NOTIFICATION OF COBRA RIGHTS

IMPORTANT NOTICE TO EMPLOYEES OF THE CAPITAL AREA HEALTH CONSORTIUM AND THEIR SPOUSES

Federal law requires that we offer employees and their families the opportunity for a temporary extension of health coverage at group plan rates in certain instances where coverage under the plan would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, contact the Plan Administrator. Both you and your spouse should take the time to read this notice carefully in that it explains when it may become available to you and your family, and what you need to do to protect the right to receive it. **If you are married, your spouse must also sign the form**.

If you are **covered** by the Capital Area Health Consortium (CAHC) health plan, as **employee, spouse of employee or dependent of employee**, you have the right to choose this continuation coverage for up to 18 months if you lose group coverage because of:

1. Termination/resignation of employee's employment (for reasons other than gross misconduct on employee's part)
2. Reduction in employee's hours of employment.

If you are the **spouse** of an employee covered by the group health plan, you have the right to choose continuation coverage for yourself for up to 36 months if you lose group health coverage for any of the following reasons:

1. The death of your spouse.
2. Divorce or legal separation from your spouse.
3. Your spouse becomes entitled to Medicare

In the case of a **dependent child** of an employee covered by the group health plan, including a newborn infant or a newly adopted child , he or she has the right to continuation coverage for up to 36 months if group health coverage is lost for any of the following reasons:

1. The death of - the employee parent
2. The employee- parent becomes entitled to Medicare
3. The dependent ceases to be eligible as a "dependent child" (due to age) under the group plan.

Employees or family members have the sole responsibility to promptly inform CAHC in the event of a divorce, legal separation, or child losing dependent status under the group plan. In addition,

employees or family members must keep CAHC informed of their current addresses and marital status.

When CAHC is notified that one of these events has happened, you will be sent the paperwork needed for continuation coverage. Under COBRA, you have 60 days to enroll in COBRA coverage from the date you would lose coverage. from the date of the notification letter following your termination of employment to complete and return the paperwork to sign up for continuation coverage. If you choose coverage, it will be identical to the coverage provided under the plan to employees and their dependents. The 18 month period may be extended to 36 months for qualified dependents if other events (divorce, legal separation, death, or Medicare entitlement) occur during that 18 month period. In addition, the 18 month period will be extended up to 29 months if you or a family member entitled to continuation coverage are disabled (per Social Security disability determination) before the end of 60 days after continuation coverage begins and the insurance carrier is notified of that determination before the end of the 18 months. The affected individual must also notify the insurance carrier of any final determination that the individual is no longer disabled.

However, COBRA also provides that your continuation coverage may be cut short for <u>any</u> of the following 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. After you elect COBRA, you become covered under another group health plan.
4. After you elect COBRA, you become entitled to Medicare.
5. You extended coverage for up to 29 months due to a disability and there has been a final determination that you are no longer disabled.

If you elect continuation coverage, you must complete the proper COBRA election form. You will be responsible for 100% of the total premium, plus an additional 2% for administrative costs.

Instead of choosing COBRA, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower monthly premiums. You can find additional information on the Health Care Exchanges on the following websites:

Federal Health Care Exchange	www.healthcare.gov
CT Health Care Exchange	www.accesshealthct.com

COBRA RIGHTS ACKNOWLEDGEMENT

I hereby acknowledge that I have received notification of my COBRA continuation rights to extend my group plan health coverage. I understand that all costs for continuation coverage will be at my own expense. I must also submit a COBRA Continuation Election Form to elect for coverage within 60 days of the loss of coverage.

I understand that all costs for continuation coverage will be at my expense, and coverage will only be reinstated once payment is received. I understand my COBRA coverage will automatically terminate once I cease remitting the required monthly payments. **CAHC will not send notices or invoices of payments due**.

Employee Signature: ___________________________ Date: _____________

Printed Name: _________________________________

YOUR SPOUSE MUST ALSO SIGN THIS FORM IF ARE MARRIED AND INCLUDING THEM ON THE HEALTH INSURANCE PLAN.

Spouse's Signature: __________________________________ Date: _____________

Spouse's Printed Name: _________________________________

Employees and their spouses are responsible for promptly informing CAHC of a divorce, legal separation, or child losing dependent status under the group plan. In addition, employees or family members must keep CAHC informed of their current addresses.

Please return completed form to CAHC by emailing it to cahcgroup@uchc.edu.