BlueCross BlueShield of Texas

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 enrolled in 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 will lose coverage under the Plan because any of the following qualifying events happens:

- 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 enrolled in Medicare (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 health care coverage to retired employees, the following applies: 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 your employer, 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 with respect to the bankruptcy. 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee 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), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the 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 after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA QUALIFYING EVENTS

Who is Eligible?

Any individual who, on the day before a qualifying event, is covered under a group health plan either as the employee, the spouse of the employee, or the dependent child of the employee and loses coverage due to specific COBRA Qualifying Events. Individuals who are eligible are referred to as qualified beneficiaries. Each qualified beneficiary has a separate right to elect continuation coverage.

How Long Will COBRA Continuation Last?

Eighteen (18) months

Continuation of coverage may last up to a maximum of eighteen (18) months if the COBRA Qualifying Event is the termination of employment for any reason other than gross misconduct or due to a reduction in work hours causing loss of eligibility under the plan.

Thirty-six (36) months

Continuation of coverage for Dependents may last up to a maximum of thirty-six (36) months if the COBRA Qualifying Event is the death of the employee, divorce or separation from the covered employee, Medicare entitlement of the employee, or a child losing dependent status under the plan (such as an over age child).

Indefinite

Covered retirees, their spouses, surviving spouses and dependents of an employer, which has filed for Chapter XI bankruptcy are eligible for COBRA continuation coverage within one (1) year before or after the bankruptcy proceedings begin. NOTE: The maximum coverage period for a qualified beneficiary of the retiree, which terminates upon the qualified beneficiary's death or the date that is thirty-six (36) months past the death of the retired covered employee.

Social Security Disability Extension (if applicable)

Twenty-nine (29) months – Disability Extension Only

Continuation of coverage may last up to a maximum of twenty-nine (29) months if any of the qualified beneficiaries is determined by the Social Security Administration to be disabled. The disability must have occurred prior to the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. Notice of the determination of disability must be provided within sixty (60) days of receipt of this notice and before the end of the eighteen (18) month period. Each qualified beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if the qualified beneficiary is deemed disabled and may be charged up to 150% of the applicable cost for the additional eleven (11) months of coverage. To apply for your Social Security Disability extension, please contact Customer Service at **(800) 521-2227** for further details.

COBRA SECOND QUALIFYING EVENTS

Who is Eligible?

Any dependent of a qualified beneficiary covered under the plan at the time of the second qualifying event.

How Long Will the Second Qualifying Events for COBRA Continuation Last?

Thirty-six (36) months

A thirty-six (36)-month extension of coverage will be available to spouses and dependent children who elect continuation of coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months from the date of the second qualifying event. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee is becoming entitled to Medicare benefits under Part A and/or Part B, or a dependent child is ceasing to be eligible for coverage

as a dependent under the plan. These events can be a COBRA second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the COBRA first qualifying event had not occurred. Notice of a second qualifying event must be given within sixty (60) days after the event occurs

Termination of COBRA coverage

A qualified beneficiary's right to COBRA continuation of coverage will be terminated when:

- Any required premium is not paid in full on time;
- The qualified beneficiary becomes covered, after election of COBRA, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary or dependent(s);
- The qualified beneficiary becomes entitled to Medicare Part A and/or Part B after electing continuation of coverage;
- The employer ceases to provide any group health plan for its employees.

How to Apply?

The covered employee or qualified beneficiary is required to notify the employer or plan administrator of the qualifying event occurrence within sixty (60) days after the date of the event or the date of loss of coverage. Complete the attached application sign and return to Customer Service.

NOTICE TO GROUP ADMINISTRATOR

ALL APPLICATIONS SUBMITTED WITHOUT A SIGNATURE OF BOTH THE BENEFICIARY AND THE GROUP ADMINISTRATOR WILL BE RETURNED.

BlueCross BlueShield of Texas

P.O. Box 655730
Dallas, Texas 75265-5730

COBRA - Continuation of Coverage Application

To: Group Membership Department

From: Group Name _____ Group/Section Number:_____

Part I
Application For COBRA First Qualifying Event

Name of Subscriber: _____

Name of Applicant (if not Subscriber): _____

Social Security number of Applicant (if not Subscriber): _____

Individual number(s) under which applicant had coverage: Health _____ Dental _____

Select Coverage being applied for: ☐ Health ☐ Dental

Applicant is requesting continuation of coverage pursuant to COBRA due to the following reason (check applicable box):

1. Continued coverage for a maximum of **eighteen (18) months** due to employee's reduction in work hours, retirement or termination on _____. (Specify last workday)
   Coverage requested for:
   - ☐ Employee and all dependent(s) listed on prior group coverage.
   - ☐ Employee and specific dependent(s) listed on prior group coverage.
   - ☐ Employee only **(Please Complete the Enrollment Application/Change Form to drop dependents - Required)**
   - ☐ Dependent(s) only, if listed on prior group coverage - **(Please Complete the Enrollment Application/Change Form - Required)** Should a dependent with continued coverage for a maximum of **eighteen (18) months** experience a second qualifying event during this period, they may be eligible to extend their coverage. See the reverse side of this form for details.
2. Dependent coverage continuation for a maximum of **thirty-six (36) months** due to the following **(Please Complete the Enrollment Application/ Change Form - Required)**:
   - ☐ Death of employee on _____.
   - ☐ Finalized date of divorce from employee on _____.
   - ☐ Dependent child ceasing to meet the dependent requirements of your group contract (e.g. age limit). Please give the reason and date of loss of dependency status:

