



DOL AUDIT GUIDE:

Employee Benefit Plans

Presented by **Fred Brown**
Insurance Brokerage

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This guide is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. This guide may not address all compliance issues with federal, state and local laws or identify all possible requests that may be made in connection with an audit. Compliance with all applicable legal requirements is the responsibility of the health plan sponsor. Using the materials in this guide does not guarantee that a plan sponsor will be able to avoid an audit or is in compliance with all applicable requirements. Use this guide as reference, but contact legal counsel to discuss compliance requirements.

INTRODUCTION

The Department of Labor (DOL) has broad authority to investigate or audit an employee benefit plan's compliance with the Employee Retirement Income Security Act (ERISA). Audits are performed by the DOL's Employee Benefits Security Administration (EBSA). To perform these audits, EBSA employs over 400 investigators working out of field offices, many of whom are lawyers or CPAs or have advanced degrees in business and finance.

DOL audits often focus on violations of ERISA's fiduciary obligations and reporting and disclosure requirements. The DOL may also investigate whether an employee benefit plan complies with ERISA's protections for plan participants, such as the special enrollment rules or mental health parity requirements. Recently, the DOL has been using its investigative authority to enforce compliance with the health care reform law, or the Affordable Care Act (ACA).

Traditionally, DOL audits of employee benefit plans have focused primarily on retirement plans, such as 401(k) plans. However, now that the DOL has started enforcing compliance with the ACA, health plan audits are on the rise.

Being selected for a DOL audit can have **serious consequences** for an employer. According to a DOL audit report for the 2013 fiscal year, almost 3 out of 4 investigations resulted in penalties or required other corrective action, such as paying amounts to restore losses, disgorging profits and ensuring claims were properly processed and paid. In addition, a DOL audit may negatively affect an employer's normal business operations because the audit process can be both stressful and time-consuming. The best time for an employer to analyze whether it is ready for a DOL audit is **before** the DOL comes knocking.

This Guide is your manual for preparing for a DOL audit of your HEALTH PLAN. This Guide is designed to provide you with an overview of why certain health plans are selected for audit and what you can do to prepare for an audit and reduce your risk of being audited. It also describes what is typically required of an employer during a health plan audit. It includes:

- Suggestions on how to prepare for a DOL audit;
- Tips for responding to a DOL audit letter;
- A list of documents that DOL investigators commonly request during an audit; and
- A list of available resources and sample documents to help you prepare for an audit.

PREPARING FOR (AND AVOIDING) A DOL AUDIT

Because a DOL audit can disrupt an employer's day-to-day business operations and possibly result in penalties (or other corrective action), it is important for employers to know how to prepare for, and potentially avoid, a DOL audit of their health plan.

As a general rule, the best way to prepare for a DOL audit of your health plan is to confirm that your plan complies with all applicable federal laws, such as HIPAA and the ACA. It is also important to have documents showing your compliance and to maintain these documents so they are easy to access in the event of a DOL audit. If an employer takes these steps before being selected for audit, it can reduce its exposure to penalties. It can also make the audit process more manageable and less time-consuming.

It is also important for an employer to understand why the DOL selects certain health plans for audit and take steps to minimize that audit risk.

AUDIT TRIGGERS

A DOL audit can be triggered for a variety of reasons. In most cases, the DOL investigator will not disclose to an employer why its health plan was selected for audit. However, there are some common audit triggers that an employer should keep in mind.

Common triggers for a DOL audit include:

- **Participant complaints** to the DOL about potential ERISA violations. In 2013, according to a DOL audit summary, 775 new investigations were opened as a result of participant complaints.
- Answers on the plan's **Form 5500**. For example, if a plan's Form 5500 is incomplete, or if inconsistent information is reported from year to year, the DOL may investigate the issue further.
- The DOL's **national enforcement** priorities or projects, which target the DOL's resources on certain issues. For example, the DOL's Health Benefits Security Project focuses on making sure health plans and health insurance issuers comply with the ACA's mandates.

