
## GENERAL NOTICE - INFORMATION ABOUT CONTINUATION RIGHTS UNDER COBRA

### Introduction

You are receiving this notice because you have recently become covered under a group health 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 can become available to you when you would otherwise lose your group health coverage. COBRA continuation coverage can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either 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 it 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 who are covered under the Plan could become qualified beneficiaries if coverage under the Plan is lost because of a 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 will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) 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 will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both); or
(5) 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:

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

If you lose group coverage in anticipation of one of the above events (for example, your spouse terminates your coverage in anticipation of a divorce, but before the divorce becomes final) you may have the right to elect COBRA continuation coverage, beginning on the date of the actual “qualifying event” even though you did not actually maintain coverage when that event occurred.

If coverage is provided by the Plan to retirees, 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 the group health 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 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 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, or if the Plan provides retiree health coverage: commencement of a proceeding in a bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (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**

If you and your spouse divorce or legally separate or if a dependent child loses eligibility for coverage as a dependent child, you must notify the Plan Administrator within 60 days. If you do not provide this notice within 60 days after the qualifying event occurs, COBRA continuation coverage will not be available to the person losing coverage. Notice needs to be made in writing and sent to the Plan Administrator (address provided at the bottom of this letter).

**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, i.e. you, your spouse and/or children covered under the Plan. 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, entitlement of the employee to Medicare benefits (Part A, Part B, or both), the employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts for up to 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). If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military (Rights under USERRA). 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.

Notwithstanding the preceding paragraphs, if the Plan is a health flexible spending account (FSA), you will not be allowed to continue coverage under the Plan (except as required by Federal law) for any subsequent plan year because the expected contributions will exceed the maximum benefit available under the Plan for that entire year. Further, you will be allowed to continue coverage for the current year only if the maximum amount that you are required to pay does not exceed the maximum benefit available under that Plan for the remainder of the plan year in which the qualifying event occurred.

There are two ways in which the 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 must have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. This notice should be made in writing and sent to the Plan Administrator (address provided at the bottom of this letter) within 60 days of the Social Security Administration's determination of disability. If you do not timely provide the notice, this extension will not be available to you or your family.

**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, up to 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 any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (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 do not notify the Plan in writing within 60 days of the qualifying event, this extension will not be available to your family. Again, this notice needs be made in writing and sent to the Plan Administrator (address provided at the bottom of this letter).

**Premium assistance availability under ARRA**

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act 2010 (TEA), and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period of September 1, 2008 through May 31, 2010 or a qualifying event that is a reduction of hours occurring at any point from September 1, 2008 through May 31, 2010 that is followed by a termination of employment on or after March 2, 2010 and by May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

For general information about the ARRA Premium Reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator identified below. For more information about your rights under the Employee Retirement Income Security Act (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 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**

Choice Employer Solutions
9007 Brittany Way
Tampa, FL 33619
Phone: 813-643-4000

## The HIPAA Law (Required Notice)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted into law, and we want you to know about some of its provisions as they may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). HIPAA's provisions fall into these areas:

**1.** Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.
Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

**2**. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

**3.** In addition to changing some of the COBRA requirements, HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations.

**4.** If you were covered by a group health plan(s) prior to your employment with us, your previous employer/insurance carrier should have provided you with a Certificate of Creditable Coverage (form required by HIPAA law that describes the health coverage for you and your dependents, if any, have or had, and the dates you were covered). IF YOU HAVE NOT RECEIVED A CERTIFICATE OF CREDITABLE COVERAGE, PLEASE CONTACT YOUR FORMER EMPLOYER. Once you deliver the Certificate of Creditable Coverage to us, your entitlement to restriction from pre-existing condition exclusions in our group health plan(s), as long as you had twelve months of creditable coverage (eighteen months if a late enrollment) and have not had more than a sixty-three day gap in coverage.

**5.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997.
HIPAA coordinates COBRA coverage with these new limits as follows. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your preexisting conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

**6.** If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Group Health Plan may terminate your COBRA coverage.

If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact our office in writing.

## Women's Health and Cancer Rights Act Notice (HIPAA REQUIREMENT)

“Did 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 reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator for more information.”

### What is the Women's Health and Cancer Rights Act (WHCRA)?

The Women's Health and Cancer Rights Act (WHCRA) was signed into law on October 21, 1998. The law includes important protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

### I have been diagnosed with breast cancer and plan to have a mastectomy. How will WHCRA affect my benefits?

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

**Will WHCRA require all group health plans, insurance companies and HMOs to provide reconstructive surgery benefits?**

All group health plans, and their insurance companies or HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of WHCRA.

**Under WHCRA, may group health plans, insurance companies and HMOs impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy?**

Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

### When do these requirements take effect?

The reconstructive surgery requirements apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator. These requirements also apply to individual health insurance policies offered, sold, issued, renewed, in effect, or operated on or after October 21, 1998. These requirements were placed in the PHS Act within the jurisdiction of the Department of Health and Human Services.

**My state requires the coverage for breast reconstruction that is required by WHCRA and also requires minimum hospital stays in connection with a mastectomy that are not required by WHCRA. If I have a mastectomy and breast reconstruction, am I also entitled to the minimum hospital stay?**

It depends. The federal WHCRA permits state law protections to apply to certain health coverage. State law protections apply if the state law is in effect on October 21, 1998 (date of enactment of WHCRA) and the state law requires at least the coverage for reconstructive breast surgery that is required by the federal WHCRA.

If state law meets these requirements, then it applies to coverage provided by an insurance company or HMO ("insured" coverage). If you obtained your coverage through your employer and your coverage is "insured," you would be entitled to the minimum hospital stay required by state law. If you obtained your coverage through your employer but your coverage is not provided by an insurance company of HMO (that is, your employer "self-insures" your coverage), then state law does not apply. In that case, only the federal WHCRA applies and it does not require minimum hospital stays. To find out if your group health coverage is "insured" or "self-insured," check your Summary Plan Description (SPD) or contact your plan administrator.

**If you obtained your coverage under a private individual health insurance policy (not through your employer), check with your State Insurance Commissioner's Office to learn if state law applies.**