

**ELIGIBILITY FOR  
CONTINUATION OF COVERAGE**

PLEASE COMPLETE & RETURN IF ELECTING COBRA

*As a retiree or vested member* you are eligible to retain your health, dental, vision and/or life insurance **with no time limitations** as long as your premiums are paid each month. If you elect to continue your coverage as retiree or vested member, please complete the required vesting or retirement insurance forms.

*As a COBRA participant* you are eligible to retain health, dental and/or vision for a **maximum time period of 18 months. Once you have reached the maximum 18 month limit there is no insurance coverage available through the Office of Management and Enterprise Services Employees Group Insurance Division.**

By signing this form, I acknowledge that I have read the above and understand the options regarding my continuation of insurance coverage. I cannot transfer coverage once my election is made.

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Signature

Date

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Social Security Number

# **IMPORTANT INFORMATION**

## **COBRA Continuation Coverage and Other Health Coverage Alternatives**

(Please read carefully and retain for future reference)

### **What is continuation coverage?**

Federal law requires that most group health plans, including this Plan, give employees and their families the opportunity to continue their health care coverage 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, or former employee, covered under the group health plan, the covered employee's spouse, and the covered employee's dependent children.

COBRA continuation coverage is the same coverage the Plan provides 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, including the option to enroll in or add coverage during Option Period enrollment.

### **How long will continuation coverage last?**

In the case of a loss of coverage due to the end of employment or reduction in hours of employment, coverage generally can be continued for up to a total of 18 months. In cases of loss of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits, or a dependent child ceasing to be a dependent under the terms of the Plan, coverage can be continued 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 until 36 months after the date of Medicare entitlement. The "COBRA Continuation Coverage Notice" lists the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- The required premium is not paid in full on time;
- A qualified beneficiary becomes covered under another group health plan;
- A qualified beneficiary becomes entitled to Medicare Part A and/or Part B; or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage can 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 I extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if you are disabled or a second qualifying event occurs. You must notify the Office of Management and Enterprise Services Employees Group Insurance Department (EGID) 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 your right to extend the period of continuation coverage.

### ***Disability***

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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. A copy of the SSA determination must be sent to EGID within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage. Each qualified beneficiary who has 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, the qualified beneficiary must notify the Plan of that fact within 30 days after the SSA determination.

### ***Second Qualifying Event***

An 18-month extension of coverage is 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. Such second qualifying events can include the death of the covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. The qualified beneficiary must notify the Plan in writing within 30 days after a second qualifying event occurs if you want to extend your continuation coverage.

### **How can I elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse can elect continuation coverage even if the employee does not. Continuation coverage can be elected for only one, several, or all dependent children who are qualified beneficiaries. A parent can elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

### **How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary is required to pay cannot exceed 102 percent or, in the case of an extension of continuation coverage due to a disability, 150 percent, of the cost to the group health plan, including both employer and employee contributions, for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in the "COBRA Continuation Coverage Notice." You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

### **What is the Health Insurance Marketplace?**

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copays) right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at [www.HealthCare.gov](http://www.HealthCare.gov). Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

### **When can I enroll in Marketplace coverage?**

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace because losing your Job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period ends and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov](http://www.HealthCare.gov).

## **If I elect COBRA continuation coverage, can I switch to coverage in the Marketplace? What if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?**

If you elect COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also terminate your COBRA continuation coverage early and switch to a Marketplace plan through a “special enrollment period” if you have another qualifying event such as marriage or birth of a child. If you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you are eligible to enroll in Marketplace coverage through a special enrollment period even if Marketplace open enrollment has ended. If you elect Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

## **Can I enroll in another group health plan?**

You may be eligible to enroll in coverage under another group health plan, such as your spouse's plan, if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage rather than enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

## **What factors should I consider when choosing coverage options?**

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102 percent of total plan premiums for COBRA coverage. Other options such as coverage on your spouse's plan or through the Marketplace may be less expensive.
- **Provider Networks:** If you are currently receiving care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a different network.
- **Drug Formularies:** If you are currently taking medication, a change in your health coverage may affect your costs for medications. In some cases, your medication may not be covered by another plan. You may want to verify if your current medications are listed in drug formularies for other health coverage.
- **Severance Package:** If you lost your job and receive a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA premiums for a period of time. In this scenario, you may want to contact the U.S. Department of Labor toll-free at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas, so you may not be able to use your benefits if you move to another area of the country. You may want to see if your plan has a service or coverage area or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage you probably pay copays, deductibles, coinsurance or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums but much higher deductibles and copays.

