

# Continuing Your Health Care Coverage (COBRA)

**Underwritten/Administered by:**

Coventry Health Care of Nebraska, Inc.

Coventry Health and Life Insurance Company

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CONSOLIDATED

MNIBUS

BUDGET

RECONCILIATION

ACT

## Employee Information

(COBRA Administration handled by Policyholder/Contractholder

COBRA Billing and Collection Services handled by Coventry Health Care)

Your employer has contracted with Coventry Health Care to perform certain administrative services with respect to COBRA. Coventry Health Care has prepared this information to explain, in a summary fashion, your rights and responsibilities under COBRA. This information, however, is not intended to serve as legal advice. The law regarding COBRA may change, necessitating revisions to this information. You should consult your own legal counsel regarding your rights under COBRA. Further details on COBRA coverage are set forth in your plan booklet and in the COBRA Group Health Insurance Continuation Rider, which is part of the group health plan.

**What is COBRA?**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law which requires most employers with 20 or more employees (including part time) to offer group health continuation coverage rights to persons whose insurance would otherwise end due to a “qualifying event.”

Group health plans include medical, vision and dental coverages that your employer offers to employees and eligible dependents. COBRA does not affect group life, AD&D and disability coverages.

**What are the Qualifying Events?**

| QUALIFIED BENEFICIARY  | QUALIFYING EVENT   | LENGTH OF CONTINUATION |
|--|--|------------------------|
| Employee and/or Covered Dependent(s)   | <ol style="list-style-type: none"> <li>1. Voluntary or involuntary termination of employment (except for gross misconduct), including retirement.</li> <li>2. Reduction of hours.</li> </ol>   | 18 Months              |
| Disabled* Employee and/or Covered Dependent(s) or Disabled Covered Dependent | <ol style="list-style-type: none"> <li>1. Voluntary or involuntary termination of employment (except for gross misconduct), including retirement.</li> <li>2. Reduction of hours.</li> </ol>   | 29 Months              |
| Covered Dependent(s)   | <ol style="list-style-type: none"> <li>1. Death of employee.</li> <li>2. Divorce or legal separation.</li> <li>3. Dependent child ceases to qualify as a dependent under the Plan (limiting age).</li> <li>4. Active employee becomes entitled to Medicare.**</li> </ol> | 36 Months              |

\*A qualified beneficiary is considered disabled if he or she has been determined to be disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of continued coverage. The qualified beneficiary must notify the Plan Administrator within 60 days of the determination and before the end of the 18-month continuation.

\*\*36 months continuation is calculated from the employee’s Medicare entitlement date, however, in no event will it be less than 18 months.

## **What if a Second Qualifying Event Occurs?**

If a second Qualifying Event occurs while COBRA coverage is ongoing during the initial 18 months or during the initial 29 months in the case of disability (if applicable), COBRA continuation coverage may continue until thirty-six (36) months from the first Qualifying Event. The Qualified Beneficiary must notify the employer of any second Qualifying Event within 60 days after the second Qualifying Event occurs in order to receive this extension to thirty-six (36) months. (see chart)

In case of multiple qualifying events, the maximum continuation for dependents will be 36 months.

## **Who is a Qualified Beneficiary?**

In most cases, a Qualified Beneficiary is any person who was "covered" by the group health plan by virtue of being an employee, employee's spouse, or employee's dependent child. "Covered" means having coverage under the plan on the day before the qualifying event.

"Qualified Beneficiary" also includes a child born, or placed for adoption, during the period that COBRA coverage is ongoing provided you notify the Plan Administrator of the birth or adoption in accordance to the plan provisions. A Qualified Beneficiary who does not make a timely COBRA election is thereafter no longer considered a Qualified Beneficiary and cannot later decide to elect.

## **When Does Continuation of Coverage End?**

COBRA continuation coverage may be terminated on the earliest of the following:

- (a) The last day of the maximum coverage period (see chart);
- (b) The first day for which timely payment is not made;
- (c) The date upon which the employer ceases to maintain any group health plan;
- (d) The date the qualified beneficiary is covered under another group health plan whose exclusion or limitation with respect to any preexisting condition no longer applies;
- (e) The date the qualified beneficiary is entitled to Medicare benefits under Title XVIII of the Social Security Act;
- (f) The month that begins more than 30 days after the date a disabled qualified beneficiary is determined to be no longer disabled under Title II or XVI of the Social Security Act. If such a determination is made, Coventry Health Care must be notified within 30 days of the date of the determination.

