Qualifying Event Forms Packet (CA)

This packet contains form for use following a qualifying event that is:

Termination of employment

Reduction in hours of employment

Death of employee

Divorce or legal separation

Employee becomes qualified Medicare

Child’s loss of dependent status

Packet Contents:

Qualifying Event Notice

Election Notice

ERISA Section 606(c) requires the plan administrator to notify a qualified beneficiary of their COBRA rights within 14 days after the plan administrator is notified by the employer that a qualifying event has occurred. When the employer is also the plan administrator, the employer must provide notice to the qualified beneficiary within 44 days of the qualifying event date.

For qualifying events where the qualified beneficiary is required to notify the plan administrator (divorce or legal separation, Medicare entitlement, loss of dependent status), the administrator has **14 days** to provide the notice.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Notice** |  | **Mailing Method** |  |
| **Name of Individual(s)** |  | | |
| **Address** |  | | |
| **City, St, Zip** |  | | |
| **Notes:** | | | |

**Please note text in red. Some sections of this document can be removed if not applicable to your plan.**

**Model COBRA Continuation Coverage Election Notice**

**(For use by single-employer group health plans)**

**IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives**

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

**This notice has 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 options that may be available to you, including coverage through the Health Insurance Marketplace at** [**www.HealthCare.gov**](http://www.healthcare.gov/) or call1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

### Why am I getting this notice?

You’re getting this notice because your coverage under the Plan will end on [*enter date*]due to [*check appropriate box*]:

 End of employment  Reduction in hours of employment

 Death of employee  Divorce or legal separation

 Entitlement to Medicare  Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there’s a “qualifying event” that would result in a loss of coverage under an employer’s plan.

### What’s COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren’t getting continuation coverage. Each “qualified beneficiary” (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

**Who are the qualified beneficiaries?**

Each person (“qualified beneficiary”) in the category(ies) checked below can elect COBRA continuation coverage:

 Employee or former employee

 Spouse or former spouse

 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

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

**If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?**

|  |  |
| --- | --- |
| Coverage Begin Date: |  |
| Coverage End Date:  (18 or 36 months from qualifying event date, depending on the type of qualifying event. |  |

|  |  |
| --- | --- |
|  | 18 months (for termination of employment and reduction of hours). |
|  | 36 months (for other qualifying events). |

You may elect any of the following options for COBRA continuation coverage:

|  |  |
| --- | --- |
| Coverage Type | Plan Name |
|  |  |
|  |  |
|  |  |
|  |  |

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

# Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don’t provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

### How much does COBRA continuation coverage cost?

COBRA continuation coverage will cost:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Coverage/Plan | Monthly Premium | | | | |
|  | Employee | EE+ Spouse | EE+ Child(ren) | Family |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Election Timeframe for COBRA**

|  |  |
| --- | --- |
| You have 60 days to elect COBRA, measured from the later of the date of this notice or date coverage is lost. Coverage must be elected by this date. | COBRA Election Deadline |
|  |

Other coverage options may cost less. If you choose to elect continuation coverage, you don’t have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

**You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** You can learn more about the Marketplace below.

**What is the Health Insurance Marketplace?**

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you’ll also learn if you qualify for free or low-cost coverage from [Medicaid](https://www.healthcare.gov/do-i-qualify-for-medicaid) or the [Children’s Health Insurance Program (CHIP)](https://www.healthcare.gov/are-my-children-eligible-for-chip). You can access the Marketplace for your state at [www.HealthCare.gov](http://www.HealthCare.gov).

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

**When can I enroll in Marketplace coverage?**

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

**Can I enroll in another group health plan?**

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

**What factors should I consider when choosing coverage options?**

When considering your options for health coverage, you may want to think about:

* Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
* Provider Networks: If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
* Drug Formularies: If you’re currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
* Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
* Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
* Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

### For more information

This notice doesn’t 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 descriptionor from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact:

|  |  |
| --- | --- |
| Company Name |  |
| Contact Name |  |
| Phone |  |
| Address |  |
| City, State, Zip |  |

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep Your Plan Informed of Address Changes**

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

###### COBRA Continuation Coverage Election Form

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

**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: [*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 [*enter date*].**

**If you don’t submit a completed Election Form by the due date shown above, you’ll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit 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 submit the completed Election Form.**

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

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

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

[*Add if appropriate:* Coverage option elected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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

[*Add if appropriate:* Coverage option elected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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

[*Add if appropriate:* Coverage option elected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship to individual(s) listed above

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Print Address Telephone number

