**Prepare on Local Employer Letterhead**

**Extended Coverage/COBRA Election Notice**

**Direct Bill**

**To Benefits Administrators: COBRA/Extended Coverage is available only for groups with 20 or more employees. In using this notice format, instructions are highlighted (such as this paragraph) and should not be included when preparing a notice to be sent to qualified beneficiaries. Information in red type identifies individual notice-specific information that you need to provide when preparing a notice for qualified beneficiaries. After entering the information, please change the red type to black.**

**(Enter Date of Notice)**

**(Enter Name and Address)** of the employee, former employee and/or other qualified beneficiaries—those covered on the day before the qualifying event who lost coverage due to that event. If there is more than one qualified beneficiary and they all live at the same address, only one notice, properly addressed, is sufficient. You may use the status instead of the name of the covered family members—see examples.

Examples: --Just the employee--Mary Smith

 --Employee and spouse--Mary Smith and spouse or Mary Smith and John Smith

 --Employee and child—Mary Smith and covered child or Mary Smith and Sally Smith

 --Family coverage--Mary Smith, spouse and children covered under the plan prior to the qualifying event

or Mary Smith and (all names);

 --Just Mary’s daughter who is losing eligibility as a covered child—Jane Smith

If you know that one or more qualified beneficiaries live at a separate address, mail the Notice to the correct address for each qualified beneficiary and document the mailing.

**This notice contains important information about your right to continue your health care coverage in The Local Choice Health Benefits Program (the Plan) sponsored by (Insert Name of Local Employer), as well as other health coverage alternatives that may become available to you through the Health Insurance Marketplace.** Please read the information contained in this notice very carefully. In this notice, the words “you” or “your” refer to each of the individuals included at the above address by name or status.

To elect Extended Coverage/COBRA, follow the instructions in this Notice to complete the Election Form that follows and submit it to the designated individual by the end of the 60-day election period, as noted.

If you do not elect Extended Coverage/COBRA, your coverage under the Plan will end on **(Enter Date)** due to: Check appropriate box below.

 □ End of employment

□ Reduction in hours of employment resulting in loss of coverage/loss of employer premium contribution\*

 □ Death of employee or former employee

□ Divorce from employee or former employee

 □ Loss of covered child status

□ Entitlement to Medicare (group-specific retirees only)

The event designated above that caused you to lose coverage under the Plan is called your “qualifying event” in this notice. As explained above, under the Plan, your coverage will be lost at the end of the month in which the qualifying event takes place. Loss of coverage includes a change in the terms and conditions of coverage.\*

Each family member who is covered on the day before the qualifying event and loses coverage due to the qualifying event is called a “qualified beneficiary” and has an independent right to elect Extended Coverage/COBRA. Timely election of Extended Coverage/COBRA will result in continuing group health care coverage under the Plan for up to **(Enter 18 or 36, as appropriate)** months. Check the box or boxes that apply to all qualified beneficiaries and enter the name/s after the box checked.

 □ Employee or former employee: **(Enter Name)**

 □ Spouse or former spouse: **(Enter Name)**

□ Child(ren) covered under the Plan on the day before the qualifying event that caused the loss of coverage: **(Enter Name/s)**

□ Child who is losing coverage under the Plan because he or she lost eligibility as a covered child: **(Enter Name)**

If elected, Extended Coverage/COBRA will begin on (Enter Date) and can last until **(Enter Date)**.

The monthly premium cost for Extended Coverage/COBRA for the plan in which all qualified beneficiaries were enrolled prior to the qualifying event is provided below. It also includes all membership levels that could apply based on qualified beneficiaries’ independent rights to elect continuation coverage.

**TLC Extended Coverage/COBRA COBRA Premium Rates**

**(Insert Plan Year Begin Date – Plan Year End Date)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Plan Name****For example, Key Advantage Expanded or Key Advantage 500.** | **Single** | **Two Persons** | **Family** |
| **(Enter Plan Name)** | $ **(Enter Rate)** | $ **(Enter Rate)** | $ **(Enter Rate)** |

If this is a family group, provide the plan name and premium for each membership level that could apply. For example, if a family membership is being lost, provide the family, dual and single premium amount since any or all qualified beneficiaries can elect Extended Coverage/COBRA.

