COBRA AND Cal-COBRA

What is COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law enacted to help prevent gaps in healthcare coverage. COBRA applies in general to companies that employ 20 or more employees on at least 50% of the working days during the preceding calendar year.

COBRA requires employers, who provide employees with healthcare coverage (including dental) to permit employees to continue the coverage under certain circumstances when it would otherwise terminate. The employee is responsible for paying the full cost of the continued coverage, in addition to an administrative fee.

Please note that under COBRA, employers are required to administer continuation of coverage benefits. To obtain more information about COBRA, including responsibilities as an employer and the duration of the continuation periods, please contact your own legal counsel.

Employer Administration Guidelines:

- As soon as the employee terminates, fax the "Termination of Enrollee's Coverage"form to Allied Administrators at (415) 439-5861. This will terminate the employee from your roster. Credit on your account can only be applied for 60 days.
- Notify the employee of their COBRA right to continued coverage.

What is Cal-COBRA?

The California Continuation Benefits Replacement Act (Cal-COBRA), which became effective on January 1, 1998, requires that every healthcare service plan contract with a small employer provide a similar opportunity to continue that coverage. A small employer is defined as one that employed between 2 and 19 employees on at least 50% of the working days during the preceding calendar year. Either the small group employer or Delta can distribute a copy of the disclosure and election form to employees enrolled in their dental plan at the time an enrollee qualifies for Cal-COBRA.

Cal-COBRA requires a small group employer to notify Delta's and PMI's designated administrator, Allied Administrators, of any employee who has experienced a loss of coverage due to termination of employment or reduction in hours, within 31 days after such loss of coverage. The employee is responsible for paying the full cost of the continued coverage in addition to an administrative fee.

If the small group employer chooses Delta to send the Cal-COBRA notice to an employee who has qualified for Cal-COBRA, they must provide Allied Administrators (Delta's and PMI's designated administrator) with the employee's and/or dependent's name and address to whom the forms should be sent

NOTICE TO SMALL EMPLOYER OF CAL-COBRA CONTINUATION COVERAGE UNDER DELTA DENTAL PLAN CONTRACTS

The California continuation Benefits Replacement Act (Cal-COBRA) became effective January 1, 1998. This new law requires that every health care service plan contract with a small employer must offer continuation coverage to enrollees under the plan who experience a loss of coverage due to the occurrence of certain qualifying events. The Cost of such continuation coverage will be charged entirely to those electing the coverage. **There is no charge to the employer.**

If you are a small employer, please distribute copies of the enclosed disclosure to all employees enrolled in your Delta program as soon as you receive this notice. A small employer is one which employs 2 – 19 eligible employees on at least 50% of its working days during the preceding calendar year. We also remind you to distribute this information to all new hires.

The Law requires a small employer to notify Delta of any employee who has experienced a loss of coverage due to termination of employment of reduction in hours within 30 days of such loss of coverage. Please indicate an employee's loss of coverage by reporting the information through your normal submission procedures and distribute the enclosed packet of information again to any employee whose loss of coverage is due to termination of employment or reduction in hours.

Delta appreciates your assistance in implementing this required change in your dental program.

In summary, if you are a small employer:

· Distribute copies of the enclosed Disclosure and Election Form to all Delta enrollees.

· When an employee is terminated or experiences a reduction in hours, indicate the enrollee's loss of coverage by reporting the information according to your usual procedures. This must be done within 30 days of the enrollee's loss of coverage.

DISCLOSURE AND ELECTION FORM TO EMPLOYEES OF CAL-COBRA CONTINUATION COVERAGE

Option to Continue Dental Coverage

The California Continuation Benefits Replacement Act (Cal-COBRA) provides continuation coverage for small employer (2-19 employees) dental programs.

In the event of a loss of coverage under your Delta program following the occurrence of certain "Qualifying Events," you and your dependents are entitled to continue your dental coverage at your expense, if certain conditions are met. The length of time during which you may continue your coverage depends upon the Qualifying Event.

Qualifying Events

Qualifying Events are:

1.	Member Election	36 Months' Coverage*	The termination or reduction of hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event;
2.	Dependent Election	36 Months' Coverage	The death of the covered employee;
3.	Dependent Election	36 Months' Coverage	The divorce or legal separation of the covered employee from the covered employee's spouse;
4.	Dependent Election	36 Months' Coverage	The loss of dependent status by a dependent Enrolled in the plan;
5.	Dependent Election	36 Months' Coverage	With respect to a dependent only, the covered employee's entitlement to coverage under Medicare.

*If the enrollee or dependent enrollee was disabled at any time during the first 60 days of this continued coverage, the coverage may be continued for a total of 29 months, provided that there is a determination under Title II or Title XVI of the Social Security Act that the disabled person was disabled at the time Qualifying Event 1 occurred. Extended coverage under these conditions ends either 36 months after the Occurrence of Qualifying Event 1, or on the first of the month that begins more than 31 days after the date of the final determination that the enrollee is no longer disabled, whichever is later.

Please note that Delta has contracted with Allied Administrators to administer Cal-COBRA benefits for your Delta Dental Program. Therefore, while Delta provides your dental coverage, Allied Administrators will coordinate the collection of dues and reporting of eligibility. **Any Cal-COBRA questions should be directed to Allied Administrators at (415) 989-7443.**

How to Continue Dental Coverage

You or your dependents must give written notice of your election to continue coverage to Delta within 60 days of your termination of coverage under your Delta program or the date you receive this Election Form, whichever is later. To elect coverage, please complete and return the enclosed Election Form together with your payment. ***Failure to provide this written notice of election to Allied Administrators within 60 days will result in the loss of continued coverage. This is the only notification you will receive regarding this election. You may enclose your initial premium payment with your Election Form.***

Continued coverage will be the same as you would receive if you were still an enrollee of the dental program. If your employer changes the coverage for active employees, your continued coverage will change as well.