MINIMIZING THE RISK

As a practical matter, an employer has little control over whether it will be audited by the DOL. **However, an employer can take the following steps to help minimize its exposure to a DOL audit:**

- Respond to participants' benefit questions and requests for information on a timely basis;
- File Form 5500 on time and make sure it is complete and accurate;
- Distribute participant notices required by law (for example, the Summary of Benefits and Coverage) by the deadline; and
- Make timely updates to plan documents and summary plan descriptions (SPDs) to reflect legal and design changes.

COMPLIANCE REVIEW

Just because an employer has been selected for an audit does not mean that the employer has violated an employee benefits law. Even an employer in compliance can encounter an unexpected audit. A DOL audit is not a simple process and being "ahead of the game" can potentially save an employer a large amount of money, time and stress.

The best way to prepare for a DOL audit is to remain in compliance with the law and establish a recordkeeping system for maintaining all of the important documents relating to your employee benefit plans. Retaining complete and accurate records will help move along the audit process and provide an accurate picture of your employee benefits. As a general rule, these records should be retained for seven years.

Example: If your health plan is "grandfathered" under the ACA, confirm that you have included the notice of grandfathered status in materials that describe the plan's benefits, such as the plan's SPD, and document that you provided the notice at the required times. Maintain this documentation so that it is easily accessible to you in the future.

Because the DOL has increased the frequency of health plan audits, employers should consider reviewing their health plans for compliance now, before they are selected for audit. It is important for employers to get their health plans' paperwork in order as part of this process. Employers may want to designate one location for maintaining records relating to their health

plans, such as plan documents and insurance contracts, SPDs and notices required under the ACA and other federal laws (for example, the Women's Health and Cancer Rights Act). Even though a compliance review will require some time and effort now, it will likely pay off in the future in the event the employer is selected for a DOL audit.

This Guide includes a list of available resources and sample documents that employers can use as part of their health plan compliance review.

CORRECTING MISTAKES

If an employer reviews its health plan's compliance with employee benefit laws and discovers a violation, there may be a way to address the mistake before the DOL discovers it and assesses a penalty. The DOL has self-correction programs for certain violations that an employer discovers prior to being audited. These programs offer incentives to an employer to file delinquent Forms 5500 and correct fiduciary breaches.

- The Delinquent Filer Voluntary Compliance Program (DFVCP) encourages plan administrators to bring their plans into compliance with ERISA's Form 5500 filing requirements. The DFVCP gives delinquent plan administrators a way to avoid potentially higher civil penalty assessments by voluntarily filing late Forms 5500 and paying reduced penalties. More than 23,000 annual reports were received through this program in fiscal year 2013.
- The Voluntary Fiduciary Correction Program (VFCP) allows plan officials who have identified certain violations of ERISA to take corrective action to remedy the breaches and voluntarily report the violations to EBSA, without becoming the subject of an enforcement action. In fiscal year 2013, EBSA received 1,535 applications for the VFCP.

PENALTIES FOR NON-COMPLIANCE

On top of dealing with the disruption of an audit, employers that are found to be not in compliance with applicable requirements can be subject to penalties. The DOL assesses a **20 percent civil penalty** for breaches of fiduciary duty, and may bring civil litigation against fiduciaries for ERISA breaches. In extreme cases, criminal actions can significantly increase the overall amount of any penalty.

A DOL audit can be a lengthy and time-consuming process, causing disruptions in day-to-day business operations. Thus, it is important for employers to know how to prepare for, and potentially avoid, a DOL audit.

Enforcement Statistics: During the 2013 fiscal year, EBSA closed 3,677 civil investigations. Of these, 72.8 percent resulted in monetary results for employee benefit plans or other corrective action. In addition, EBSA filed 111 civil lawsuits and closed 320 criminal investigations. EBSA's criminal investigations led to the indictment of 88 individuals—including plan officials, corporate officers and service providers—for offenses related to employee benefit plans.

NAVIGATING A DOL AUDIT

Every year, thousands of employee benefit plan fiduciaries (including plan sponsors) are selected by the DOL for audit. Knowing how the DOL audit process works will help an employer successfully respond to and navigate an audit.

