

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(FOR USE WHEN THE EMPLOYER IS THE PLAN ADMINISTRATOR)

INSTRUCTION SHEET (E9)

EMPLOYERS THAT SHOULD USE THIS FORM: Organizations that self administer (i.e., internally handle) COBRA benefits. This form applies to single employer plans but not multi-employer plans.

RECIPIENTS: Employees and spouses when they enroll in the Plan. A separate notice to any covered dependents living with the employee or spouse is not required.

DELIVERY: If the *General Notice* is hand-delivered to an employee at work, a separate *General Notice* must be mailed to the covered spouse at his/her home address, if applicable. Another option is to mail the *General Notice* to the attention of both the covered employee and covered spouse if they live at the same address and their coverage begins at the same time. If the spouse enrolls in the Plan more than 90 days after the covered employee or if the spouse lives at a different address, a separate *General Notice* must be furnished to the spouse.

DEADLINE DATE: The *General Notice* must be provided no later than 90 days from the date an employee and/or covered spouse become covered under the Plan. However, if a qualifying event occurs during this 90-day period and the *General Notice* has not yet been provided, the Plan Administrator need only provide an *Election Notice* to qualified beneficiaries.

OPTION: Employers can satisfy the general notice requirements by adding the required information to their Plan's Summary Plan Description (SPD) and distributing it to both the covered employee and covered spouse within 90 days of becoming covered under the Plan.

RESPONSIBILITY FOR FORM COMPLETION:

Page 1: The Plan Administrator should complete the table at the top of the page.

Page 2: The Plan Administrator should fill in his/her contact information in the box.

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Name of Group Health Plan:	Date of Notice:
Individuals Covered Under the Group Health Plan:	
Employee Name:	
Spouse's Name (if applicable):	
Name of Dependent(s) (if applicable):	

Purpose of This Notice

You are receiving this notice because you have recently become covered under one or more of the organization's group health insurance plans (e.g., medical, dental, vision, prescription, and/or medical flexible spending account), which will collectively be referred to as "the Plan" throughout this notice. The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you and any family members who are covered under the Plan the opportunity to temporarily extend your insurance coverage in certain instances (referred to as "qualifying events") when coverage would otherwise end. This notice provides an overview of COBRA continuation coverage, including when it may become available to you and your family members and what you need to do to protect your right to receive this coverage at the time of a qualifying event. Both you and any family members covered under the Plan should read this notice carefully and retain it with your other benefit documents. **This notice does not fully describe your rights and obligations under the Plan and COBRA. Complete information is available from the Plan Administrator and in the Plan's Summary Plan Description (SPD).**

Who is Covered

COBRA continuation coverage must be offered to each "qualified beneficiary" when coverage would otherwise end due to a qualifying event (a list of qualifying events is provided below). A qualified beneficiary is someone who is covered by the Plan on the day before a qualifying event. Depending on the type of qualifying event, you, your spouse, and/or your dependent children may be qualified beneficiaries.

Employee - If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of:

- A reduction in your work hours; or
- Your employment ends for any reason other than termination for gross misconduct.

Spouse of Employee - If you are a covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of:

- The death of your spouse;
- A reduction in the number of hours your spouse is employed which makes your spouse ineligible for coverage;
- Termination of your spouse's employment for any reason other than gross misconduct;
- Your spouse's enrollment in Medicare (Part A, Part B, or both); or
- Divorce or legal separation from your spouse.

Dependent Children - If you are a covered dependent child of an employee (including a child born to, or placed for adoption with, an employee during the period of continuation coverage), you will become a qualified beneficiary if you lose coverage under the Plan because of:

- The death of your parent;
- A reduction in the number of hours your parent is employed which makes your parent ineligible for coverage;
- Termination of your parent's employment for any reason other than gross misconduct;
- Your parent 's enrollment in Medicare (Part A, Part B, or both);
- The divorce or legal separation of your parents; or
- You are no longer eligible for coverage as a "dependent child" under the terms of the Plan (e.g., due to age and/or change in student status).

Retired Employee and Dependents - If you are a retired employee covered under the Plan, the organization's filing under Title 11 Bankruptcy proceedings of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the organization and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, you are a qualified beneficiary with respect to the bankruptcy. Your spouse and/or any dependent children covered under the Plan will also be qualified beneficiaries if bankruptcy results in the loss of their coverage.

