****COBRA CONTINUATION COVERAGE ELECTION NOTICE****
Henrico County Human Resources Department
P.O. Box 90775, Henrico, VA 23273-0775
(804) 501-4355 or (804 501-7371

This notice contains important information about your right to continue your health, dental and/or flexible spending coverage in the Henrico County plans (the Plans). Please read the information contained in this Notice and the attached Election Forms very carefully. This notice provides important information concerning your rights and what you have to do to continue your health, dental and/or flexible spending coverage under the Plan(s). If you have questions concerning the information in this notice or your rights to coverage, you should contact the Henrico Human Resources Department, P.O. Box 90775, Henrico, VA 23273-0775, (804) 501-4355 or (804) 501-7371.

If you do not elect to continue your health dental and/or flexible spending coverage by completing the enclosed "Election Form(s)" and returning it to us, your coverage under the health and/or dental Plan(s) will end on**:**
(If applicable, see flexible spending election form for coverage end dates.)

*Reason for coverage ending***:**

Each of the following persons is a "qualified beneficiary" and is entitled to elect to continue health, dental and/or coverage under the Health FSA:

Names - Coverage

Because of the event (listed above) that will end your coverage under the Plan(s), the person(s) identified above are entitled to continue health, dental and/or flexible spending coverage. If you elect COBRA coverage, your continuation coverage for health and/or dental will begin **on** and can last **until** . (If applicable, see flexible spending election form for coverage dates.)

You are entitled to continue coverage under the following plan(s):
Health: plan name
Dental: plan name
Flexible:
R*ates are listed on a separate page.*

IMPORTANT – To elect continuation coverage you MUST complete the enclosed "Election Form(s)" and return it to us. You may mail it to the address shown on the Election Form or bring it to the Human Resources Department at the Administration Building of Henrico County's Western Government Center at Parham and Hungary Spring Roads. The completed Election Form(s) must be received by . If you do not submit a completed Election Form(s) by this date, you will lose your right to elect continuation coverage.

If you have any questions about this notice or your rights to COBRA continuation coverage, contact:

Henrico County Human Resources Dept.
804-501-4355
Bal02@co.henrico.va.us

COBRA CONTINUATION COVERAGE ELECTION FORM
Health Care Coverage

name

IMPORTANT: This form **must** be completed and returned by mail or delivered by**:** . If you do not submit a completed Election Form by this date, you will lose your right to elect COBRA. If you reject COBRA before the due date, you may change your mind as long as you furnish 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 furnish the completed Election Form.

Send completed form to:

Henrico Human Resources Department
P.O. Box 90775, Henrico, VA 23273-0775
(804) 501-4355 or (804) 501-7371

I (We) elect to continue coverage in **the** plan as indicated below:

Name	Date of Birth	Relationship to Employee	SSN

a.____

b.____

c.____

d.____

Type of health care coverage elected (check only one): *All rates are listed on a separate page*

☐ Single
☐ Single and Family
☐Single and Child
☐ Single and Children
☐ Single and Spouse

______________________________ Signature
______________________________ Date

______________________________ Print Name
______________________________ Relationship to individual(s) listed above

______________________________ Street Address
______________________________ Telephone Number

______________________________ City, State, Zip

Your enrollment will be held until we receive your first payment. We must receive your first payment within 45 days of the date you sign this election form. Monthly payments are due on the first of each month. If your first payment or any subsequent monthly payment is not received on time, you will lose your option to continue coverage. You have a 30-day grace period to pay subsequent premiums. Your check or money order should be made payable to: County of Henrico.

COBRA CONTINUATION COVERAGE ELECTION FORM
<u>Dental Coverage</u>

name

IMPORTANT: This form **<u>must</u>** be completed and returned by mail or delivered by**:** . If you do not submit a completed Election Form by this date, you will lose your right to elect COBRA. If you reject COBRA before the due date, you may change your mind as long as you furnish 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 furnish the completed Election Form.

Send completed form to:

Henrico County Human Resources Department
P.O. Box 90775, Henrico, VA 23273-0775
(804) 501-4355 or (804) 501-7371

I (We) elect to continue coverage in the as indicated below:

	Name	Date of Birth	Relationship to Employee	SSN
a.				
b.				
c.				
d.				