For purposes of this continued coverage, dependent enrollees will include any child born to or placed for adoption with the primary enrollee during continued coverage, if the child is enrolled within 30 days of birth or placement for adoption.

In accordance with this law, you will be charged 110% of the premium previously paid by the employer from whom you received coverage. Please call Allied Administrators should you have any questions in this regard. Delta will deny any dental claims incurred during the election period until you have elected Cal-COBRA and made the initial premium payment. If you did not enclose your initial premium payment with your Election Form, you will have 45 days from your written election of continued coverage to pay the initial premium, which includes the premium for each month since the loss of coverage. **Failure to pay the required premium within the 45 days will result in the loss of continued coverage, with no reinstatement.**

Payment for subsequent months is due by the 25th of the month PRIOR to the month of coverage. ***If your payment is more than 30 days late, your Cal-COBRA coverage will be terminated and will not be reinstated.***

Termination of Continued Dental Coverage

Your continued coverage will terminate at the end of the month in which any of the following events first occurs:

1. The allowable number of consecutive months of continued coverage is reached;
2. You fail to pay the required premium in a timely manner;
3. Eligibility requirements for this continuation coverage no longer apply to you;
4. The employer ceases to provide any group dental program to its employees.

Eligibility Requirements

The continuation coverage is not available to the following individuals:

1. Individuals who are entitled or become entitled to coverage pursuant to Medicare;
2. Individuals who are covered or become covered under another group benefit plan (other than a group conversion option plan that provides coverage for individuals) that does not impose any exclusion or limitation with respect to any preexisting condition of the individual (other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the enrollee pursuant to applicable law);
3. Individuals who are covered, become covered, or could become covered pursuant to federal COBRA laws;
4. Enrollees who fail to meet the requirements regarding notification of a Qualifying Event or the election of continuation coverage within the specified time limits;
5. Enrollees who fail to submit the correct premium amount in accordance with the terms and conditions of the plan contract.

Termination of the Employer's Dental Contract

If the dental contract between your employer and Delta terminates prior to the time that your continuation coverage would otherwise terminate, you (or your eligible dependents) may elect continuation coverage under your employer's subsequent dental plan, if any. The continuation coverage shall be provided only for the balance of the period that you (or your eligible dependents) would have remained covered under the Delta program had such program with your employer not been terminated. ***The continuation coverage shall terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the Delta program.***

Open Enrollment Change of Coverage

You or your eligible dependents may elect to change your continuation coverage during any employer open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan shall be provided only for the balance of the period that you (or your eligible dependents) would have remained covered under the Delta program.

In summary:

· You may choose to enroll under Cal-COBRA if you experience a Qualifying Event.

· To enroll under Cal-COBRA, you must give written notice of your election to Allied Administrators within 60 days of your termination of coverage under your Delta program or the date you receive this Election Form, whichever is later. (Complete and send the attached Election Form.) Send a check and include any amounts owed for previous months' coverage.

· **Payment for subsequent months is due by the 25th of the month PRIOR to the coverage month. You will not receive a monthly bill or coupons. Simply mail your payments to the address indicated on the Election Form. If your payment is more than 30 days late, your Cal-COBRA coverage will be terminated and will not be reinstated.**

ELECTION FORM FOR CAL-COBRA CONTINUATIO N COVERAGE

I have read this form and the disclosure accompanying it, and I understand my right to elect continuation coverage. I elect continuation coverage as indicated below.

I understand that if I fail to pay any premium on time, my coverage will terminate. I also understand that my coverage may terminate for any of the reasons listed in the enclosed **Cal-COBRA Disclosure and Election Form.**

I agree to keep the administration office informed of any changes of address and/or family member changes. I also agree to notify the administration office of any other group dental or Medicare plan coverage for either my beneficiaries or me.

I qualify for Cal-COBRA due to Qualifying Event # (circle one) 1 2 3 4 5
(Refer to attached **Disclosure and Election Form** for qualifying events.)

Enrollee Name _____

Enrollee Signature _____

Address _____ _____
Street

_____ _____
City State Zip Telephone Number

Social Security Number _____ - _____ - _____ Date of Birth _____
(VERY IMPORTANT – WRITE LEGIBILY)

Name of Employer Providing Delta Dental Coverage _____

_____

Name of Primary Enrollee (originally covered under the Delta Dental program) _____
_____

Relationship to Primary Enrollee _____

If you have dependents, please complete the reverse side of this page. If you are married and decline coverage for yourself, it is also your responsibility to provide the name and address of your spouse on the reverse side.

Effective Date ` _____

Amount of Check Enclosed $_____
(Monthly Premium previously paid by employer plus 10%)

Submit this form with a check (including any amounts owed for previous months' coverage to:

Allied Administrators Telephone: (415) 989-7443
ATTN: Cal-COBRA
P.O. Box 26908
San Francisco CA 94126

DEPENDENTS FOR CAL-COBRA CONTINUATION COVERAGE

If you have dependents that are covered by the Plan, you must provide pertinent information below for each of them. **Please write legibly.**

Name	**Date of Birth**	**SSN**
_____ Spouse	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____
_____ Child	_____	_____

Important Notice: If you acquire a newborn or adopt a child after you have begun coverage under Cal-COBRA, you may enroll that child under this plan.