Due Date: _____

TO: _____

ADDRESS: _____

_____

FROM: Pamala Robinson, Employee Benefits Specialist
Allegany County Department of Human Resources & Personnel Services

RE: **HEALTH INSURANCE CONTINUATION COVERAGE**

DATE: _____

Under Public Law 99-272 (COBRA) you are eligible to continue coverage under the Allegany County Government Health Insurance.

According to County records you left as an employee:

Month: _____

Year: _____

Under COBRA you are eligible to continue coverage until:

Month: _____

Year: _____

Length of continued coverage: _____ months

Attachments

TITLE: COBRA COMPLIANCE

DATE: _____

TO: Terminated Employees and Their Dependents
Spouses and Dependents of Deceased Employees
Spouses and Dependents of Divorced Employees

This letter will serve as notice of your eligibility for continuation of your group health insurance benefits with Allegany County Commissioners.
(Please see attached documents).

Please complete the attached election form and return to the Plan Administrator no later than 60 days after coverage terminates.

Due Date: _____

The election form provides information on how much continued coverage will cost, what your coverage options are, when your payments are due, and where to send payments.

If you wish to decline this coverage, check the option to decline and promptly return the form to this office.

Election forms should be returned to:

Pamala Robinson, Employee Benefits Specialist
Allegany County Department of Human Resources and Personnel Services
701 Kelly Road, Suite 413
Cumberland, MD 21502

(301) 777-5979 ext. 9325

*ELECTION NOT TO CONTINUE MUST ALSO BE SENT TO THE ABOVE LISTED ADDRESS.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is generally 18 months. These 18 months may be extended for affected individuals to 36 months from the termination or reduction in hours of employment of other events (i.e., the employee's death, divorce, legal separation, or Medicare entitlement) occur during the original 18-month period. In no event will continuation last beyond 36 month from the date of the event that originally made an individual eligible to elect coverage.

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment (or, effective January 1, 1997, during the 60 day period thereafter). To benefit from this extension, you must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual also must notify the Plan Administrator within 30 days of any final determination that the individuals in no longer disabled.

However, the law also provides that your continuation coverage may be cut short for any of the following five (5) reasons:

1. The Employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have;
4. You become entitled to (that is, covered by) Medicare; or
5. Your extended coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

Effective January 1, 1997, children born to, or placed for adoption with, a covered employee during continuation coverage period also has the right to elect COBRA continuation coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation of coverage under COBRA is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively as you are determined ineligible.

Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the 18, 29 or 36-month continuation coverage period, you are allowed to enroll in an individual conversion health plan of otherwise provided under the Plan.

If there are any changes to your marital status, you or your spouse's address(es), or the dependent status of any of your children under the Plan, please notify the Plan Administrator immediately.

Please note that this Notice is merely a summary of a very complicated federal law. In the event of any inconsistency between this Notice and federal law, federal law will control. Also, please note that this Notice in not intended to inform you about any details of the Plan. You should contact the Plan Administrator regarding this matter.

INITIAL COBRA NOTICE

TO: All Employees Covered Under the Plan and Their Covered Spouse/Dependents

FROM: Allegany County Department of Human Resources and Personnel Services

RE: Continuation Coverage Requirements for Health Care Plans

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you in a summary fashion of your rights and obligations under the continuation coverage provisions of the law. (Both you and, if you are married, your spouse is covered by the plan. Your spouse should take time to read this Notice carefully.)

If you are an employee of the Employer and covered be the Employer's group health plan (called "the Plan" in this Notice), you have the right to choose this continuation coverage if you lose your group health coverage because of reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee and you are covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following four (4) reasons:

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

In the case of a covered dependent child of an employee, he or she has the right to choose continuation coverage if group health coverage under the Plan is lost for any of the following five (5) reasons:

1. The death of the employee;
2. The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment by the Employer;
3. The employee's divorce or separation;
4. The employee becomes entitled to (that is, covered) Medicare;
5. The dependent ceases to be a "dependent child" under the Plan.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, of a legal separation, or of a child losing dependent status under the Plan, within 60 days of the event. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment, or Medicare entitlement. (Similar rights may apply to certain retirees, spouses, and dependent children if the Employer commences a bankruptcy proceeding and these individuals lose coverage.)

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you; so that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.

If you do NOT choose continuation coverage, your group health insurance coverage will end.

PLEASE RETURN COMPLETED FORM TO: Due Date: _____

Allegany County Department of Human Resources & Personnel Services
701 Kelly Road, Suite 413
Cumberland, MD 21502
Attn: Pamala Robinson, Employee Benefits Specialist

Phone: (301) 777-5979 ext. 325

NOTICE OF RIGHT TO CONTINUE GROUP MEDICAL BENEFITS

TO RETAIN YOUR COVERAGE, THIS FORM MUST BE COMPLETED AND RETURNED TO THE EMPLOYER BY THE ABOVE DATE (60 days after the insurance would terminate).

Policyholder Name: _____

Address: _____

Group Number: _____

As an employee of the Allegany County Commissioners who is about to terminate, or has terminated coverage, I understand my right to elect or reject the option to continue group medical expense benefits under my Employer's Plan.

After being informed of my option to continue the group medical plan coverage for myself and my dependents, if any, I have chosen to:

Accept Hospital Coverage _____
Accept Drug Coverage _____

Decline Hospital Coverage _____
Decline Drug Coverage _____

Signature of Employee: _____ Date: _____

My spouse and dependents are eligible to continue their insurance upon the occurrence of the following events:

- Upon my Death
- When my spouse becomes legally separated or divorced from me
- When I become Medicare - eligible

Please circle if you accept or decline the following:

Spouse ACCEPTS/DECLINES Hospital Coverage
Spouse ACCEPTS/DECLINES Drug Coverage

Dependent ACCEPTS/DECLINES Hospital Coverage
Dependent ACCEPTS/DECLINES Drug Coverage

MONTHLY RATES

Monthly Rates – January 1, 2016 to December 31, 2016

Group 1901464-MD40 – Hospitalization and Drug Coverage (COBRA)

Individual	611.61
Parent/Child	1,267.78
Husband/Wife	1,671.18
Family	1,801.70

Group 1901465-MD20 – Hospitalization and Drug Coverage
(Retirees Under 65)

Individual	575.56
Parent/Child	1,207.40
Husband/Wife	1,628.65
Family	1,737.09

* A 2% Administration Fee is included in the total amount due.

** Rates are subject to change as the result of any benefit plan revision or rate change.

Your first payment will be due **AS BILLED** and subsequent payments are due quarterly on the **FIRST** day of each **Quarter**. Failure to remit this payment by the due date will result in **IMMEDIATE CANCELLATION** of the extension of coverage with no reinstatement allowed.