Type of dental coverage elected (check only one): *All rates are listed on a separate page*

- ☐ Single
- ☐ Single and Family
- ☐ Single and Child
- ☐ Single and Spouse

Signature ____________________ Date ____________________

Print Name ____________________ Relationship to individual(s) listed above ____________________

Street Address ____________________ Telephone Number ____________________

City, State, Zip ____________________

<u>Your enrollment will be held until you have paid your first payment</u>. We must receive your first payment within 45 days of the date you sign this election form. Monthly payments are due on the first of each month. If your first payment or any subsequent payment is not received on time, you will lose your option to continue coverage. You have a 30-day grace period to pay subsequent premiums due. Your check or money order should be made payable to: County of Henrico.

COBRA CONTINUATION COVERAGE ELECTION FORM
<u>Health Care Flexible Spending Accounts</u>

IMPORTANT: This form **must** be completed and returned by mail or delivered **by:**

If you do not submit a completed Election Form by this date, you will lose your right to elect COBRA. If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. In that event, however, your COBRA continuation coverage will begin on the date you furnish the completed election form, and will **not** be retroactive to the date you lost coverage due to your qualifying event.

Send completed form to:
Henrico County Human Resources Department
P.O. Box 90775, Henrico, VA 23273-0775
(804) 501-4355 or (804) 501-7371

You are eligible to continue coverage under the County's Health Care Flexible Spending Account plan from the date your active coverage ends through the end of the Plan Year **December 31, 2009** by making payments on an AFTER-TAX basis.

If you have funds remaining in your Health Care Flexible Spending Account for the plan year but you have not incurred qualified expenses prior to your coverage termination date, you will lose those funds unless you elect to participate in continuation coverage.

If you elect to participate, your benefits under the County's Health Care Flexible Spending Account (FSA) Plan will be continued until the earlier of the following:

- The end of the Health Care FSA Plan Year (shown above);
- The date you fail to pay the required premium on time;
- The date the County of Henrico terminates its Health Care FSA Plan.

Before termination of your coverage, you had elected **$** for your annual health care flexible spending account, for which you were contributing **$** per pay period through a payroll deduction. You have the right to continue the amount that you have remaining in your health care FSA by continuing to pay the above amount plus a 25 administrative fee. I you elect to continue coverage, a monthly payment of **$** will be required. The initial premium payment covers the period from the date coverage terminates to 60 days from the date of this notice.

We must receive your first payment within 24 days of the date you sign this election form. Monthly payments are due on the first of each month. If your first payment or any subsequent monthly payment is not received on time, you will lose your option to continue coverage. You will have a 30-day grace period to pay premiums due. Your check or money order should be made payable to: County of Henrico.

I wish to continue my participation in the:

Health Care Flexible Spending Account Plan	_____yes	_____no
My first payment is enclosed	_____yes	_____no
I will make my first payment within 45 days	_____yes	_____no

_______________________________________ Signature

_____________________ Date

_______________________________________ Print name

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is COBRA continuation coverage?

Federal law known as "COBRA" requires that most group health, dental and health care FSA plans give employees and their families the opportunity to continue their coverage in these plans when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the Plans, as well as the covered employee's spouse and dependent children.

Certain newborns, newly adopted children and alternate recipients under qualified medical child support orders (QMCSO'S) may also be qualified beneficiaries with a right to purchase COBRA continuation coverage. In addition, in certain cases a person, such as the employee's former spouse, may purchase coverage for dependents he or she acquires while purchasing COBRA continuation coverage. This is discussed in more detail in separate paragraphs below.

Continuation coverage is the same coverage that is given to other participants or beneficiaries under the Plan(s) who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan(s) as other participants or beneficiaries covered under the Plan(s), including open enrollment and special enrollment rights. The persons listed on page one of this notice have been identified by the Plan(s) as qualified beneficiaries entitled to elect continuation coverage. Specific information describing the health care Plans' continuation coverage policies can be found in the Plan's Certificate of Insurance (COI) or Evidence of Coverage (EOC). The information can be obtained from Southern Health Services, Inc. (mailing address: 9881 Mayland Drive, Richmond, VA 23233; phone: 866-533-5149). The Summary Plan Descriptions (SPDs) for dental coverage (all PPO plans) can be obtained from Henrico County Human Resources Department, P.O. Box 90775, Henrico, VA 23273-0775 or by calling (804)501-7371. Specific information about the health care FSA can be found in the County of Henrico, Virginia Flexible Benefits Plan. A copy of this plan can be obtained from the Henrico County Human Resources Department (mailing address: P.O. Box 90775, Henrico, VA 23273-0775; phone 804-501-7371).