## **When and how must payment for COBRA continuation coverage be made?**

### ***First payment for continuation coverage***

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. This is the date the “COBRA Continuation Coverage Election Form” is postmarked, if mailed. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. **You are responsible for making sure that the amount of your first payment is correct.** To confirm the correct amount of your first payment, contact member services by mail at, Office of Management and Enterprise Services Employees Group Insurance Department, 3545 N.W.

58th St., Ste. 110, Oklahoma City, Oklahoma 73112, or call 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

### ***Periodic payments for continuation coverage***

After you make your first payment for continuation coverage, you are required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the "COBRA Continuation Coverage Notice". The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the 20th day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

### ***Grace periods for periodic payments***

Although periodic payments are due on the dates stated above, you are given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage is provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated back to the first day of the coverage period when the periodic payment is received. This means any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you may lose all rights to continuation coverage under the Plan.

**Your first payment and all periodic payments for continuation coverage should be sent to:**

**OMES EGID  
Member Accounts  
P.O. Box 58010  
Oklahoma City, Oklahoma 73157-8010**

### **For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the plan administrator.

If you have any questions concerning the information in this notice or your rights to coverage, or if you want a copy of your summary plan description, you should contact Member Services, Office of Management and Enterprise Services Employees Group Insurance Department by mail at 3545 N.W. 58th St., Ste. 110, Oklahoma City, Oklahoma 73112 or call 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

For more information about your rights under the *Employee Retirement Income Security Act* (ERISA), including COBRA, the *Patient Protection and Affordable Care Act*, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call toll-free 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace and to locate someone in your area who you can talk to about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep your plan informed of address changes**

In order to protect your and your family's rights, keep the plan administrator (OMES EGID) informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to OMES EGID.

# Monthly Premiums for COBRA Participants

Plan Year Jan. 1 – Dec. 31, 2016

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Aetna INTEGRIS HMO	\$ 526.14	\$ 862.68	\$ 277.15	\$ 441.88
BlueLincs HMO	\$ 607.25	\$ 995.93	\$ 320.04	\$ 510.18
CommunityCare HMO	\$ 812.06	\$ 1182.87	\$ 413.59	\$ 661.76
GlobalHealth HMO	\$ 509.76	\$ 752.43	\$ 275.38	\$ 449.68
HealthChoice High and High Alternative	\$ 537.42	\$ 674.44	\$ 272.85	\$ 420.97
HealthChoice Basic and Basic Alternative	\$ 405.78	\$ 498.15	\$ 232.38	\$ 358.16
HealthChoice High Deductible Health Plan (HDHP)	\$ 352.78	\$ 430.20	\$ 201.02	\$ 308.98
HealthChoice USA	\$ 822.61	\$ 822.61	\$ 270.16	\$ 416.63
HealthChoice FOCUS	\$ 537.42	\$ 674.44	\$ 272.85	\$ 420.97
DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Assurant Freedom Preferred	\$ 29.40	\$ 29.23	\$ 21.93	\$ 58.96
Assurant Heritage Plus with SBA (Prepaid)	\$ 11.97	\$ 9.04	\$ 7.75	\$ 15.50
Assurant Heritage Secure (Prepaid)	\$ 7.34	\$ 6.10	\$ 5.30	\$ 10.59
CIGNA Dental Care Plan (Prepaid)	\$ 9.45	\$ 6.18	\$ 7.22	\$ 15.63
Delta Dental PPO	\$ 34.31	\$ 34.29	\$ 29.85	\$ 75.52
Delta Dental PPO Plus Premier	\$ 45.41	\$ 45.41	\$ 39.56	\$ 100.02
Delta Dental PPO – Choice	\$ 15.36	\$ 34.86	\$ 35.13	\$ 85.27
HealthChoice Dental	\$ 32.64	\$ 32.64	\$ 27.95	\$ 69.56
VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Humana Vision Care Plan	\$ 7.28	\$ 12.71	\$ 11.12	\$ 12.08
Primary Vision Care Services (PVCS)	\$ 9.55	\$ 8.16	\$ 8.16	\$ 11.22
Superior Vision	\$ 7.55	\$ 7.51	\$ 7.10	\$ 14.59
UnitedHealthcare Vision	\$ 8.34	\$ 5.90	\$ 4.67	\$ 7.12
Vision Care Direct	\$ 16.22	\$ 9.93	\$ 9.93	\$ 13.26
Vision Service Plan (VSP)	\$ 9.69	\$ 6.49	\$ 6.24	\$ 13.99

EGID policy states that one person must always pay the primary member premium. When a spouse, child or children are insured under a particular benefit but the primary member did not keep that benefit, one person is always billed the primary member rate.



OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES  
EMPLOYEES GROUP INSURANCE DIVISION

**COBRA QUALIFYING EVENT NOTICE (Q. E. Notice)**

This notice must be sent with the COBRA Election Form if member or dependent elects COBRA.

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer name: \_\_\_\_\_ Group/Division number: \_\_\_\_\_

Employer address: \_\_\_\_\_

Insurance Coordinator: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date: \_\_\_\_\_ **Is the employee eligible to Vest / Retire? Yes\* \_\_\_ No \_\_\_**

**\*Insurance Coordinator: If yes, explain the options of both vesting/retirement and COBRA so the member can make an informed choice.**

***This employee and/or dependent(s) is entitled to continuation of coverage for the following reason (COBRA event):***

\_\_\_ Termination date\*\*: \_\_\_\_\_

\*\*Was employee terminated for gross misconduct? Yes \_\_\_ No \_\_\_

\*\*Was employee called to military duty (USERRA)? Yes \_\_\_ No \_\_\_

\_\_\_ Reduction of work hours - date: \_\_\_\_\_

\_\_\_ Death date: \_\_\_\_\_

\_\_\_ No longer an eligible dependent as of (date)\*\*\*: \_\_\_\_\_

\*\*\*Reason dependent is not eligible (**Required**): \_\_\_\_\_

Name and current mailing address of ineligible dependent(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Office of Management and Enterprise Services Employees Group Insurance Division**  
**COBRA CONTINUATION COVERAGE ELECTION FORM-Education or Local Government**  
(PLEASE PRINT)

NAME (COBRA Applicant) \_\_\_\_\_ SOCIAL SECURITY NUMBER (COBRA Applicant) \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

Coverage elections (please circle Yes or No):

HEALTH: Yes No DENTAL: Yes No

VISION: Yes No FLEXIBLE SPENDING ACCOUNT: Yes No

(NOTE: You may not change plans at this time; however, if you are on an HMO and move out of their service area, your coverage will default to HealthChoice High. Members residing outside Oklahoma and Arkansas may choose HealthChoice USA.)

PRIMARY CARE DOCTOR (if you are on an HMO) \_\_\_\_\_

PRIMARY DENTIST (if you are on a DMO) \_\_\_\_\_

**DEPENDENTS TO BE COVERED (Only if applicable)**

NAME	SSN	RELATION	SEX	BIRTHDATE	HEALTH (Yes/No)	DENTAL (Yes/No)	VISION (Yes/No)
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-Are you or any dependents to be covered on this plan covered by any other group insurance? Yes No

If yes, name of persons covered: \_\_\_\_\_

Name of Plan \_\_\_\_\_ Policy Number & Effective Date \_\_\_\_\_

-Are you or any dependents to be covered on this plan entitled to Medicare? Yes No

If yes, name of persons covered and effective date: \_\_\_\_\_

-Were you terminated for gross misconduct? Yes No

I understand that my eligibility will be determined upon the information stated on this form. I must notify the EGID if any changes occur which affect my eligibility. I understand that new dependents may be enrolled under limited circumstances. I understand all premiums from my active coverage must be paid in full to be eligible for COBRA continuation coverage.

I understand that all premiums due from the effective date of COBRA must be post-marked within 45 days following the date of signing this election form. Coverage will not be set up until premiums are received. To expedite coverage, you may submit premiums with this application.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**IMPORTANT INSTRUCTIONS:** To elect COBRA continuation coverage, complete this election form and return it to your Insurance Coordinator. Under federal law, you have at least 60 days after the date of this notice, \_\_\_\_\_, to decide whether you want to elect COBRA continuation coverage under the Plan. If you do not submit a completed election form by the due date shown below, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. Read and retain the important information about your rights.

This form must be completed and returned to your Insurance Coordinator either by mail or fax. It must be postmarked or faxed no later than: \_\_\_\_\_

Forward completed election form to your Insurance Coordinator at:

(FOR OFFICE USE ONLY)

Health Plan \_\_\_\_\_ Effective date \_\_\_\_\_

Dental Plan \_\_\_\_\_ Time limit \_\_\_\_\_

Vision Plan \_\_\_\_\_ Eligibility Ends \_\_\_\_\_

Total Premium \_\_\_\_\_ 1<sup>st</sup> Payment Due \_\_\_\_\_