AUDIT LETTER

When the DOL selects an employer's health plan for audit, the DOL will send out an investigatory letter. This letter serves to notify the employer that a DOL investigation will take place. Investigations can be in the form of a "limited review" or a full-scale investigation. Regardless of the scope, the next steps are crucial to reducing an employer's liability and making the investigation as seamless as possible.

DOCUMENT REQUEST

Generally, the initial letter from the DOL will include a request for a list of plan-related documents. Employers that receive audit letters may be surprised and overwhelmed by the number of documents requested by the DOL auditor. Although employers generally have no way of knowing whether they will be selected for an audit, it is important for them to maintain employee benefit documents in an organized fashion so they can respond to a DOL audit request in the event this occurs.

DEADLINES

Typically, the audit letter will request that the documents be provided by a specified date. It is critical to respond by this deadline. Inadequate or late responses could trigger additional document requests, interviews, on-site visits and even DOL enforcement actions.

ACTION ITEMS

Once an employer knows that it's being audited by the DOL, there are a number of things it can do to prepare for the investigation:

- Establish a contact person at the company for the investigation
- If desired, secure legal counsel for assistance with the audit process

- Negotiate or clarify the scope of the document request and, if necessary, ask for an extension to the response deadline
- Make copies of all the requested documents for the DOL and review them for accuracy
- If a discrepancy is found while compiling the documents, consider providing an explanation
- Prepare your staff for on-site visits and interviews

CHECKLIST OF REQUESTED DOCUMENTS

This checklist includes documents that are commonly requested by the DOL during an audit of an employer’s health plan. In addition to maintaining these documents in an easily accessible location, employers should keep records showing that participant notices and other required disclosures are provided in a timely fashion.

As health plan sponsors, employers should ideally confirm that they maintain these documents and records, and should not create them in response to a DOL audit letter. The “Sample Documents” section of this guide contains some model documents that health plan sponsors may use. Contact Fred Brown Insurance Brokerage for help in gathering other compliance documents.

Also, keep in mind that, during an audit, the DOL may request fewer documents or an employer may be subject to a more expansive document request, depending on the scope of the audit.

Type of Document	Maintained by Employer
Plan document (or insurance booklet/certificate for an insured plan)	<input type="checkbox"/>
Summary plan description (SPD), including updates or summaries of material modifications (SMMs)	<input type="checkbox"/>
Forms 5500 and attachments, including supporting documentation (if applicable)	<input type="checkbox"/>
Summary annual reports (if required for plan)	<input type="checkbox"/>
List of all plan service providers and related contracts	<input type="checkbox"/>
All contracts with insurance companies	<input type="checkbox"/>
Open enrollment materials, including documents describing cost responsibilities for the employer and employees	<input type="checkbox"/>

Newborns' and Mothers' Health Protection Act notice (may be included in the SPD)	<input type="checkbox"/>
Women's Health & Cancer Rights Act notice	<input type="checkbox"/>
Annual Children's Health Insurance Program (CHIP) notice	<input type="checkbox"/>
Materials describing any wellness programs or disease management programs offered by the plan, including rewards based on a health factor	<input type="checkbox"/>
Documents showing compliance with HIPAA's portability rules, including certificates of creditable coverage, pre-existing condition exclusions and special enrollment rights	<input type="checkbox"/>
Documents showing compliance with COBRA, including general notice, election notice, notice of COBRA unavailability, notice of early termination and notice of insufficient payment	<input type="checkbox"/>
If the plan has grandfathered status under the ACA, documents that verify the plan's status and the notice of grandfathered plan status	<input type="checkbox"/>
If the plan has rescinded coverage, a list of those participants and dependents whose coverage has been rescinded, the reasons for the rescission and the notice of rescission	<input type="checkbox"/>
Plan provisions regarding lifetime and annual limits and the notice describing enrollment opportunities for individuals who previously lost coverage due to a lifetime limit	<input type="checkbox"/>
Summary of Benefits and Coverage and any 60-day advance notice of a mid-year material change to the plan	<input type="checkbox"/>
Exchange notice	<input type="checkbox"/>
For non-grandfathered plans, notice of patient protections and selection of providers	<input type="checkbox"/>
For non-grandfathered plans, information on the plan's claims and appeals procedures	<input type="checkbox"/>
A notice describing enrollment opportunities for children up to age 26 for plans with dependent coverage	<input type="checkbox"/>