**Extended Coverage/COBRA Premium Payments**

You do not have to send any payment with your Election Form. However, important additional information about payment for Extended Coverage/COBRA is included in the pages following your Election Form.

**Health Care Reform**

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

**If You Have Questions:**

Questions about your rights to Extended Coverage/COBRA and this Notice should be directed to:

|  |
| --- |
| **(Enter Name of Local Employer)** |
| Benefits Administrator’s Name | **(Enter Information about the BA Issuing this Notice)** |
| Benefits Administrator’s Address |  |
| Benefit Administrator’s Telephone Number |  |

###### \*Some leaves of absence without pay may allow for continuation of the employer contribution toward the cost of coverage. This is an Extended Coverage/COBRA qualifying event since it results in a change in the terms and conditions of coverage, which qualifies as a loss of coverage. The period after the end of the month in which the reduction-of-hours event takes place will run concurrently with the Extended Coverage/COBRA eligibility period. If you elect to continue coverage with the employer contribution at the start of the Extended Coverage/COBRA period, and that contribution ends prior to the full 18-month eligibility period for the reduction-of-hours event, you may elect to use any remaining months by submitting the Election Form within 60 days of the loss of the employer contribution toward premium cost, at which time, the full Extended Coverage/COBRA premium will be billed for any remaining Extended Coverage/COBRA months.

###### Extended Coverage/COBRA Continuation Coverage Election Form

**Direct Bill**

**Instructions: To elect Extended Coverage/COBRA, complete this Election Form and return it to the recipient listed below. Under federal law, you must have 60 days after the date of this notice (or 60 days after coverage is lost if that is later) to decide whether you want to elect Extended Coverage/COBRA under the Plan.**

**Send this completed Election Form to:**

DHRM – TLC

101 N. 14th St.

12th Floor

Richmond, VA 23219.

**This Election Form must be completed and returned by mail or in person. No other forms of delivery (e.g., oral communication, telephone statements or electronic communications) will be accepted. If mailed, it must be post-marked no later than (enter 60-day deadline as described above). If delivered in person, it must be delivered to the recipient listed above no later than (enter 60-day deadline as described above).**

**If you do not submit a completed Election Form by the deadline shown above, you will lose your right to elect Extended Coverage/COBRA. If you reject Extended Coverage/COBRA before the deadline, you may change your mind as long as you furnish a completed Election Form before the above deadline.**

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

I (We) elect Extended Coverage/COBRA in The Local Choice Health Benefits Program (the Plan) sponsored by **(Insert name of local employer)** as indicated below. (List all qualified beneficiaries enrolling in Extended Coverage/COBRA.)

Member’s Current Heath Plan Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Name | Date of Birth | Relationship to the Employee /Former Employee |
|  |  |  |
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Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship to individual(s) listed above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Address to which Premium Billing Should Be Sent Telephone Number

□ Please check here if the qualified beneficiary, who was the covered employee, if applicable, was entitled to Medicare Part A, Part B, or both within the 18 months prior to this loss of coverage. If so, please indicate the entitlement date shown on the Medicare ID card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS IS THE BLANK BACK OF THE ELECTION FORM**

**Important Information**

**About Your Extended Coverage/COBRA Continuation Rights**

### What is Extended Coverage/COBRA?

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 (see page one) that would result in a loss of coverage under an employer’s plan. Extended Coverage is a term used to describe the continuation coverage provisions of the Public Health Service Act. These provisions for state and local government employees are comparable to COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage for private employers. Depending on the type of qualifying event, qualified beneficiaries (see page one) can include the employee (or former employee) covered under the group health plan, the covered spouse and/or the covered children.

Extended Coverage/COBRA 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 Extended Coverage/COBRA will have the same rights under the Plan as non-Extended Coverage/COBRA participants, including open enrollment and special enrollment rights.

Qualified beneficiaries who are entitled to elect Extended Coverage/COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which Extended Coverage/COBRA is elected. However, a qualified beneficiary’s Extended Coverage/COBRA will terminate if, after electing Extended Coverage/COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary.

### How can you elect Extended Coverage/COBRA?

To elect Extended Coverage/COBRA, 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 Extended Coverage/COBRA. For example, the employee’s covered spouse may elect Extended Coverage/COBRA even if the covered employee does not. Extended Coverage/COBRA may be elected for only one, several, or for all covered children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any minor children. The employee or the employee's spouse can elect Extended Coverage/COBRA on behalf of all of the qualified beneficiaries.