### Important Information about Payment

*First payment for continuation coverage*

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don’t make your first payment in full no later than 45 days after the date of your election, you’ll lose all continuation coverage rights under the Plan. You’re responsible for making sure that the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

|  |  |
| --- | --- |
| Company Name |  |
| Company Contact |  |
| Phone: |  |
| Address |  |
| City, State, Zip |  |

*Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you’ll have to make periodic payments for each coverage period that follows. 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 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’ll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You’ll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. 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 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 don’t make a periodic payment before the end of the grace period for that coverage period, you’ll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

|  |  |
| --- | --- |
| Company Name |  |
| Contact Name |  |
| Phone |  |
| Address |  |
| City, State, Zip |  |

**Notice to Terminating Employees in California**

**Health Insurance Premium Payment Program (HIPP)**

The California Department of Health Services will pay health insurance premiums for certain persons who are losing employment and have a high cost medical condition. In order to qualify for the **Health Insurance Premium Payment (HIPP) Program**, you must meet **ALL** of the following conditions:

*1) You must currently be on Medi-Cal;*

*2) Your Medi-Cal Share of Cost, if any, must be $200 or less;*

*3) You must have an expensive medical condition. The average monthly savings to Medi-Cal from your health insurance must be at least twice the monthly insurance premiums. If you have Medi-Cal Share of Cost, that amount will be subtracted from your monthly health care costs to determine if paying the premiums is cost-effective;*

*4) You must have a current health insurance policy, COBRA or Cal-COBRA continuation policy, or a COBRA conversion policy in effect or available at the time of application;*

*5) Your health insurance policy* ***must*** *cover your high cost medical condition;*

*6) Your application must be completed and returned in time for the State of California to process your application and pay your premium;*

*7) Your health insurance policy* ***must not*** *be issued through the California Managed Risk Medical Insurance Board; and*

*8) You* ***must not*** *be enrolled in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care Program, of the County Medical Services Program (CMSP).*

**NOTE:** If an absent parent has been ordered by the court to provide your health insurance, you will not be eligible for the HIPP Program.

**For Persons Disabled by HIV/AIDS**

**CARE/HIPP Program**

**AIDS Hotline**

**1-800-367-2437**

Under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, persons unable to work because of disability due to HIV/AIDS and are losing their private health insurance may qualify for premium payment assistance through the CARE Health Insurance Premium Payment (CARE/HIPP) program for up to 29 months, if they meet the following criteria:

*1) Have applied for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), State Disability Insurance (SDI), or other disability programs;*

*2) Are currently covered by a health insurance plan (COBRA, Cal-COBRA individual or group), which includes outpatient prescription drug coverage and HIV-related treatment services;*

*3) Are not currently on the AIDS Drug Assistance Program (ADAP) for any outpatient prescription drug that can be covered by private insurance;*

*4) Have a total monthly income of no more than 400 percent of the current federal poverty level; and*

*5) Will be eligible for the Medi-Cal/HIPP or a County Organized Health System (COHS) HIPP program by the end of the 29-monthcoverage period (some clients may be eligible for extended program coverage)*

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**Important Information about California Bill No. 1401**

This law revised certain provisions of Cal-COBRA and other existing laws that require plans and insurers to offer health benefit coverage to certain individuals. The law, effective September 1, 2003, requires a health care service plan and a health insurer to offer specified individuals who begin receiving continuation coverage on or after January 1, 2003, and who have exhausted their continuation coverage under federal continuation coverage provisions an opportunity to extend the term of their coverage to 36 months. The law would also extend continuation coverage for specified individuals under Cal-COBRA to 36 months.

Section 10128.59 has been added to the California Insurance Code and reads:

A health insurer that provides coverage under a group benefit plan to an employer shall offer an insured who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the insured’s continuation coverage began if the insured is entitled to less than 36 months of continuation coverage under COBRA. The health insurer shall offer coverage pursuant to terms of this article, including the rate limitations contained in Section

10128.56 of the California Insurance Code.

**Options under Covered California:**

1. Continue coverage under COBRA. You might choose this option if you are undergoing medical treatment or if you don’t want to change anything about your plan or current network of doctors and hospitals, for example.
2. [special enrollment](http://www.coveredca.com/individuals-and-families/getting-covered/special-enrollment/) in a Covered California health insurance plan outside of the annual open-enrollment period. To take advantage of the special-enrollment opportunity, you have 60 days before and 60 days after your employer-sponsored coverage ends to apply for and select a Covered California plan. It is important to note that if you miss this special-enrollment period, you have to wait for the next annual open-enrollment period to enroll in a health plan unless you have a qualifying life event for another special-enrollment period.
3. Seek coverage elsewhere, in the individual market outside of Covered California or through a spouse’s employer-sponsored health plan, for example.

For more, visit www.coveredca.com.