CSU The California State University

COBRA Continuation Coverage Election Notice

Date:

Dear:

This notice contains important information about your right to continue your health care coverage in the enter name of group health plan (the Plan), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on _____ due to [see *checked box below*]:

- ☐ End of employment
- ☐ Death of employee
- ☐ Entitlement to Medicare
- ☐ Loss of dependent child status
- ☐ Reduction in hours of employment
- ☐ Divorce or legal separation or Annulment
- ☐ Dissolution of Registered Domestic Partnership
- ☐ Non-certification of Dependent Eligibility Verification which was due by (18 months)

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to _____ **months** for the following qualified beneficiaries specified below:

- ☐ Employee or former employee
- ☐ Spouse or former spouse
- ☐ Registered Domestic Partner or Former Registered Domestic Partner
- ☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage _____

_____

- ☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan Date

If elected, COBRA continuation coverage will begin on ***Date***:_____ ____and can last until_____ .
You may elect any of the following checked options for COBRA continuation coverage:

- ☐ CalPERS Health Coverage: _____ $_____PerMonth
- ☐ CSU Dental Coverage: _____ $_____**PerMonth**
- ☐ CSU Vision Coverage (VSP) $_____**Per Month**
- ☐ Health Care Reimbursement Account (HCRA) Plan (Monthly COBRA Cost based on 102% of monthly election amount).

You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

There may be other coverage options for you and your family. In the Health Insurance 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 any questions about your rights to COBRA continuation coverage, you should contact *Human Resources Benefits, 5150 N. Maple Ave. Fresno, CA 93740, (559) 278-2032.*

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: Benefits Analyst, 5150 N. Maple Ave., M/S JA 41, Fresno, CA 93740

This Election Form must be completed and returned by mail *or dropped of at Human Resources Office by* _____. If mailed, it must be post-marked no later than _____.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the date: _____, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

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

I (We) elect COBRA continuation coverage in the _____ (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. Insert Appropriate Information			

[*Add if appropriate:* Coverage option elected: Insert Plan]

b. Insert Appropriate Information

[*Add if appropriate:* Coverage option elected: Insert Plan]

c. Insert Appropriate Information

[*Add if appropriate:* Coverage option elected: Insert Plan]

d. Insert Appropriate Information

[*Add if appropriate:* Coverage option elected: Insert Plan]

_____ _____

Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number

Important Information
About Your COBRA Continuation Coverage Rights

What is continuation coverage?

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" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. CSU is voluntarily treating current and former registered domestic partners as qualified beneficiaries for COBRA purposes.

Continuation coverage 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 continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage 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, divorce or legal separation, the termination of a registered domestic partnership or the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent 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, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage 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 continuation coverage, 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 continuation coverage, 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 or beneficiary not receiving continuation coverage (such as fraud).

[*If the maximum period shown on page 1 of this notice is less than 36 months, the following three paragraphs are applicable to you:*]

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [***Enter Name and Address of Campus Benefits Office Contact Person***] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Social Security Disability Extension to the 18-Month Period
The 18 months of continuation coverage may be extended for an additional 11 months of coverage, up to a maximum of 29 months if any of the qualified beneficiaries 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 COBRA continuation coverage and must last at least until the end of the 18- month period of continuation coverage.

This extended period allows disabled persons continued coverage for the period of time that it normally takes to become eligible for Medicare. Premiums for this coverage beyond the initial 18 months will be calculated at 150% of the State's group coverage premium rate and will continue to be paid monthly directly to the plan or its designee.

It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the appropriate plan within 60 days after the date of determination and before the original 18-month COBRA eligibility period expires.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the termination of a registered domestic partnership, or the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent 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 continuation coverage.

Special Medicare Entitlement Rule for Dependents Only
If an employee becomes entitled to Medicare benefits prior to the date of an 18-month qualifying event, then his/her dependents is eligible for 18 months of COBRA continuation coverage, or 36 months measured from the date of the Medicare entitlement, whichever is greater.