How long will continuation coverage last for medical and dental plans?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to **18 months.** In the case of losses of coverage due to an employee's death, divorce, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to **36 months**. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated **before** the end of the maximum period if after electing COBRA continuation coverage: (1) premiums are not paid on time. (2) A qualified beneficiary becomes covered under another group plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. (3) covered employee enrolls in Medicare. (4) employer ceases to provide any group health and/or dental plans for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify Henrico County Human Resources in writing within 31 days if after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare. You must use the notice procedures specified in the section "Notification Procedures." If you fail to provide this notice to Henrico Human Resources, the plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the date of commencement of other group plans or Medicare entitlement.

How can you extend the length of continuation coverage for Medical and Dental Plans?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled (as determined by the Social Security Administration) or a second qualifying event occurs. You must timely notify in writing the Henrico County Human Resources Department of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. Use the procedures specified in “Notice Procedures” stated on the following page.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled as of the date of the qualifying event or at some time during the first 60 days of continuation coverage, and you must notify the Henrico County Human Resources Department of that fact within 60days of the SSA’s determination and before the end of the first 18 months of continuation coverage. You must notify Henrico County Human Resources of the fact **in writing,** using the procedures specified in “Notice Procedures,” **within 60 days** after SSA’s determination or the date of the qualifying event or the date you lose coverage due to the qualifying event, whichever date occurs last. In any event you must provide your notice before the end of the first 18 months of continuation coverage. If these procedures are not followed or if a **written notice** of a disability is not provided to Henrico Human Resources within the required period, **there will be no extension of COBRA on account of the disability.** All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Henrico County Human Resources Department of that fact **in writing** within 30 days of SSA’s determination. Use the procedures specified in “Notice Procedures” stated on the following page. COBRA coverage for all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA’s determination that the qualified beneficiary is no longer disabled. If you fail to timely notify Henrico Human Resources of the SSA’s determination the plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months (measured from the first qualifying event). Such second qualifying events include: (1) death of a covered employee (2) divorce from the covered employee (3) the covered employee’s enrolling in Medicare (4) a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan(s). Please note, however, that these events are considered a second qualifying event only if they would have caused the qualifying beneficiary to lose coverage under the plan if the first qualifying event had not occurred. You must notify the Henrico County Human Resources Department **in writing within 60 days** after a second qualifying event occurs or the date coverage under the plan is lost, whichever occurs last. Use the procedures specified in “Notice Procedures” stated on the following page. If these procedures are not followed or if a **written notice** of a second qualifying event is not provided to Henrico Human Resources with the required period, **there will be no extension of COBRA due to a second qualifying event.**

Medicare Extension for Spouse and Dependent Children

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months **after** the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and dependent children is **36 months** from the date the employee became entitled to Medicare (but the covered employee’s maximum coverage period will be 18 months).

How long will continuation coverage last for Health Care FSA?

If you have funds remaining in your Health Care FSA on your coverage termination date, you and/or your dependents may elect to continue coverage under the County’s Health Care FSA plan through the end of the Plan Year.

****Notice Procedures****

Any notice that you provide must be **in writing.** Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to Henrico Human Resources. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- The name of the health care plan or plans to which the notice pertains,
- The name and address of the employee covered under the plan,
- The name(s) and address(es) of the qualified beneficiary(ies), and
- The type of qualifying event and the date it happened

Your notice of a **second qualifying event** also must name the type of second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. Your notice of **disability** must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the SSA made its determination. Your notice of disability must include a copy of the SSA's determination.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan(s). A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. If you choose not to continue your group health and/or dental coverage, your future rights to coverage under federal law will be affected. 1. You can lose the right to avoid having pre-existing condition exclusions applied to you by group health and/or dental plans if you have more than a 63-day gap in health and/or dental coverage. An election of continuation coverage may help you not have such a gap. 2. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. 3. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health and/or dental plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health and/or dental coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health dental and/or health care FSA plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. In the case of an extension of continuation coverage due to a disability, the payment may not exceed 150% of the cost to a similarly situated participant or beneficiary. The required payment for continuation coverage is listed on the Rate Sheet accompanying this notice.