     _____ _____
     (Reason) (Date)
   - ☐ Employee's coverage cancelled as a result of becoming entitled to Medicare benefits on _____. Only dependent coverage to be continued.
3. ☐ Continued coverage as a result of the employer filing a Title XI bankruptcy proceeding on _____ as long as the employer continues to provide coverage for any of its employees. Applicant must have been covered as an employee, dependent, a retiree, a dependent of a retiree, or a surviving spouse of a retiree.

Are you or any member of your family covered by:

A. Medicare: ☐ Yes ☐ No **OR**

B. Any other group Health or Dental Plan: ☐ Yes ☐ No

Type of Other Group Coverage: ☐ Health ☐ Dental

Effective Date of Other Coverage: _____

If the answer to A or B is Yes, please complete the remainder of this section:

Name of Subscriber:	Date of Birth:	Relationship to Applicant: ☐ Self ☐ Spouse ☐ Child
Group/Policy Number:	ID Number:	
Name(s) of Person(s) Covered: _____		
Name and Address of Other Health Care or Dental Carrier: _____ _____	Phone Number: _____ _____	Other Group Employer's Name: _____ _____

I have read this Application for COBRA continuation of coverage, and I certify the information stated hereion is correct. I understand that coverage under any ***other group health plan*** *(which does not contain any applicable exclusion or limitation with respect to any pre-existing condition) or* ***entitlement to Medicare will terminate the continued coverage. I also understand this application does NOT provide any life or disability insurance coverage****.*

I understand that Blue Cross and Blue Shield of Texas' use or disclosure of individually identifiable health information whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulation under HIPAA (Health Insurance Portability and Accountability Act of 1996).

_____ _____

Applicant Signature Date

_____ _____ _____ _____

Applicant's Home Address Number and Street Name City State ZIP

See below for COBRA second qualifying event.

Part II
Application For COBRA Second Qualifying Event

Name of Subscriber: _____

Name of Applicant (if not Subscriber): _____

Social Security number of Applicant (if not Subscriber): _____

Identification number(s) under which applicant had coverage: Health _____ Dental _____

Select Coverage being applied for: ☐ Health ☐ Dental

Applicant is requesting an extension of continued coverage due to the occurrence of a second qualifying event during the **eighteen (18) -month** period of continued coverage. If approved, the Applicant will be entitled to continued coverage for a period (which began on the effective date of the continued coverage) not to exceed **thirty-six (36) months**. The second qualifying event was the following **(Please Complete the Enrollment Application/ Change Form - Required)**:

☐ Finalized date of divorce from employee: _____ .

☐ Death of former employee on: _____ .

☐ Dependent child ceasing to meet the dependent requirements of the group contract. Please give reason and date of loss of dependency status:

_____ _____

(Reason) (Date)

☐ Former Employee's coverage cancelled as a result of being entitled to Medicare Benefits on _____ . Only dependent coverage to be continued.

Are you or any member of your family covered by: **A.** Medicare: ☐ Yes ☐ No **OR**

B. Any other group Health or Dental Plan: ☐ Yes ☐ No

Type of Other Group Coverage: ☐ Health ☐ Dental

Effective Date of Other Coverage: _____

If the answer to A or B is Yes, please complete the remainder of this section:

Name of Subscriber:	Date of Birth:	Relationship to Applicant: ☐ Self ☐ Spouse ☐ Child
Group/Policy Number:	ID Number:	
Name(s) of Person(s) Covered: _____		
Name and Address of Other Health Care or Dental Carrier: _____ _____	Phone Number: _____ _____	Other Group Employer's Name: _____ _____

I have read this Application for COBRA continuation of coverage, and I certify the information stated hereion is correct. I understand that coverage under any ***other group health plan*** *(which does not contain any applicable exclusion or limitation with respect to any pre-existing condition) or* ***entitlement to Medicare will terminate the continued coverage. I also understand this application does NOT provide any life or disability insurance coverage****.*

_____ _____

Applicant Signature Date

_____ _____ _____ _____

Applicant's Home Address Number and Street Name City State ZIP

I have read this Application for state continuation of coverage and the information stated hereoin is correct. I understand that substantially similar coverage under any other health policy or contract will terminate the continued coverage and I certify that no one applying for the continued coverage has obtained such other health coverage. I also understand this application does NOT provide any life or disability insurance coverage.

---------- For Group Representative Use Only ----------
I certify that the applicant and dependents (if applicable) are eligible to apply for continued coverage.
_____ _____ Signature of Group Representative Date

PLEASE NOTE

This application must be signed by BOTH the APPLICANT AND THE REPRESENTATIVE of the Group, or the Application will be returned.