«Print\_Date»

### «Subscriber\_Name»

«SBAD\_ADDR1»

«SBAD\_ADDR2»

«SBAD\_CITY», «SBAD\_STATE» «SBAD\_ZIP»

Dear: «Subscriber\_Name», «Spouse\_Name», «Dependent1», «Dependent2», «Dependent3»,

«Dependent4», «Dependent5», «Dependent6», «Dependent7», «Dependent8»

Colorado Continuation of Coverage (CCOC) Election Notice

**This notice contains important information about your right to continue your health care coverage in the «GRGR\_NAME» Group Health Plan (the Plan). Other health coverage alternatives may be available to you through the Health Insurance Marketplace.** 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 not recommence.

Each of the listed persons is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to the period of time that Colorado law provides under

C.R.S. 10-16-108.

If elected, continuation coverage will begin on **«CC\_Begin\_Date»** and can last no longer than 18 months from the date coverage was lost due to employment termination, change in marital or civil union status or the death of a covered employee*.*

***This plan may not cover you outside of Colorado. If you have moved outside of the State of CO, it is advisable to check with the Plan Administrator whether you will have coverage out of state, should you decide to elect to continue.***

## Based upon the covered family members that were enrolled on the date you lost coverage, continuation coverage will cost:

|  |  |
| --- | --- |
| Medical | «Med» |
| Dental | «Den» |
| Vision | «Vis» |
| **Total Due**: | **«Total»** |

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### Though you do not have to send any payment with the Election Form, you must actually pay for elected continuation coverage, in full and in good funds, within the thirty (30) days of the date of this notice. You are not entitled to add dependents to receive CCOC continuation coverage if such dependents were not covered on the day before you lost coverage.

You must pay the premiums for CCOC continuation coverage no later than sixty (60) days after the date of this notice, for all months of coverage prior to your payment. You are responsible for making sure that the amount of your first payment is correct. Please be advised that until your payment is received, your enrollment will be pended. Coverage will retroactively begin with no lapse in coverage upon receipt of premiums due. Important additional information about payment for continuation coverage is included in the pages following the Election Form. You may mail a check payable to your prior employer.

### There may be other coverage options for you and your family. For example, you can buy individual or family coverage through the Health Insurance Marketplace or directly from a health insurance carrier. In the Marketplace, you may be eligible for a tax credit that lowers your monthly premiums. Being eligible for CCOC does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For more information about the Health Insurance Marketplace, which in Colorado is known as Connect for Health Colorado, you may contact Connect for Health Colorado direct at [www.connectforhealthco.com](http://www.connectforhealthco.com/) / Toll-Free: (855)752-6749.

If you have any questions about this notice or your rights to continuation coverage, you may contact the Plan Administrator:

«GRGR\_NAME»

«GRGR\_ADDR1»

### «GRGR\_ADDR2»

### «GRGR\_CITY», «GRGR\_STATE» «GRGR\_ZIP» , «GRGR\_PHONE».

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**Continuation Coverage Election Form**

**Instructions: To elect continuation coverage, complete this Election Form and return it to us. You have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage, and to pay for any continuation coverage that you elect.**

**Send completed Election Form to:**

«GRGR\_NAME»

«GRGR\_ADDR1»

### «GRGR\_ADDR2»

### «GRGR\_CITY», «GRGR\_STATE» «GRGR\_ZIP» , «GRGR\_PHONE».

**This Election Form must be completed and returned by mail, email or fax by «Date1». If mailed, it must be post-marked no later than «Date1».** If sent to us by email or fax, it must be **received** by us by **«Date1».**

**If you do not submit a completed Election Form and make payment 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 and make payment before the due date. Elected continuation coverage will be retroactive to the date following your loss of coverage.**

### I (We) elect continuation coverage in the «GRGR\_NAME» Group Health Plan (the

Plan) for the individuals listed below. I can elect to cover myself and dependents noted or remove individuals by writing “NONE” on the “Coverage option(s) elected” line.

I understand that I cannot add new dependents who were not covered at the time I lost coverage.

Name Date of Birth Relationship to Employee SSN (or other identifier)

1. Coverage option(s) elected (medical, dental, vision, none, etc.):
2. Coverage option(s) elected (medical, dental, vision, none, etc.):
3. Coverage option(s) elected (medical, dental, vision, none, etc.):

Signature Date

Print Name Relationship to individual(s) listed above

Print Address Telephone number

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#### Important Information about Your Continuation Coverage Rights

**What is continuation coverage?**

Colorado state law requires that employers who offer group health plan (the Plan) coverage offer employees whose employment is terminated, and their covered dependents who lose their Plan coverage because of the employee’s termination of employment, the employee’s change in marital or civil union status, or the employee’s death, the opportunity to continue Plan coverage for up to eighteen months.

This continuation coverage is the same coverage that the Plan gives to other active employees and their dependents under the Plan who are enrolled in the Plan coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other active employees and their dependents covered under the Plan, including open and special enrollment rights.

#### How long will continuation coverage last?

Continuation coverage may last for up to eighteen months. It will end on the earliest of (a) the date through which premiums for continuation coverage are paid; (b) the date other group health plan coverage becomes available to a person covered under continuation coverage; (c) the date a person covered under continuation coverage becomes covered by Medicare; (d) the date a person covered under continuation coverage becomes covered by Medicaid; or (e) the date the Plan coverage terminates for other participants or beneficiaries under the Plan who are not receiving continuation coverage.

#### 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. Each former employee and his or her covered dependents may elect continuation coverage separately.

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 more than a ninety (90) day gap in health coverage, and election of continuation coverage may help prevent such a gap (note: there are limitations on plans imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act). Second, if your coverage ends before or after an open or special enrollment period, you may not be able to enroll in new coverage until the next open enrollment period starts.

#### How much does continuation coverage cost?

Continuation coverage costs 100% of the premium that is charged by the Health Insurance Company to the Plan sponsor for the coverage provided to other active employees and their dependents under the Plan.

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

Though payment for elected continuation coverage need not accompany your Election Form, payment must be made in full, in good funds, by the date the Election Form is due. Payment for subsequent months of coverage is billed on or about the fifth of the month prior to the month for which CCOC coverage is sought and is due on the first of the month for which CCOC coverage is sought. If premium for CCOC coverage is not timely paid, then you will be sent a late notice on or about the tenth of the month. If payment is not received by the last day of the month, your CCOC coverage will be terminated the end of

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that month. You are responsible to your prior employer for all unpaid premium; your coverage will not be terminated retroactively. You will be responsible for paying claims for health care services you receive after continuation coverage ends.

Your payment(s) for continuation coverage should be sent to:

«GRGR\_NAME»,

«GRGR\_ADDR1»,

«GRGR\_ADDR2», «GRGR\_CITY», «GRGR\_STATE» «GRGR\_ZIP»

#### For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from your Plan Administrator:

«GRGR\_NAME»,

«GRGR\_ADDR1»,

«GRGR\_ADDR2», «GRGR\_CITY», «GRGR\_STATE» «GRGR\_ZIP»

«GRGR\_PHONE».

If you have any questions concerning the information in this notice or your rights to coverage you should contact your Plan Administrator.

For more information about your rights under state law, contact the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202, 303-894-7499, toll-free outside Denver,

800-930-3745.

#### Keep Your Plan Informed of Address Changes

In order to protect you and your family’s rights, you should keep your previous employer 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 your previous employer.

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