AVAILABLE RESOURCES

The following resources are available from Fred Brown Insurance Brokerage regarding DOL audits and available correction programs:

- HR Insights: Handling a DOL Audit with Ease
- Health Care Reform: DOL Starts Auditing ACA Compliance
- Benefits Insights: Employee Benefit Plan Audits—Common Mistakes
- FAQs on the Delinquent Filer Voluntary Compliance Program
- Delinquent Filer Voluntary Compliance Program (DFVCP)

The following resources are available from Fred Brown Insurance Brokerage regarding compliance with federal employee benefit laws:

- Form 5500 Annual Return/Report of Employee Benefit Plan
- Employee Benefit Compliance Chart: Notice and Disclosure Rules
- Employee Benefits Compliance Checklist for Small Employers
- Mental Health and Substance Use Disorder Benefits: Parity Requirements
- HIPAA Portability Rules
- HIPAA Nondiscrimination Rules
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Health Care Reform Toolkit—Small Employers
- Health Care Reform Toolkit—Large Employers
- Health Care Reform: Compliance Checklist for Rescission of Coverage
- Health Care Reform: Compliance Checklist for SBC and Uniform Glossary Compliance
- Health Care Reform: Compliance Checklist for Preventive Services
- Health Care Reform: Compliance Checklist for Lifetime Limits and Annual Limits
- Health Care Reform: Compliance Checklist for Dependent Coverage to Age 26
- Health Care Reform: Compliance Checklist for Patient Protections
- Health Care Reform: Compliance Checklist for Determining Grandfathered Status
- Health Care Reform: Compliance Checklist for Internal Claims and Appeals and External Review
- Health Care Reform: Final Rules on Workplace Wellness Programs

SAMPLE DOCUMENTS

Health plan sponsors may use the sample documents on the following pages as a guide when crafting their health plan compliance documents. Many of these documents must be customized prior to being used. The following sample documents are provided:

- Newborns' and Mothers' Health Protection Act notice
- Women's Health and Cancer Rights Act—enrollment notice and annual notice
- Notice of Grandfathered Status
- Notice of Patient Protections
- Children's Health Insurance Program (CHIP) notice
- COBRA Notices
 - General Notice
 - Election Notice
 - Notice of Unavailability of COBRA Coverage
 - Notice of Early Termination of COBRA Coverage and Conversion Rights
- HIPAA Notices
 - Special Enrollment Notice
 - Certificate of Group Health Plan Coverage*
 - Notice of Pre-existing Condition Exclusion**
 - Determination of Creditable Coverage Notice**

* Beginning Dec. 31, 2014, the requirement to issue HIPAA Certificates will no longer apply due to the ACA's prohibition on pre-existing condition exclusions, which is effective for plan years beginning on or after Jan. 1, 2014.

** Effective for plan years beginning on or after Jan. 1, 2014, the ACA prohibits health plans from imposing pre-existing condition exclusions on any enrollees.

Also, the DOL has provided the following model **Exchange Notices**:

- [Model Notice to Employees of Coverage Options](#) for employers that do not offer a health plan; and
- [Model Notice to Employees of Coverage Options](#) for employers that offer a health plan to some or all employees.

Contact Fred Brown Insurance Brokerage for additional compliance documents, such as a sample SPD or a Summary of Benefits and Coverage template.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: *[insert deductibles and coinsurance applicable to these benefits]*. If you would like more information on WHCRA benefits, call your plan administrator at *[insert phone number]*.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at *[insert phone number]* for more information.

