

**CALIFORNIA SCHOOLS VEBA
\$1,800 HEALTH REIMBURSEMENT ARRANGEMENT PLAN**

PLAN SUMMARY

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ADOPTION INFORMATION

PLAN TYPE:

Health Reimbursement Arrangement (HRA)

PLAN NAME:

California Schools VEBA Health Reimbursement Arrangement Plan

EMPLOYER, PLAN SPONSOR AND PLAN ADMINISTRATOR:

California Schools VEBA
1843 Hotel Circle South, Suite 300
San Diego, CA 92108
33-0579503

EMPLOYEE CLASSIFICATION:

An employee who is enrolled in the Employer-sponsored health plan(s).
An employee is defined as an active employee, early retiree, or COBRA participant.

EMPLOYEE NEW HIRE ELIGIBILITY:

On the first day they are enrolled in an eligible Employer-sponsored health plan(s).

PLAN NUMBER:

501

ORIGINAL EFFECTIVE DATE:

January 1, 2013

PLAN YEAR:

January 1 – December 31

PLAN SERVICE PROVIDER:

OptumHealth Financial Services, Inc. (OHFS)

PLAN PARAMETERS:

The Health Reimbursement Arrangement is available for payment of eligible health insurance plan deductible, copay, coinsurance according to the following schedule:

HRA Benefit: The Health Reimbursement Arrangement will reimburse the first \$1,800 of eligible deductible, copay, coinsurance expenses.

MAXIMUM HRA CONTRIBUTION PER PLAN YEAR:

\$1,800

Important: Documentation must be submitted with each and every expense for which you request reimbursement from the Health Reimbursement Arrangement. A doctor or clinic receipt can be submitted for copay expenses. An Explanation of Benefits (EOB) from your insurance carrier is required for medical expenses for which you are responsible. **Claims cannot be considered for reimbursement without the accompanying documentation.**

ADOPTION INFORMATION (CONTINUED)

PLAN YEAR CARRYOVER PROVISION:

Any unused Health Reimbursement Arrangement dollars shall be carried forward to the next Plan Year for anyone participating in the next Plan Year. There is a \$500 maximum carry-over provision. Unused amounts are carried forward after the first day of the next Plan Year.

EMPLOYER ALLOCATIONS TO THE PLAN:

All Plan funds will be available at any time during the Plan Year for reimbursement of qualified expenses upon submission of substantiated claims.

CLAIMS PROCESSING SCHEDULE:

Daily – (turnaround time from the time claim & documentation is received by OptumHealth to when reimbursement is deposited into participant's account or mailed is 5-6 business days).

WHEN MUST CLAIMS BE RECEIVED BY OPTUMHEALTH FINANCIAL SERVICES, INC. AFTER PLAN YEAR END:

Claims for expenses incurred in the prior Plan Year must be **received no later than April 30th**.

EMPLOYEE TERMINATION GUIDELINES:

NUMBER OF DAYS TO INCUR CLAIMS AFTER LAST DAY OF EMPLOYMENT:

The remainder of the month in which termination occurs.

NUMBER OF DAYS TO SUBMIT CLAIMS AFTER LAST DAY OF EMPLOYMENT:

120 days

This Adoption Information may be used only in conjunction with the Health Reimbursement Arrangement Plan Document and Summary Plan Description. This Adoption Information and the Health Reimbursement Arrangement document shall together be known as the Health Reimbursement Arrangement Plan.

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

We have amended the Health Reimbursement Arrangement that we previously established to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Plan Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the plan document, the plan document will control.

This Summary Plan Description describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this Summary Plan Description change, we will notify you.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You will be eligible for the Plan once you have satisfied the conditions listed in the Adoption Information.

2. When is My Entry Date?

You can join the Plan on the day you meet the eligibility requirements listed in the Adoption Information.

II BENEFITS

1. **What Benefits Are Available?**

The plan allows you to be reimbursed for certain out-of-pocket medical expenses which are incurred by you and your covered dependents. The expenses, which qualify, are copays, deductibles, and coinsurance in an applicable VEBA UnitedHealthcare HMO and Express Scripts Prescription Drug Plans. Other permitted items under Section 213(d) of the Internal Revenue Code do not qualify as covered expenses under this plan, including, but not limited to dental, vision, or other medical expenses not covered by this plan.

If your Plan includes dependent coverage, you may be reimbursed for eligible medical expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. **When Must Expenses Be Incurred?**

You may submit expenses that you incur each "Plan Year." Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged for, or you pay for the medical care. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage. You may submit expenses that you incur each Plan Year (refer to the Adoption Information for your Plan Year).

3. **When Will I Receive Payments From the Plan?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. However, requests for reimbursements must be made no later than the number of days after the end of the Plan Year that is listed in the Adoption Information. The Plan Administrator will provide you with instructions for submitting these requests for reimbursement. In addition, the Plan Administrator or Plan Service Provider must receive proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Neither your employer, the Plan Administrator nor the Plan Service Provider can guarantee the tax treatment of any given Participant as individual circumstances may produce differing results. In case of doubt, you should consult with your own tax advisor.