When and how must payment for continuation coverage by made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for coverage with the Election Form. However, you must make your first payment for continuation coverage within **45 days** after the date of your election. (This is the date the Election Notice is signed.) Be aware that your enrollment in continuation coverage will be held until your first payment is made. **If you do not make your first payment for continuation coverage within 45 days, you will lose all coverage rights under the Plan(s).** Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan(s) would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of you first payment is enough to cover this entire period. Contact the Henrico County Human Resources Department (phone: 804-501-4355 or 804-501-7371) to confirm the correct amount of your first payment. Payment for continuation coverage should be sent to:

Henrico County Human Resources Department, P.O. Box 90775, Henrico, VA 23273-0775

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to pay for each subsequent month of coverage. Under the Plan(s), these periodic payments for continuation coverage are due on the first of the month of coverage. If you make a periodic payment on or before its due date, your coverage under the Plan(s) will continue for that coverage period without any break. Henrico County Human Resources Department will send a confirmation and premium information once your Election Form is received. The plan will not send periodic notices of payments due. You must make your payment by the due date or within the grace period.

Grace periods for periodic payments
Although periodic payments are due on or before the first of the month, you will be given a grace period of 30 days to make each periodic payment. Continuation coverage will be provided for each coverage period as long as payment for the coverage period is made before the end of the grace period. If you fail to make a periodic payment before the end of the grace period, you will lose all rights to continuation coverage under the Plan(s).

Same rights as active employees to add new dependents
A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact Henrico County Human Resources for more information. See also the paragraph below titled. "*Children Born to or Placed for Adoption with the Covered Employee During COBRA Period*," for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves.

Children born to or placed for adoption with the covered employee during the COBRA period
A child born to, adopted by or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, the covered employee or former employee is a qualified beneficiary and the employee has elected COBRA continuation coverage for themselves. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy applicable plan eligibility requirements (for example, age requirements).

Alternate recipients under Qualified Medical Child Support Orders
A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by Henrico County Human Resources during the employee's period of employment is entitled to the same rights under COBRA as a dependent child of the employee, regardless of whether that child would otherwise be considered a dependent.

More Information About Health Flexible Spending Account COBRA Coverage
The monthly COBRA premium for coverage under a health flexible spending account ("FSA") is 102% of the monthly contribution the employee was paying before the date of the qualifying event. The health FSA COBRA premium must be paid by check, with after-tax dollars. COBRA coverage will consist of the health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). COBRA coverage will terminate at the end of the flexible benefit plan's plan year. Unless otherwise elected, the spouse and dependents of the person electing COBRA will be covered too. Each Beneficiary has separate election rights and could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate health FSA annual limit and a separate premium.

Can you elect other health coverage besides continuation coverage?
If you are losing coverage under this plan because you are retiring from Henrico County:
You have the right to elect retiree health and/or dental coverage within 31 days of the end of your coverage as an active employee or within 31 days of your separation from payroll (if you were not covered as an active employee). If you elect retiree health care coverage on Henrico County's Plan(s), you will lose all rights to the continuation coverage described in this Notice. You should also note that if you enroll in Henrico County's retiree group health and/or dental coverage you may lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations if you cancel your retiree group health coverage or if retiree health and/or dental coverage is terminated (such as for non-payment of premiums). You must contact Henrico County Human Resources Department at 804-501-7371 if you wish to elect retiree health and/or dental coverage.

For more information
This notice does not fully describe continuation coverage or other rights under the Plan(s). For additional information/questions about continuation coverage and your rights under the Plan(s), contact Henrico County Human Resources Department. The Certificate of Insurance (PPO Plan) or Evidence of Coverage (HMO and POS Plans) for health care coverage can be obtained from Southern Health Services, Inc. 9881 Mayland Drive, Richmond, VA 23233. The Summary Plan Description (SPD) for dental coverage (all PPO plans) can be obtained from Henrico County Human Resources Department, P.O. Box 90775, Henrico, Va 23273-7032 or by calling (804) 501-7371. Information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health and/or dental plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Henrico County Human Resources Department 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 Henrico County Human Resources Department.