NOTICE OF GRANDFATHERED STATUS

This *[group health plan or health insurance issuer]* believes this *[plan or coverage]* is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your *[plan or policy]* may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at *[insert contact information]*. *[For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]*

NOTICE OF PATIENT PROTECTIONS

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally *[requires/allows]* the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. *[If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.]* For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the *[plan administrator or issuer]* at *[insert contact information]*.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from *[name of group health plan or issuer]* or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the *[plan administrator or issuer]* at *[insert contact information]*.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/
ALASKA – Medicaid	Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414

OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethiptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage **[choose and enter appropriate information: must pay or aren't required to pay]** for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to *[enter name of employer sponsoring the Plan]*, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;

- *[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;];* or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days *[or enter longer period permitted under the terms of the Plan]* after the qualifying event occurs. You must provide this notice to: *[Enter name of appropriate party]*. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]*

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have 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 COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan

as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other 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 can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

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 or call 1-800-318-2596. 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]***:

- | | |
|--|---|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> 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?

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date]*.

[Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].

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: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]*

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](#) or the [Children’s Health Insurance Program \(CHIP\)](#). You can access the Marketplace for your state at 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.

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 description or 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 *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]*.

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 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.

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

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.

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

- | 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

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 *[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment.

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 *[enter due day for each monthly payment]* for that coverage period. *[If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:].* 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'll be given a grace period of 30 days after the first day of the coverage period *[or enter longer period permitted by Plan]* 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 Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: 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:

[enter appropriate payment address]

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

[Enter date of notice]

To: *[Identify the covered employee, qualified beneficiary or other individual]*

From: *[Plan Administrator]*

The Plan Administrator of the company's group health plan was notified on *[insert date]* of the occurrence of a COBRA qualifying event, a second COBRA qualifying event or a determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary or other individual. However, the Plan Administrator has determined that you and your dependents, if any, are NOT ENTITLED to COBRA continuation coverage of the company's group health benefits. Thus, your coverage under the company's group health benefits will terminate on *[insert date]*.

The reason you are not entitled to COBRA continuation coverage is as follows:

[Describe reason]

If any of the individuals listed above does not reside at this same address, please immediately notify the Plan Administrator so that we may provide a copy of this notice to that individual.

Appeal Procedure

You may appeal this decision to deny your COBRA coverage if you believe your rights to COBRA continuation coverage have been improperly denied. The procedures to appeal this decision are as follows:

[Describe appeal procedure for plan.]

Other Coverage Options

You may have other coverage options available to you. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. More information on the Marketplace is available at: www.healthcare.gov. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Additional Information

Please contact the Plan Administrator immediately if you have questions about this notice or your COBRA rights. The Plan Administrator can be reached at *[insert contact information]*.

NOTICE OF EARLY TERMINATION OF COBRA COVERAGE AND CONVERSION RIGHTS

[Enter date of notice]

To: *[Identify the qualified beneficiary]*

From: *[Plan Administrator]*

Effective *[insert date]*, COBRA continuation coverage of your group health benefits will terminate. This termination is earlier than the end of the maximum period of COBRA continuation coverage that applies to your original qualifying event.

If any of the individuals listed above does not reside at this same address, please immediately notify the Plan Administrator so that we may provide a copy of this notice to that individual.

Reason for Early Termination of COBRA Coverage

Your COBRA continuation coverage is terminating before the end of the maximum coverage period due to *[check appropriate box]*:

- Coverage under another group health plan that does not limit or exclude pre-existing conditions of the individual
- Failure to pay required premium on time
- Termination of all company group health plans
- Eligibility for Medicare
- During a 29-month maximum coverage period based on disability, the Social Security Administration made a determination that the individual is no longer disabled
- Other *[describe other event]*

Conversion Rights

You may have the right to convert your group health benefits under COBRA to an alternative group or individual health insurance policy. The Plan Administrator can provide you eligibility information, enrollment forms and other information on your conversion rights. If you qualify for a conversion policy, you will have *[insert number of days]* to submit your insurance application and first premium once your COBRA coverage ends.

Appeal Procedure

Please notify the Plan Administrator as soon as possible if you believe the termination date of your COBRA coverage is inaccurate. You may request a review of this decision. The procedures to appeal this decision are as follows: *[Describe appeal procedure for plan.]*

Additional Information

Please contact the Plan Administrator immediately if you have questions about this notice or your COBRA rights. The Plan Administrator can be reached at *[insert contact information]*.

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact *[insert contact information]*.

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, the Affordable Care Act prohibits group health plans from imposing pre-existing conditions exclusions.

