

## **Summary of Rights and Obligations Regarding Continuation of Group Health Coverage (COBRA)**

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the plan would otherwise end. A group health plan, referred to in this Summary as the "Plan", includes any medical plan, dental plan and vision plan that the employer maintains. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the premiums for your continuation coverage. At the end of the maximum coverage period (described below), you will be allowed to enroll in an individual conversion health plan if it is otherwise available under the Plan, subject to the requirement to pay the premiums required by the individual conversion health plan.

This summary is intended only to summarize, as best possible, your rights and obligations under the law. The law, however, is not clear on some points and is interpreted by Federal agencies and the courts. Congress often changes the law. Therefore, this summary is subject to change without notice as interpretations or changes of the law occur. *Both you and your spouse should read this summary carefully and keep it with your records.*

### **Qualifying Events**

If you are an **employee** of the Employer covered by the Plan you have a right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination (for reasons other than gross misconduct) of employment; or
2. Reduction in the hours of employment.

If you are the federally recognized **spouse** of an employee covered by the Plan you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse (employee);
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of an employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any following five "qualifying events":

1. The death of your parent (employee);
2. The termination of the parent's employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment with the Employer;
3. Parents' divorce or legal separation;
4. The parent becomes entitled to Medicare benefits; or
5. The dependent ceases to be a "dependent child" under the Plan.

## Notices and Election

Under the law, the employee or a family member has the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan. You or your family member must give this notice no later than 60 days after the date you would lose coverage under the Plan because of the applicable above event. If you fail to give this notice during the 60-day period, you will not be offered the option to elect continuation coverage.

When the Plan Administrator is notified that one of these events has happened, you will be notified that you have the right to elect continuation coverage. You will also be notified of your COBRA rights automatically (i.e., without any action required by you) upon the following events that result in a loss in coverage: the employee's termination of employment, reduction in hours, or death, or the employee becoming entitled to Medicare.

You must elect continuation coverage within 60 days after the Plan's coverage ends, or, if later, 60 days after the Plan Administrator sends you notice of your right to elect continuation coverage. If you do not elect continuation coverage within this 60-day period, you will lose your right to elect continuation coverage.

A covered employee or the federally recognized spouse of the covered employee may elect continuation coverage for all family members. The covered employee, and his or her spouse and dependent children, however, each has an independent right to elect continuation coverage. Thus a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it.

## Type of Coverage

If you elect continuation coverage, the Plan Administrator must give you coverage that, as of the time coverage is provided, is identical to the coverage provided under the Employer's plan to similarly situated employees or family members. If the coverage for similarly situated employees or family members is modified, your coverage will be modified.

## Maximum Coverage Periods

1. **36 Months** If you (spouse or dependent child) lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

2. **18 Months under Federal Law and an additional 18 months under California Law for a total of 36 months.** Second 18 months is administered through medical carrier. If you (employee, spouse or dependent child) lose group health coverage because of a termination or reduction in hours of the employee's employment, the maximum continuation coverage period (for the employee, spouse and dependent child) is 36 months total from the date of termination or reduction in hours as described above. There are three exceptions:

### Special Social Security Disability Rule

- If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the Plan Administrator within the 18-month coverage period and within 60 days after the date of the determination. Otherwise COBRA Coverage will not be extended beyond the 18 months. In addition, if a final determination is made that you are no longer disabled, you must notify the Employer within 30 days of the final determination. The additional 11 months of coverage under Federal COBRA law would be charged at

150% of employer's premium. At the end of the 29 months of disability coverage, an additional seven months at the 150% would be available under California AB 1401.

### **Second Qualifying Event**

- If a second qualifying event occurs that offers a 36-month maximum coverage period for the spouse/dependent (for example, the employee dies or becomes divorced) within the 18-month or 29-month coverage period, then the maximum coverage period (for spouse/dependent) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.

### **Special Medicare Entitlement Rule**

- If the employee becomes entitled to Medicare prior to a termination of employment or a reduction in hours, and then he or she has a termination or reduction in hours of employment which causes a loss of insurance, then the spouse and dependents who were on the Group Health Plan at the time of the termination or reduction in hours may elect to continue coverage for up to the greater of either; (a) 36 months from the date of the employee's Medicare entitlement; or (b) 36 months from the date of the employee's termination or reduction in hours of employment.

### **New Qualified Beneficiaries**

Any child born to, adopted by or placed for adoption with a covered employee during the period of COBRA continuation coverage shall be a qualified beneficiary and may be covered immediately under his/her parent's COBRA coverage. A new spouse cannot become a qualified beneficiary.

