



COBRA CONTINUATION COVERAGE ELECTION NOTICE

NAME and Covered Family Members

ADDRESS

CITY, STATE ZIP

Notification Date: MM/DD/YYYY

Dear Qualified Beneficiaries:

This notice contains important information about your right to continue your health care coverage in the TEST COMPANY Group Health Plans (collectively known as the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage follow the instructions and complete the COBRA CONTINUATION COVERAGE ELECTION FORM and submit it to HFS COBRA. The completed Election Form must be postmarked no later than 60 days from the date of this letter or the loss of your coverage, whichever is later. If you do not submit the completed Election Form postmarked within this 60 day election period then you will lose your right to continue coverage, and your health care coverage under the Plan will end due to your qualifying event-Termination of Employment. COBRA coverage has to be continuous coverage, you must elect and pay for the coverage back to the date you terminated under the plan. There can be no lapse in coverage for any reason. Notwithstanding any term in this notice, you can only continue a Medical FSA until the end of the current Plan Year. The FLEX eligibility and premium can change depending on claims submitted during the run out period.

Each person (qualified beneficiary) in the categories listed below who was covered under the Plan on the day before the qualifying event and lost coverage due to the qualifying event is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan.

The employee or former employee

The spouse or former spouse of the employee

Dependent children covered under the Plan on the day before the event that caused the loss of coverage

A child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan.

If elected, the COBRA coverage will begin on the day after the Coverage End Date on the following page. If you do not elect COBRA within the 60 day election period your coverage will end on the Coverage End Date. You may elect any of the following options for COBRA continuation coverage, and your monthly continuation coverage will cost (continued on next page):

Carrier Name	Description	Amount Due	Coverage Ends
MEDICAL PLAN	EMPLOYEE ONLY	\$0.00	mm/dd/yy

*Premium for the Plan(s) are set for a 12 month period commonly known as the Plan Year. Qualified Beneficiaries will be notified of the renewal rates prior to the beginning of the next Plan Year (or when made available). If there is a premium increase or reduction the COBRA premium will be adjusted accordingly.

SEVERANCE: If you are under a severance agreement with your prior employer that includes covering a portion or your entire COBRA premium, please provide HFS with the COBRA provisions as outlined in your severance agreement in order for HFS to properly calculate your portion of responsibility of COBRA payments. We do not need a copy of the severance agreement, just the COBRA provisions, which should be included with the signed election form that is returned to HFS. We will verify the terms with your prior employer and send you coupons for your share of the COBRA premium. The premium rates provided above are the monthly amounts due without regard to such an agreement.

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to HFS COBRA, P.O. Box 1610, Hunt Valley MD 21030-1610 via regular mail OR HFS COBRA, 4 North Park Drive Suite 500, Hunt Valley MD 21030 via private delivery service (UPS, FedEx, etc.).

1. RETURN COMPLETED ELECTION FORM TO HFS WITHIN 60 DAYS.

In order to continue your coverage, you must submit a completed Election Form to HFS postmarked no later than 60 days from the date of this letter or the loss of your coverage, whichever is later. If the election is not postmarked within this 60 day election period then you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before your 60 day period has expired you may change your mind as long as you furnish a completed Election Form postmarked before the end of the 60 day period. Each eligible family member may elect coverage independently by completing a separate copy of this Election Form. The primary qualified beneficiary may elect to continue coverage on behalf of all eligible dependents who were covered the day before the qualifying event. Read the important information about your rights included in the pages after this Election Form.

2. SUBMIT PAYMENT FOR YOUR FIRST COBRA PREMIUM AMOUNT. YOU ARE NOT REQUIRED TO REMIT PAYMENT WITH THIS NOTICE HOWEVER IT IS ENCOURAGED AS YOUR COVERAGE WILL NOT BE REINSTATED UNTIL THE AMOUNT DUE IS RECEIVED.