In considering whether to elect Extended Coverage/COBRA, 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 under the Plan ends because of the qualifying event described in this notice. You will also have the same special enrollment right at the end of Extended Coverage/COBRA if you get Extended Coverage/COBRA for the maximum time available to you.

**How long will Extended Coverage/COBRA 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 for up to a total of 18 months. In the case of losses of coverage due to an employee’s death or divorce, or a covered child losing eligibility 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, Extended Coverage/COBRA for qualified beneficiaries other than the employee may last until 36 months after the end of the month in which Medicare entitlement occurred. This notice shows the maximum period of Extended Coverage/COBRA available to qualified beneficiaries (see page one).

Extended Coverage/COBRA 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 Extended Coverage/COBRA, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans’ imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
* a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing Extended Coverage/COBRA, 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 not receiving Extended Coverage/COBRA (such as fraud).

If the maximum period shown on page one of this notice is less than 36 months, add the following section:

# How can you extend the length of Extended Coverage/COBRA?

If you elect Extended Coverage/COBRA for an event that provides a maximum of 18 months of coverage, an extension of that period may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of Heath Benefits COBRA Administratorof a disability or a second qualifying event in order to extend the period of Extended Coverage/COBRA. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of Extended Coverage/COBRA. Refer to the “Notification Procedures” found later in this document for specific instructions for requesting an extension of the Extended Coverage/COBRA 18-month period

## Disability

An 11-month extension of coverage may be available if any qualified beneficiary 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 Extended Coverage/COBRA and must last at least until the end of the 18-month period of Extended Coverage/COBRA. The disability extension is available only if the Office of Health Benefits COBRA Administratoris notified of the Social Security Administration’s determination of disability within 60 days of the latest of:

* the date of the Social Security Administration’s disability determination;
* the date of the covered employee’s termination of employment or reduction of hours;
* the date on which the qualified beneficiary lost (or would lose) coverage under the terms of the Plan as a result of the covered employee’s termination or reduction of hours;
* the date on which the qualified beneficiary is informed of the obligation to provide the disability notification (e.g., this notice).

Notice must also be provided within 18 months after the covered employee’s termination of employment or reduction of hours in order to be entitled to the disability extension. Each qualified beneficiary who has elected Extended Coverage/COBRA will be entitled to the 11-month disability extension if one of them qualifies. Refer to the “Notification Procedures” found later in this document for specific instructions for requesting an extension of the Extended Coverage/COBRA 18-month period.

If the qualified beneficiary is determined by SSA to no longer be disabled during the 11-month disability extension, the Plan should be notified within 30 days after SSA’s determination. Failure to report the end of the disability status within the 30-day time limit will not preclude termination back to the date that coverage would have been terminated had it been reported on time (the first of the month that is more than 30 days after the re-determination). Premium paid during any period for which coverage should have been terminated will be refunded, and any claims paid will be reversed.

## Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect Extended Coverage/COBRA if a second qualifying event occurs during the first 18 months of Extended Coverage/COBRA. The maximum amount of Extended Coverage/COBRA available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce from the covered employee, or a covered child’s ceasing to be eligible for coverage 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 Extended Coverage/COBRA. Refer to the “Notification Procedures” found later in this document for specific instructions for requesting an extension of the Extended Coverage/COBRA 18-month period.

End of added Section for 36 month events. The remainder of the document should be in all notices.

### How much does Extended Coverage/COBRA 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 who is not receiving Extended Coverage/COBRA. The required premium payment for each Extended Coverage/COBRA membership level available to you upon initial election was included earlier in this document.

