Name _____

Employers Address _____ Employer's Firm No. _____

	NAME	DATE OF BIRTH	SSN
☐	Employee _____	_____	_____
☐	Spouse _____	_____	_____

Name[s] of Dependent Child[ren]

_____	_____	_____
_____	_____	_____
_____	_____	_____

QUALIFYING EVENT:

- ☐ *Date Employment Ended* _____
- ☐ *Date Employee Elected Medicare* _____
- ☐ *Date Employee Died* _____
- ☐ *Date of Divorce* _____
- ☐ *Date Child Ceases to be Eligible* _____

You and any of your family members who are covered on the *day before the qualifying event* are eligible to continue any of the following plans. If you choose not to continue one or more of these plans and your election period expires, you will not be allowed to re-enter the plan.

I elect to continue the following coverage:

ELECT	WAIVE	TYPE OF COVERAGE	INSURANCE CARRIER	MONTHLY COST
☐	☐	Hospital/Medical	EmblemHealth, Inc	$_____
☐	☐	Hospital/Medical	Group Health, Inc.	$_____
☐	☐	HMO	HIP	$_____
☐	☐	Hospital/Medical	_____	$_____
☐	☐	Dental	_____	$_____

Any person covered on the day before the qualifying event can elect coverage, including a spouse or dependent child, even if the former employee does not elect coverage.

Your premium payments should be remitted directly to your employer, and is due by the first of each month. Payments NOT received on or before your 30-day grace period will result in cancellation of your New York State Continuation/COBRA coverage.

SIGNATURES:

Employee _____ Tel. No. _____ Date _____

Spouse _____ Tel. No. _____ Date _____

Dependent Child[ren] Signature(s)

_____ Tel. No. _____ Date_____

_____ Tel. No. _____ Date_____

_____ Tel. No. _____ Date_____

Employer Signature _____ Date_____

Please Note: Spouse and dependent child[ren] signatures are required if any family benefits are being waived.