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. **Date of this Certificate:**
2. **Name of group health plan:**
3. **Name of participant:**
4. **Identification number of participant:**
5. **Name of individuals to whom this certificate applies:**
6. **Name, address and telephone number of plan administrator or issuer responsible for providing this certificate:**
7. **For further information, call:**
8. **If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10:**
9. **Date waiting period or affiliation period (if any) began:**
10. **Date coverage began:**
11. **Date coverage ended (or if coverage has not ended, enter "continuing"):**

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary

Statement of HIPAA Portability Rights

IMPORTANT—KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Pre-existing Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or

treatment was recommended or received within the six months before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption or placement for adoption.

Under the health care reform law, effective for plan years beginning on or after Sept. 23, 2010, a pre-existing condition exclusion cannot apply to an individual under age 19. For plan years beginning on or after Jan. 1, 2014, the law’s prohibition on pre-existing condition exclusions applies to all enrollees.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP) and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

⇒ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to Get Special Enrollment in another Plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into 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. (Additional special enrollment rights are triggered by marriage, birth, adoption and placement for adoption.)

⇒ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse’s plan), you should request special enrollment as soon as possible.

Prohibition against Discrimination Based Upon a Health Factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged to a similarly situated individual.

Right to Individual Health Coverage

Under HIPAA, if you are an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare or Medicaid, and you do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired or quit your job.

⇒ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State Flexibility

This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For More Information

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at: www.dol.gov/ebsa or www.cms.gov/HealthInsReformforConsumers.

HIPAA GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION

Pre-existing Condition Exclusion

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption. Effective for plan years beginning on or after Sept. 23, 2010, the pre-existing condition exclusion does not apply to enrollees who are under the age of 19. Also, effective for plan years beginning on or after Jan. 1, 2014, the plan's pre-existing condition exclusion does not apply to any enrollees.

Length of Pre-existing Condition Exclusion

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

Reduction of Pre-existing Condition Exclusion

You can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12- month (or 18 month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior health plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For More Information or Assistance

All questions about the pre-existing condition exclusion and creditable coverage should be directed to *[insert contact information for plan administrator]*

DETERMINATION OF CREDITABLE COVERAGE NOTICE

[Enter date of notice]

To: *[Insert individual's name and address]*

From: *[Insert Plan administrator's name and address]*

[Name of Health Plan] (the "Plan")

The Plan contains a pre-existing condition exclusion of 12 months (18 months if you are a late enrollee), which begins on the first day of coverage, or, if you were in a waiting period, on the first day of your waiting period. Your pre-existing condition exclusion period began on *[insert date]* (Enrollment Date).

Based upon the information you submitted to us regarding your prior creditable coverage, we have determined that you will satisfy your pre-existing condition exclusion period as of *[insert date]*.

We originally determined that your pre-existing condition exclusion period is 12 months (365 days), beginning on the Enrollment Date. Based upon the information provided to us, we determined that you have *[insert number]* days of creditable coverage. Upon reducing the 12-month pre-existing condition exclusion period, we determined that you are required to satisfy an additional *[insert number]* days. The plan has a right to modify this determination if it learns that the information provided to us and used to make this determination is not accurate.

In the event you were not covered by insurance for a period of more than 63 days, that prior coverage is no longer "creditable coverage" for purposes of reducing your pre-existing condition exclusion period. Time spent within a waiting period will not be taken into account when calculating the break in coverage.

During the pre-existing condition exclusion period, the plan will not pay benefits for any pre-existing condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period immediately preceding your Enrollment Date.

In the event you have additional coverage that you wish the plan to consider, please provide us with that additional information as soon as possible. If you have difficulty obtaining a Certificate of Coverage (HIPAA Certificate) for that additional coverage, please let us know and we will try to help you. You may show that you have additional coverage by means other than by a HIPAA Certificate.

You have a right to appeal this determination. You may send your appeal to *[insert address]*. Your appeal must be filed within 60 days of the date of this letter and should include additional facts which you feel should be considered during our review. We will respond to your appeal within 60 days. Our response will include the specific reasons for our determination and reference any specific plan provisions within the plan documents which support our decision.