### **Open Enrollment and HIPAA Special Enrollment Rights**

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents, if such person acquires a new dependent (through marriage, certified domestic partnership, birth, adoption or placement for adoption), if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons or a domestic partner who was denied beneficiary rights at the onset of Cobra. Except for certain children described above under "New Qualified Beneficiaries" dependents who are enrolled in an open enrollment period do not become qualified beneficiaries—their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

### **Early termination of COBRA Coverage**

The law provides that your COBRA Coverage may be cut short for any of the following reasons:

1. The Employer ceases to provide group health coverage to any of its employees;
2. The required premium for your COBRA Coverage is not paid on time;
3. You fail to notify the Employer of an original or secondary event which may entitle you or your dependent child to COBRA Coverage;
4. You become covered under another group health plan that does not contain a significant gap in coverage or an exclusion or limitation with respect to any preexisting condition covered by the Employer's Group Health Plan;
5. You become entitled to benefits under title XVIII of the Social Security Act, i.e., Medicare.

6. You extended COBRA Coverage to 29 months due to a disability and a final determination has been made under Title II or XVI of the Social Security Act that you are no longer disabled. COBRA Coverage will not end, however, until the latter of 18 months from the termination of employment or reduction in hours or the month that begins 30 days after the final determination. Additional months might be available under California AB1401.

### **No Proof of Insurability**

You do not have to show that you are insurable to choose COBRA Coverage.

### **COBRA Premiums**

Each qualified beneficiary is required to pay the entire cost of continuation coverage. Under Federal Law for the 18 months of coverage, the amount a qualified beneficiary will be required to pay is 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent and due to CalCobra, 110 percent) of the cost to the group health plan (including both employer and employee contributions). The premium payments for the “initial premium months” must be paid for you (the employee) and for any spouse or dependent child by the 45<sup>th</sup> day after electing continuation coverage. The initial premium months are the months that end on or before the 45<sup>th</sup> day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month’s premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1<sup>st</sup> day of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you fail to make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1<sup>st</sup> of the month, with no possibility of reinstatement.

### **Premium Reduction**

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the “Summary of the COBRA Premium Reduction Provisions under ARRA” for more details, restrictions, and obligations as well as the Request for Treatment as an Assistance Eligible Individual Form.

### **Conversion to an Individual Plan**

At the end of the applicable COBRA Coverage period, you will need to contact the health insurance carrier directly to enroll in an individual conversion health plan if such a conversion plan is offered.

### **Uniformed Services Employment and Reemployment Rights Act of 1994**

Notwithstanding anything mentioned above, if you enroll on COBRA Coverage due to the employee voluntarily or involuntarily serving in any branch of the U.S. Armed Forces as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994, then your rights to continuation of health care may be subject to and modified by the Uniformed Services Employment and Reemployment Rights Act of 1994 pursuant to its provisions.

## **California Mandated Continuation Coverage**

Pursuant to California Labor Code Section 2807.5, an employee or spouse who elected COBRA upon termination of employment may be allowed to extend insurance coverage after COBRA ends if the employee worked for the employer for at least the prior 5 years and was 60 years old when employment ended. The premium rate may increase to 213% of the current group rate. The individual must elect to extend coverage in writing at least 30 days prior to the date COBRA is scheduled to end. The California Mandated Continuation Coverage will end on the earlier of the date the individual reaches age 65; the date the employer ceases to maintain any group health plan; the date the individual is covered under another group health plan not maintained by the employer, regardless of whether that coverage is less valuable; the date the individual becomes entitled to Medicare; or, for a spouse, 5 years from the date employment ended.

## **Right to Termination Coverage for Unqualified Persons**

*The Employer reserves the right to terminate COBRA Coverage retroactively if it is later determined that a covered person is not a qualified beneficiary. In addition, providing false information or falsifying any election form or other insurance document may cause a loss of continuation coverage.*

## **COBRA Qualified Beneficiaries and Domestic Partners**

Under Federal COBRA, only covered employees, federally recognized spouses, and dependent children may be qualified beneficiaries with independent COBRA election rights. A domestic partner will not qualify as a federally recognized spouse. For purposes of federal law, Defense of Marriage Act (DOMA), established federal definitions of "spouse" as a person only of the opposite sex who is a husband or wife. Because of DOMA's provisions, domestic partners would not be treated as spouses for federal benefit purposes.

## **Addresses Changes, Marital or Dependent Status Changes**

If you or your spouse/dependent address changes, you *must* promptly notify the Plan Administrator in writing. The Plan Administrator needs up to date addresses in order to mail important COBRA notices and other information. It could also determine eligibility in the plan.

Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse/dependent must promptly notify the Plan Administrator in writing. Such notification is necessary to protect COBRA rights for your spouse/dependents.

## **Other Information**

If you have or your spouse/dependent has any questions about this notice or COBRA, please contact the Plan Administrator.

## **Plan Administrator**

The Employer is the Plan Administrator. All notices, payments and other communications regarding the Plan and regarding COBRA must be directed to the following:

CEO-Risk Management Division  
Employee Benefits  
1010 10<sup>th</sup> Street Suite 5900  
Modesto, Ca 95354  
209-525-5717



**CHIEF EXECUTIVE OFFICE  
Risk Management Division**

1010 10<sup>TH</sup> Street, Suite 5900, Modesto, CA 95354  
P.O. Box 1723, Modesto, CA 95353-1723

Phone: 209.525.5710 Fax: 209.525.5779

## **Summary of the COBRA Premium Reduction Provisions under ARRA**

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. Eligible individuals pay only 35 percent of their COBRA premiums and the remaining 65 percent is paid by the plan administrator, Stanislaus County.

