

Revised August 25, 2010

Model Continuation Coverage Election Notice
For use where coverage is subject to State Continuation Coverage requirements.

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). Please read the information contained in this notice very carefully.

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

If you do not elect continuation coverage, 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 |

Eligible employees are entitled to elect continuation coverage for themselves and their eligible dependents which will continue group health care coverage under the Plan for up to 12 months. If elected, 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 continuation coverage: [list available coverage options]].

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]. [Indicate whether any payment is due with the Election Form]. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact [enter name of party responsible for continuation coverage administration for the issuer, with telephone number and address].

Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Ohio law you have a limited number of days to decide whether you want to elect continuation coverage. Your employer must receive the request:

- (a) 10 days after the date your coverage would end if your employer has notified you of your continuation right prior to that date; or
- (b) 10 days after your employer notifies you of your right to continuation if the notice is given after the date your coverage ends; or
- (c) 31 days after your coverage ends if that date is earlier than the date you get notice under (b).

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 do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage 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 continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

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

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
<i>[Add if appropriate: Coverage option elected: _____]</i>			
b. _____			
<i>[Add if appropriate: Coverage option elected: _____]</i>			
c. _____			
<i>[Add if appropriate: Coverage option elected: _____]</i>			

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

State law requires group sickness and accident policies and group health insuring corporation contracts to provide continuation coverage to eligible employees, and their eligible dependents. You are an eligible employee if you have been covered under your former employer's health care coverage for the past three months, you were involuntarily terminated for other than gross misconduct and you are not covered by or eligible for coverage under Medicare or any other group health care coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, except that under state law the continuation coverage is not required to include benefits in addition to hospital, surgical or major medical coverage and prescription drug coverage if covered under the group policy or contract.

How long will continuation coverage last?

State continuation coverage lasts for twelve months. Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time,
- You become covered by or eligible for Medicare
- You become covered by or eligible for other group coverage
- The employer ceases to provide any group health plan 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).

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, 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 plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health 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?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. *[Insert general information regarding the cost of continuation coverage.]*

[If employees might be eligible for trade adjustment assistance, the following information must be added: 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. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.]

When and how must payment for continuation coverage be made?

[Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]

You may contact *[enter appropriate contact information for the party responsible for continuation coverage administration under the Plan]* to confirm the correct amount of your first payment.

Your first payment and all periodic payment(s) for continuation coverage should be sent to:

[enter appropriate payment address]

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from *[enter appropriate contact information for the party responsible for continuation coverage administration under the Plan]*.

If you have any questions concerning the information in this notice, or your rights to coverage you should contact *[enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address]*.

For more information about your rights under state law, contact the Ohio Department of Insurance at 1(800) 686-1526.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep *[enter name and contact information for the appropriate party responsible for continuation coverage administration under the Plan]* informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to *[enter the name of the party responsible for continuation coverage administration under the Plan]*.