If your period of COBRA coverage continues for the maximum 18-, 29- or 36-month period, you may apply for conversion coverage at the end of your period of COBRA coverage, but only if the option to apply for conversion coverage is then available under the plan. The completed application and first premium payment for conversion coverage must be received within 31 days after COBRA coverage ends. Please contact the Plan Administrator for information. If conversion coverage is then available under the plan, please be aware that conversion coverage provides different benefits and costs than does COBRA coverage.

## What are Your Responsibilities?

### A. Continuation Election is Your Responsibility

Whether you wish to continue or not continue your group health coverage(s), it is your responsibility to complete and return the COBRA Continuation Election Forms (Employer section and Qualified Beneficiary section).

Your election period will end 60 days after the **later of:**

- (1) the date of your Qualifying Event: **or**
- (2) the Notification Date

as specified on the COBRA Continuation Election Form.

Note that a separate COBRA election may be made independently by the employee and other Qualified Beneficiaries among the coverages listed in the election form. For example, even if the employee declines COBRA coverage for himself, COBRA coverage may still be elected for the spouse and/or dependent children if they are Qualified Beneficiaries. This election may be made either by the employee or the spouse.

If you do not submit this completed Election Form by the end of your 60-day election period, you will lose your right to elect COBRA continuation coverage. If you declined COBRA continuation coverage(s) before the end of your 60-day election period, you may change your decision to elect COBRA continuation coverage provided that you furnish a completed Election Form by the end of your original 60-day election period; however, your COBRA continuation coverage will begin on the date you send the completed Election Form to your employer.

### Health Insurance Portability And Accountability Act Of 1996 (HIPAA) (Applicable to Medical Plans Only)

Please note that failure to continue your group health coverage will affect your future rights under the federal law known as HIPAA. First, you can lose the right to avoid having pre-existing condition exclusions applied to you (and your dependents, if applicable) by other group health plans if you have more than a 63-day gap in health coverage, which an election of continuation coverage may help prevent such gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not continue COBRA coverage for the maximum time available to you. Finally, you have special enrollment rights under HIPAA 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. You will also have the same special enrollment right at the end of the COBRA continuation coverage if you continue coverage for the maximum time available to you.

### B. Payments are Your Responsibility

Coverage will be terminated until an election is made and initial payment of premium is timely submitted. After an election is made, the initial premium must be submitted within **45 days** of the date of the election. If the initial premium is paid within the 45-day period, coverage will be reinstated as of the date coverage terminated in order to provide continuous coverage. Failure to pay the premium within this 45-day period will result in a retroactive termination of coverage and you will lose all continuation coverage rights under the Plan. Your initial payment must cover the number of months from the qualifying event through the end of the month in which you mail your initial payment. The initial payment and continuation election form along with all subsequent payments should be submitted to the address shown on the election form. After the initial payment, the regular monthly premium (unless otherwise notified of a change) must be received timely or COBRA coverage will terminate. Subsequent monthly premiums are normally due within 30 days after the first day of each monthly period of COBRA coverage. All subsequent payments following your initial payment should be submitted to Coventry Health Care, P.O. Box 2147, Omaha, NE 68103-2147. If you fail to make timely subsequent monthly premium payments, you will lose all continuation coverage rights under the Plan.

## **What are Your Responsibilities?**

### **C. Notification of an Address Change is Your Responsibility**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator advising them of you or your family's address change. It is still your responsibility to make timely monthly payment of premiums even if you have a change of address. If you fail to make timely premium payments as described in item B., you (and your family) will lose all rights to continuation coverage under the Plan.

### **D. Notification of Coverage Under Another Group Health Plan is Your Responsibility**

You must notify the Plan Administrator immediately when you and/or your family member becomes covered under another group health plan (includes entitlement to Medicare Part A and/or B) which the exclusion or limitation with respect to any preexisting condition no longer applies.