Example: If an employee becomes entitled to Medicare seven (7) months prior to termination of employment, then the dependents will be offered 29 months of continuation coverage. The employee is only offered 18 months.

Additional Continuation of Coverage Rights for Certain Qualified Beneficiaries (for California only)
Assembly Bill (AB) 1401 (Cal-COBRA) permits specified individuals who begin continuation coverage on or after January 1, 2003, and who subsequently exhaust all available Federal COBRA continuation coverage, the opportunity to extend their coverage term up to 36 months (includes all prior COBRA coverage), regardless of the nature of the initial COBRA qualifying event. The provisions of AB 1401 apply to health coverage only (not dental or vision) and became effective on September 1, 2003. Premiums are 110% of the corresponding group rate.

An individual who terminated employment may continue coverage for 18 months under Federal COBRA (at a cost of 102%), and then may request continued coverage for an additional 18 months (at a cost of 110%) under AB 1401. An individual who meets the Social Security Administration's definition of disabled (which entitles the disabled individual to up to 29 months of continuation coverage) is eligible for an additional seven months of coverage under AB 1401. The coverage cost would be 102% for 18 months of coverage under Federal COBRA, 150% during the disability extension period (months 19 through 29) and 110% for the additional seven months of coverage under AB 1401.

Participants must apply for the extension directly with the insurance carrier or health plan prior to the expiration of their Federal COBRA coverage. Participants should be referred to CalPERS or their health plan for additional information.

How can you elect COBRA continuation coverage?

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

In considering whether to elect continuation coverage, 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 ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Electing COBRA under the HCRA
COBRA coverage under the HCRA will be offered only to qualified beneficiaries if there is a positive balance in the HCRA at the time of the qualifying event. If you elect to continue HCRA participation, you will make payments on an after-tax basis, and pay an additional 2% administrative fee. You will have access to your HCRA account balance for the remainder of the year. Note that employees can continue to submit claims incurred prior to the date that their participation in the HCRA plan ended. Eligibility for participation in the HCRA plan ceases at the end of the plan year. If you are interested in this alternative, contact [***Insert Benefits Office Staff Contact Information***] for more information.

How much does COBRA continuation coverage 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 or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment with the Election Form. **However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. Y**ou are responsible for making sure that the amount of your first payment is correct. You may contact ***Enter Name, Address and Telephone Number of Campus Benefits Office Contact*** to confirm the correct amount of your first payment.

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. **Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period.** If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

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

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to: [*See Payment Addresses Below:*]

Health	**Dental**
Payment address information will be provided by the Health Plan	For Delta Dental (PPO) and DeltaCare USA (DHMO) Plans: Delta Dental P.O. Box 537011 Sacramento, California 95853-7011 Telephone: (800) 594-6957 Email: isolvedCOBRA@delta.org

Vision	**HCRA**
VSP/COBRA ADMINISTRATION P.O. Box 997100 Sacramento, California 95899-7100 Telephone: (800) 400-4569 Fax: 916-463-9031	ASI P. O. Box 6044 Columbia, MO 65205-6044 Attention: COBRA Telephone: (800) 659-3035 Fax: 877-879-9038

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 summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact ***Campus Benefits Office Staff Responsible For Cobra Administration For The Plan, With Telephone Number And Address***.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

For Persons Eligible for Medi-Cal
The Health Insurance Premium Payment (HIPP) Program may pay COBRA premiums in certain cases for persons eligible for Medi-Cal. You may e-mail your questions to the Department of Health Care Services at: www.HIPP@dhs.ca.gov.

For Persons Disabled by HIV/AIDS
Under the Comprehensive AIDS Resources Emergency (CARE) Act of 1990, the Health Insurance Premium Payment (HIPP) Program may pay COBRA premiums for persons unable to work because of a disability due to HIV/AIDS. You may e-mail your questions to the Department of Health Care Services at: www.HIPP@dhs.ca.gov.

Keep Your Plan Informed of Address Changes

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