Employer's Responsibilities

At the time of a qualifying event, the Plan Administrator will notify you (and your family members if you do not live together) in writing of your right to elect COBRA continuation coverage. When the qualifying event is a result of separation from employment, reduction in work hours, death, enrollment in Medicare, or bankruptcy, you will receive notification within 44 days of either the qualifying event or following the date your coverage will end. When the qualifying event is due to a legal separation, divorce, or a dependent child losing dependent status under the Plan, you will be notified of your right to COBRA continuation coverage within 30 days of either the qualifying event or following the date your coverage will end.

Employee's Responsibilities

You or a family member has the responsibility of notifying the Plan Administrator in writing within 60 days of a legal separation, divorce, or the date a dependent child ceases to be a covered dependent under the Plan.

In the event that a child is born to you or placed in your home for adoption during your period of continuation coverage, the child shall be a qualified beneficiary and may be covered under the Plan immediately so long as you inform the Plan Administrator in writing within 30 days of the event.

Election Rights

The Plan will offer COBRA continuation coverage to each qualified beneficiary only after the Plan Administrator has been notified that a qualifying event has occurred. Each qualified beneficiary may independently elect continuation coverage. You may elect coverage on behalf of your covered spouse. Likewise, you or your spouse may elect continuation coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect coverage on behalf of a minor child. Qualified beneficiaries have 60 days from the date they would otherwise lose coverage or the date of the notice, whichever is later, to inform the Plan Administrator that they want continuation coverage. For each qualified beneficiary who elects COBRA continuation coverage, such coverage will begin on the day after coverage would otherwise end.

If you do not choose continuation coverage within the 60-day period, your coverage will end. If you choose continuation coverage, the organization is required to provide coverage that, as of the time it is provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. Therefore, if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

Length of Coverage

When the qualifying event is the end of employment or reduction in work hours, COBRA continuation coverage lasts for up to 18 months. When the qualifying event is the death of an employee, enrollment in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months for covered family members.

Extension of Coverage

If you or anyone in your family that is covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, the coverage period can be extended to 29 months for all family members, even those who are not disabled, so long as the Plan Administrator is notified in writing within 60 days of the determination and before the end of the 18-month period.

If a second qualifying event occurs (e.g., death, divorce, legal separation, loss of dependent child status) within the initial 18-month or 29-month period of continuation coverage, your spouse and dependent children can receive additional months of COBRA coverage, up to a maximum of 36 months. Medicare entitlement of a covered employee is not a second qualifying event unless (ignoring the first qualifying event) such entitlement would have resulted in a loss of coverage under the group health plan. In no event is COBRA continuation available for more than 36 months. The Plan Administrator must be notified in writing of a second qualifying event within 60 days of such event.

Notice Requirements

When there is a legal separation, divorce, or loss of dependent status, you or a family member is responsible for submitting a completed *Qualified Beneficiary Notice to Plan Administrator of Qualifying Event Form* to the Plan Administrator within 60 days of the qualifying event.

Upon notification from the Plan Administrator of your right to COBRA continuation coverage, you will have 60 days to notify the Plan Administrator of your decision to elect or waive coverage by submitting a completed *COBRA Continuation Coverage Election Notice Form*.

COBRA forms may be hand delivered or mailed to the Plan Administrator at the address listed below. Forms are available at no charge by contacting the Plan Administrator.

Cost of Coverage

Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of such coverage. A 2% administrative fee may also be added. For qualified beneficiaries receiving the 11-month disability extension of coverage, the premium for those additional 11 months may be increased up to 150% of the Plan's applicable premium.

End of Continuation Coverage

Once COBRA continuation coverage ends for any person, it cannot be reinstated. At the end of the continuation coverage period, you and any covered family members are allowed to enroll in an individual conversion health plan, if the Plan provides a conversion privilege. In addition, under the Health Insurance Portability and Accountability Act (HIPAA), you and your covered family members may have the right to buy individual health coverage with no pre-existing condition exclusion and without having to provide evidence of good health.

Questions

Questions about COBRA continuation coverage should be directed to the Plan Administrator at the address and telephone number listed below. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep the Plan Administrator Up-to-Date

In order to protect you and your family members' rights, keep the Plan Administrator informed of the current address of all participant(s) under the Plan who are or may become qualified beneficiaries. We recommend that you keep a copy of any notices you send to the Plan Administrator for your records.

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Plan Administrator
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Telephone Number
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Address