

## **Notice of Employee's Rights to Continue Group Health Insurance Coverage New York State Continuation/COBRA General Notice**

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 because of a reduction in hours or termination of employment (for reasons other than gross misconduct on your part).

If you are a *spouse* 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. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a *dependent child* of an employee covered by the employer's health insurance plan, he or she has the right to continuation coverage if the group health coverage is lost for any of the following reasons:

1. The death of a parent;
2. A termination of parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
3. Parent's divorce or legal separation;
4. A parent becomes entitled to Medicare; or
5. The dependent child ceases to be an eligible dependent under employer's group health plan.

*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 within 60 days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. 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 New York State Continuation/COBRA.

If you do not choose to continue your group health insurance coverage under New York State Continuation/COBRA, your coverage will end.

If you choose to continue your group health insurance coverage under New York State Continuation/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 nonCOBRA 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. If you are disabled and extend coverage from 18 to 29 months, you must pay a different premium for the 19<sup>th</sup> through 29<sup>th</sup> month. You must pay your employers 150% of the group rate for continuation coverage. This premium may be collected on a monthly basis.

The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health insurance coverage because of a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period.

*Disability Extension.* Under current law, if an individual is entitled to New York State Continuation/COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan is generally required to make New York State Continuation/COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to the New York State Continuation/COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide New York State Continuation/COBRA continuation for 29 months, rather than 18 months. Under current law, the individual must be disabled at the time of termination of employment or reduction in hours of employment. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) makes changes to current law to provide that, beginning January 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of New York State Continuation/COBRA continuation coverage. HIPPA also makes it clear that, if the individual entitled to the disability extension has non-disabled family members who are entitled to New York State Continuation/COBRA continuation coverage, those non-disabled family members are also entitled to the 29-month disability extension.

The affected individual must notify his or her employer within 30 days of any final determination that the individual is no longer disabled. In no event will continuation coverage last beyond 3 years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

*Definition of Qualified Beneficiary.* Individuals entitled to New York State Continuation/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 New York State Continuation/COBRA continuation coverage, is also a qualified beneficiary.

*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 New York State Continuation/COBRA Continuation*, below;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

*Duration of New York State Continuation/COBRA Continuation.* Under the New York State Continuation/COBRA rules there are situations in which a group health plan may stop making New York State Continuation/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 New York State Continuation/COBRA continuation coverage cannot stop making the New York State Continuation/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 State Continuation/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 New York State Continuation/COBRA continuation coverage, then the plan providing New York State Continuation/COBRA continuation coverage can stop making the New York State Continuation/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 18-month or 36-month New York State Continuation/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: New York State Business Group/Conference Associates, Inc., 180 East Main Street, Patchogue, New York, 11772 Tel. No. 1-800-456-9724/Fax No. (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.

**FORM A**  
**Continuation Coverage Election Form**

**Instructions:** To elect continuation coverage, complete this Election Form and return it to us. Under New York State law, you have 60 after the date of this notice or after the date of termination, whichever is longer, to decide whether you want to elect continuation coverage.

Send completed Election Form to: *[Enter Name and Address]*

This Election Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than 60 after the date of this notice or after the date of termination, whichever is longer.

If you do not submit a completed Election Form by the due date, you will lose your right to elect continuation coverage.

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

I (We) elect continuation coverage in the *[enter name of plan]* (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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a. \_\_\_\_\_  
    *[Add if appropriate: Coverage option(s): \_\_\_\_\_]*

b. \_\_\_\_\_  
    *[Add if appropriate: Coverage option(s): \_\_\_\_\_]*

c. \_\_\_\_\_  
    *[Add if appropriate: Coverage option(s): \_\_\_\_\_]*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

FORM B

To apply for ARRA Premium Reduction, complete this form and return it to us with FORM A, the "Continuation Coverage Election Form." You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: [Enter Name and Address]

You may also want to read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA."

[Insert Plan Name]

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

[Insert Plan Mailing Address]

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.

- 1. The loss of employment was involuntary.
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.
3. I elected (or am electing) continuation coverage.
4. I am NOT eligible for other group health plan coverage...
5. I am NOT eligible for Medicare...

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature -> Date ->

Type or print name -> Relationship to employee ->

FOR ISSUER USE ONLY

This application is: [ ] Approved [ ] Denied [ ] Approved for some/denied for others (explain in #4 below) Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

- 1. Loss of employment was voluntary.
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.
3. Individual did not elect continuation coverage.
4. Other (please explain)

Signature of party responsible for continuation coverage administration for the Plan

-> Date ->

Type or print name ->

Telephone number -> E-mail address ->

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

a. \_\_\_\_\_

1. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

b. \_\_\_\_\_

1. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

c. \_\_\_\_\_

1. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_