### When and how must payment for Extended Coverage/COBRA coverage be made?

*First payment for Extended Coverage/COBRA*

If you elect Extended Coverage/COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for Extended Coverage/COBRA not later than 45 days after the date of your election. (Under The Local Choice Health Benefits Program, this is the date that your Election Form is set up in the billing system.) If you do not make your first payment for Extended Coverage/COBRA, in full, within 45 days after the date your billing begins, 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 billing administrator listed below for your plan to confirm the correct amount of your first payment and the address to which your payment should be sent. Claims will not be paid until your premium payment is received.

|  |  |  |
| --- | --- | --- |
| **Plan** | **Billing Administrator** | **Telephone Number**  |
| Any Key Advantage Plan | Anthem Blue Cross and Blue Shield | 800-552-2682 |
| The TLC HDHP Plan | Anthem Blue Cross and Blue Shield | 800-552-2682 |
| Kaiser Permanente HMO | Kaiser Permanente | 800-777-7902 |

*Periodic Payments for Extended Coverage/COBRA*

After you make your first payment for Extended Coverage/COBRA, you will be required to make periodic payments for each subsequent coverage month. The current amount due for each coverage month is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for Extended Coverage/COBRA is due on the first day of the coverage month. If you make a periodic payment on or before the first day of the coverage month to which it applies, your coverage under the Plan will continue for that coverage period without any break.

*Grace periods for periodic payments*

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days after the first day of the coverage month. Your continuation coverage will be provided for each coverage month as long as payment for that coverage month is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage month to which it applies, but before the end of the grace period for the coverage month, your coverage under the Plan will be suspended as of the first day of the coverage month and then retroactively reinstated (going back to the first day of the coverage month) when the periodic payment is received. This means that any claim you submit for benefits while your coverage was suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment by the end of the grace period for that coverage month, you will lose all rights to Extended Coverage/COBRA under the Plan. Payments are considered to be made on the date they are mailed. You will not be considered to have made any payment if your check is returned due to insufficient funds.

Your first payment and all periodic payments for Extended Coverage/COBRA should be sent to the billing administrator listed above for your plan. It is your responsibility to make these payments. Although these billing administrators generally provide either a monthly invoice (Anthem and Kaiser) as a courtesy, you are responsible for payment regardless of receipt of any monthly or annual reminder once you have received your first invoice and information as to where to send your payment. Any change in your basic premium will be provided during the annual open enrollment period for your group each year for coverage beginning the following July or October, as applicable, if you continue to be eligible.

**Other Qualified Beneficiaries**

A child born to or placed for adoption with the covered employee during Extended Coverage/COBRA period is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected Extended Coverage/COBRA for him or herself. The child’s Extended Coverage/COBRA period begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as Extended Coverage/COBRA lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Local Employer during the covered employee’s period of employment is entitled to the same rights to elect continuation coverage as any eligible child.

### 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 Member Handbook or by contacting your Group Benefits Administrator:

**[Insert Group Benefits Administrator]**

**[Insert Local Employer Address]**

If you have any questions concerning the information in this Notice or your rights to coverage, contact the Benefits Administrator who prepared this Notice. If you want a copy of your Member Handbook, you should contact your plan’s Member Services number listed on your plan identification card.

For more information about Extended Coverage under the Public Health Service Act for state and local government employees, consult the Department of Health and Human Services, Centers for Medicare and Medicaid Services.  You can write them at this address:

Center for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S3-16-26
Baltimore, MD 21244-1850
Tel 410.786.3000

For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

**Keep Your Plan Informed of Address Changes**

In order to protect your and your family’s rights, you should keep the Office of Health Benefits COBRA Administrator informed of any changes in your address and the addresses of covered family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

**Notification Procedures**

**Following are specific instructions for providing notification to extend an 18-month Extended Coverage/COBRA period due to disability or a second qualifying event. Failure to comply with the following procedures will result in the loss of additional Extended Coverage/COBRA rights.**

**Notices must be written and submitted with all information listed below, and within the required time limit, to:**

DHRM – TLC

101 N. 14th St.

12th Floor

Richmond, VA 23219.

**Your notice must be mailed no later than the last day of the applicable notice period as described previously.**

**The following information must be provided:**

* **The name/s of the affected qualified beneficiary or qualified beneficiaries;**
* **The type of event about which you are providing notification (e.g., Social Security Disability, second qualifying event);**
* **The date of the event;**
* **Documentation to support the event (e.g., SSA disability determination, death certificate, divorce decree);**
* **The written signature, address and telephone number of the notifying party (qualified beneficiary or representative).**

**Notification may be provided by a qualified beneficiary or by a representative acting on behalf of a qualified beneficiary. The notice will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in this notice.**

Enclosures: HIPAA Certificate of Creditable Coverage

 The Local Choice Enrollment Form