# COBRA Continuation Election Form

**This Section Must Be Completed By Employer Before Giving To Applicant:**

Employer Name \_\_\_\_\_ Group I.D. No. \_\_\_\_\_

Employee Name \_\_\_\_\_

Employee Social Security No. \_\_\_\_\_

Qualified Beneficiary \_\_\_\_\_

Qualifying Event (check one):

- Death of employee
- Employee's termination of employment (for reasons other than gross misconduct)
- Employee's reduction of hours
- Divorce or legal separation
- Covered employee becomes entitled to Medicare benefits  
 Medicare eligibility was due to:  Age     Disability     ESRD (End-stage Renal Disease)
- Dependent child ceases to qualify as a dependent under the Plan

Date of Qualifying Event \_\_\_\_\_ Date Last Worked \_\_\_\_\_

Shown below are premium rates and coverage(s) in force on the day immediately preceding the qualifying event (Rates are subject to change):

| Coverage(s)                                      | Dependent(s) Covered?    |                          | Employee Only | Dependent(s) Only | Employee & Family or Specify _____ |
|--|--------------------------|--------------------------|---------------|-------------------|------------------------------------|
|  | Yes                      | No                       |               |                   |                                    |
| <input type="checkbox"/> Medical                 | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____      | \$ _____          | \$ _____                           |
| <input type="checkbox"/> Vision                  | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____      | \$ _____          | \$ _____                           |
| <input type="checkbox"/> Medical/Vision          | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____      | \$ _____          | \$ _____                           |
| <input type="checkbox"/> Medical with HRA        | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____      | \$ _____          | \$ _____                           |
| <input type="checkbox"/> Medical with HRA/Vision | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____      | \$ _____          | \$ _____                           |

Employer's Signature \_\_\_\_\_

Notification Date \_\_\_\_\_

**Note to Qualified Beneficiary:**

The completed election form must be received at the address indicated on this form by \_\_\_\_\_ .

**These Sections (both sides) Must Be Completed By Qualified Beneficiary or Legal Guardian, as Applicable.**

Employer Name \_\_\_\_\_ Employee Name \_\_\_\_\_

It is your responsibility to complete and return this section and the Employer section to the address indicated on the reverse side of this form. We must receive this form no later than the date indicated on previous page.

- I elect not to continue this group health coverage for myself and/or eligible dependents.
- I elect to continue this group health coverage for myself and/or eligible dependents, as checked below:

Election — Please check the coverage(s) you wish to continue for yourself and/or your eligible dependents. The coverage(s) elected must have been in force for you on the day immediately preceding your qualifying event:

Coverages: Employee     Medical     Vision  
 Spouse                 Medical     Vision  
 Child(ren)           Medical     Vision

Premium Remittance (Refer to Employer’s Section of this form for monthly contribution rates, which rates are subject to change.)

|                             | <b>Employee<br/>Only</b> | <b>Dependent(s)<br/>Only</b> | <b>Employee &amp;<br/>Family or<br/>Specify _____</b> |
|-----------------------------|--------------------------|------------------------------|---|
| Medical                     | \$ _____                 | \$ _____                     | \$ _____  |
| Vision                      | \$ _____                 | \$ _____                     | \$ _____  |
| Medical/Vision              | \$ _____                 | \$ _____                     | \$ _____  |
| Medical with HRA            | \$ _____                 | \$ _____                     | \$ _____  |
| Medical with HRA and Vision | \$ _____                 | \$ _____                     | \$ _____  |
| Total Premium Remittance    |                          |                              | \$ _____  |

List all currently covered individuals (including employee) who wish to continue coverage:

| <b>Name</b>    | <b>Date of Birth<br/>(Mo./Day/Yr.)</b> | <b>Social Security Number</b> |
|----------------|--|-------------------------------|
| Employee _____ | _____                                  | _____                         |
| Spouse _____   | _____                                  | _____                         |
| Child _____    | _____                                  | _____                         |
| Child _____    | _____                                  | _____                         |
| Child _____    | _____                                  | _____                         |
| Child _____    | _____                                  | _____                         |

Is any individual(s) listed currently covered under any other group health plan or Medicare?

- Yes     No

If “Yes,” check coverages currently covered under:

- Medicare     Medical     Vision