4. **New Hires and Adjustments for Status Changes**

Mid-Year Enrollment

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period as a result of a change in status, the amount of the Employer Contribution allocated to your HRA will be prorated on a quarterly basis effective retroactive to the first day of the month in which you are enrolled in the Plan.

Status Changes

When you switch among Coverage Categories, VEBA's contribution amount allocated to your HRA may increase or decrease by category.

Reinstatement without a break in coverage.

Following a termination, if you are rehired, can you be reinstated without experiencing any break in coverage?

No, your HRA Plan does not allow reinstatement without experiencing any break in coverage. When you are rehired and re-enroll in the active medical plan and the HRA Plan the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

Reinstatement with a break in coverage.

Are you able to recover funds after a break in employment?

No, you cannot use prior accumulated balances after re-enrollment as a result of a break in employment. When you are rehired by a participating school or community college district and re-enroll in a medical plan that is paired with this HRA Plan the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

You can keep track of the funds in your HRA by going online to www.optumhealthfinancial.com, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

5. What Happens If I Terminate Employment?

If your employment is terminated during the Plan Year for any reason, your participation in the Health Reimbursement Arrangement Plan will continue only as long as described in the Adoption Information.

For Health Reimbursement Arrangement Plan coverage on termination of employment, please see CONTINUATION COVERAGE RIGHTS UNDER COBRA under the section titled "Additional Plan Information".

6. Can I Opt Out of the Plan?

Yes, once per Plan Year, you can opt out of the Plan and receive no further reimbursement.

7. Family and Medical Leave Act (FMLA)

If your Employer is subject to the requirements of the Family and Medical Leave Act, and if you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to “catch up” your payments when you return.

8. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Reimbursement Arrangement under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

9. Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

10. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be “qualified.” You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. **Employer Information**

Your Employer's name, address, and identification number are listed in the Adoption Information.

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted the Plan by making a written request to the Plan Administrator.

2. **Plan Administrator Information**

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the Plan.

3. **Third Party Claims Administrator Information**

The name, address, telephone and fax number of your Plan's service provider are:

OptumHealth Financial Services
P.O. Box 30516
Salt Lake City, UT 84130-0516
Attention: EV1 Team
Customer Care Center: 1-800-243-5543
Fax: 855-244-5016

4. **Service of Legal Process**

The Employer is the Plan's agent for service of legal process.

5. **Type of Administration**

The Plan is a Health Reimbursement Arrangement and the administration is provided through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

IV
ADDITIONAL PLAN INFORMATION

1. How to Submit a Claim

Follow the directions provided with your claim information for reimbursement from the Health Reimbursement Arrangement Plan. Documentation, such as an *Explanation of Benefits* from your insurance carrier showing your responsibility of the charges, is required as documentation to substantiate your claim.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator or Plan Service Provider will provide written or electronic notification of any claim denial or request for additional information. The notice will state:

- (a) The specific reason or reasons for the denial.
- (b) Reference to the specific Plan provisions on which the denial was based.
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (e) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents, and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

V
CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

2. Who Can Become a Qualified Beneficiary?

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happen:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of the following qualifying events:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of the following qualifying events:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

3. When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the employer has been notified that a qualifying event has occurred. The employee must notify the employer of the following qualifying events:

1. The end of employment or reduction of hours of employment;
2. Death of the employee;
3. The employee's becoming entitled to Medicare (Part A, Part B, or both); or
4. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer.

The employer has to notify the Plan Administrator, in writing, within 30 days of the date that a qualifying event occurs.

4. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the employer. The Plan requires you to notify the employer within 60 days after the qualifying event occurs.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

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 the Plan Administrator or other designee as defined by the Employer.

The name and address of the Plan Administrator and Employer are listed in the Adoption Information.

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 plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

5. How is COBRA Coverage Provided?

Once the employer receives notice that a qualifying event has occurred, and the employer notifies the Plan Administrator, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either the later of (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the employer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have 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.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months, if the employer is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the employer is notified of the second qualifying event within 60 days of the second qualifying event.

6. Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage.

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.

7. 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 copayments) 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’ll 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.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

8. When Can I Enroll in the Marketplace Coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days your special enrollment period will end 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 the 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.

9. If I Sign Up for COBRA Continuation Coverage, Can I Switch to Coverage in the Marketplace? What About if I Choose Marketplace Coverage and Want to Switch Back to COBRA Continuation Coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” Please note – if you terminate your COBRA continuation coverage early without another qualifying event, you’ll 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’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in the Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

10. Can I Enroll in Another Group Health Plan?

You may be eligible to enroll in coverage under another group health plan (like a 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 instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

11. **Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

1. The month after your employment ends; or
2. The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your employer and Plan Administrator 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 your employer or the Plan Administrator.