Your amount due can be calculated by adding the Amount Due amounts (listed on the previous page) of the plans you select. If payment is not included with this notice, your amount due MUST be received within 45 days from the date of your election. (This is the date the Election Notice is postmarked if mailed.) If payment is not made in full by 45 days from the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for assuring that your total amount due is correct. If you need assistance calculating your amount due please contact HFS COBRA. Prior to receiving your payment, any claims submitted will not be paid and health care providers will be told that you do not have coverage, but will have coverage retroactively to the date of your termination of coverage when the COBRA premium is paid. Reinstatement is not automatic on the date you make your first payment. HFS will send the carrier a notice to reinstate your coverage on the date your payment is received, however getting you back in the system can take time. Some carriers take several days to update their system.

MEMBER and Covered Family Members

Date of Birth: mm/dd/yyyy

ADDRESS

CITY, STATE ZIP

Company Name: TEST COMPANY

Notification Date: mm/dd/yyyy

I elect the coverage(s) that I have checked below for myself and my eligible dependents, if any:

PERSON(S) ELECTING COBRA	SELECTED PLAN(S)	SSN	PREMIUM
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL PREMIUM _____

Additional Instructions for your Premium Payments:

HFS accepts payment by mail only. Please note that by law the premium is paid on the date of the postmark on the envelope, not when received by HFS. If an envelope is postmarked on or before the last day of the grace period it will be accepted. Make your check payable to Hirsch Financial Services, Inc. and mail your check to HFS COBRA, PO Box 1610, Hunt Valley, MD 21030-1610.

I have read the NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE and understand my election rights. I agree to notify HFS if any covered person becomes covered by another group health plan, or entitled to Medicare, or has a change of address.

SIGNATURE: _____ EMAIL ADDRESS: _____

PHONE NUMBER: _____ DATE: _____

Providing your email address will enable HFS to communicate with you in the fastest manner available.

Important Information About Your COBRA Continuation Coverage Rights

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 retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

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, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses 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 may 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. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

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

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- 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 extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify HFS COBRA 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 the 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 under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or 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 Social Security Determination of Disability must be delivered within 60 days after the later of: (1) The date of the disability determination by the Social Security Administration; (2) The date on which a qualifying event occurs; (3) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) The date on which the qualified beneficiary is informed, through the furnishing of the summary plan description or the General Notice, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

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 to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

An 18-month extension of coverage will be 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 may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), 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. You must notify the Plan in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began.

How can you 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 may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may 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. Note: Generally, after you leave a job, you have 60 days to enroll in COBRA. When you qualify for Trade Adjustment Assistance (TAA), you may have a second chance to elect to receive COBRA benefits. If you are within the 60-day period or believe that you are eligible for this second election period, contact your former employer.

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 COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not 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 this notice.

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 percent of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80 percent of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

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 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 Election Notice is post-marked, 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. You may contact HFS COBRA to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this 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 first day of the 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 not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be 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, in some cases 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 (going back to the first day of the coverage period) when the periodic payment is received. This means that 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 will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to: HFS COBRA, 4 North Park Drive, Suite 500, Hunt Valley, MD 21030

Notice Regarding a Leave of Absence for Military Service

If you go on a leave of absence because of military service, you may be able to continue coverage under your health plan as required by the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"). This continuation right is separate from COBRA rights described in this notice. You will be required to pay for the coverage in an amount allowed under USERRA. This extension of coverage will end on the earlier of: (1) the last day of the 24 month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer as required by USERRA. Your Employer can provide additional information upon request.

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, your rights to coverage, or if you want a copy of your summary plan description, you should contact HFS COBRA, 4 North Park Drive, Suite 500, Hunt Valley, MD 21030 or call 410-771-1331, toll free 888-460-8005.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact Maximus, a CMS-sponsored contractor, at www.ContinuationCoverage.net or ContinuationCoverage@maximus.com.

Keep Your Plan Informed of Address Changes

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