### **Premium Reduction**

The premium reduction for COBRA continuation coverage is available to "assistance eligible individuals". An "assistance eligible individual" is the employee and/or a member of his/her family who: is eligible for COBRA continuation coverage at any time between September 1, 2008 and December 31, 2009; elects COBRA coverage; and is eligible for COBRA as a result of the employee's involuntary termination. The premium reduction for an individual ends upon eligibility for other group coverage (or Medicare), after 9 months of the reduction, or when the maximum period of COBRA coverage ends, whichever occurs first. The election of COBRA coverage is not required to occur during the period from September 1, 2008 through December 31, 2009, as long as the resulting COBRA coverage begins during that period.

Individuals paying reduced COBRA premiums must inform their plans if they become eligible for coverage under another group health plan or Medicare.

### **Income limits**

If an individual's modified adjusted gross income for the tax year in which the premium assistance is received exceeds \$145,000 (or \$290,000 for joint filers), then the amount of the premium reduction during the tax year must be repaid. For taxpayers with adjusted gross income between \$125,000 and \$145,000 (or \$250,000 and \$290,000 for joint filers), the amount of the premium reduction that must be repaid is reduced proportionately. Individuals may permanently waive the right to premium reduction but may not later obtain the premium reduction if their adjusted gross incomes end up below the limits. If you think that your income may exceed the amounts above, consult your tax preparer or contact the IRS at [www.irs.gov](http://www.irs.gov).

### **How to Enroll**

To enroll in COBRA coverage, please complete the **Initial COBRA Enrollment** and the **Request for Treatment as an Assistance Eligible Individual Form**.

**\*NOTE:** The rates on the Initial COBRA Enrollment form reflect the **original total premium**. Please refer to the COBRA Rate sheet to calculate the reduced monthly premium. Refer to the Subsidy Rate column on the rate sheet for each plan your are electing. If you choose to elect COBRA coverage, the subsidy premium reduction will remain in effect for up to nine months. Payments for COBRA are due on the first day of every month of coverage. If you fail to make your monthly payment within the 30 day grace period, your COBRA coverage will be terminated with no possibility of re-enrollment.

If you have any questions, please contact Stanislaus County Employee Benefits at 209-525-5717.

**To apply for ARRA Premium Reduction, complete this form and return it to the CEO-Risk Management Division Employee Benefits along with your Initial Cobra Election Form.**

**You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."**

Stanislaus County  
CEO-Risk Management Division  
Employee Benefits

**REQUEST FOR TREATMENT AS AN ASSISTANCE  
ELIGIBLE INDIVIDUAL**

1010 10<sup>th</sup> Street  
Suite 5900  
Modesto, Ca 95354

**PERSONAL INFORMATION**

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address

**To qualify, you must be able to check 'Yes' for all statements.\***

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

**\*If you checked NO for statement 3, you may still be eligible. See below for more information.**

**\*ADDITIONAL ELECTION PERIOD\***

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should have received a new election notice with an Election Form which you **MUST** complete and return.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

**FOR EMPLOYER OR PLAN USE ONLY**

This application is:  Approved  Denied  Approved for some/denied for others (explain in #4 below)  
Specify reason below and then return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

**\*If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?**

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

Telephone number → \_\_\_\_\_ E-mail address → \_\_\_\_\_

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

Name                      Date of Birth                      Relationship to Employee                      SSN

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

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name                      Date of Birth                      Relationship to Employee                      SSN

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

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name                      Date of Birth                      Relationship to Employee                      SSN

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

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name                      Date of Birth                      Relationship to Employee                      SSN

d. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

## 2009 STANISLAUS COUNTY COBRA RATES

HEALTH PLAN OF SAN JOAQUIN	MONTHLY RATE	SUBSIDY RATE
EE ONLY	513.41	179.69
EE+ 1	1026.79	359.38
FAMILY	1386.16	485.16
<b>KAISER</b>		
EE ONLY	558.51	195.48
EE+ 1	1117.02	390.96
FAMILY	1507.97	527.79
<b>PACIFICARE HMO</b>		
EE ONLY	560.82	196.29
EE+ 1	1121.63	392.57
FAMILY	1514.19	529.97
<b>PACIFICARE POS</b>		
EE ONLY	747.25	261.54
EE+ 1	1576.51	551.78
FAMILY	2256.42	789.75
<b>VISION INSURANCE</b>		
EMPLOYEE ONLY	10.06	3.52
EMPLOYEE + 1	20.62	7.22
FAMILY	28.17	9.86
<b>DENTAL INSURANCE</b>		
EMPLOYEE ONLY	37.74	13.21
EMPLOYEE + 1	75.48	26.42
FAMILY	129.34	45.27

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