

UNIVERSITY OF VIRGINIA
2009 COBRA ELIGIBILITY AND ENROLLMENT

*This is important information about your COBRA rights and responsibilities.
Please be sure to read and understand all information.*

Employees of the University of Virginia or its Health System covered under the University of Virginia Health Plan or the Davis Vision Plan who: 1) terminate employment for any reason other than as the result of gross misconduct; 2) become a part-time employee who would otherwise no longer be eligible for coverage; or 3) become a non-salaried employee no longer eligible for coverage, may elect to continue coverage on a self-payment basis through the COBRA plan for themselves, their spouse, and/or their dependents from the date coverage in the active employee group would otherwise end. Covered spouses or dependents who lose coverage as a result of no longer qualifying as a dependent or spouse under the terms of the Plan (examples of these qualifying events are divorce and reaching age limits) may also elect to continue coverage on a self-payment basis through the COBRA plan for themselves from the date coverage as a qualified dependent would otherwise end.

- COBRA coverage begins the day after coverage in the active employee plan ends.
- Enrollment in the COBRA plan is not an opportunity to change from one program to another (for example, from High Premium to Low Premium or vice versa); COBRA participants can choose enrollment only in the same program in which they were enrolled on their last day of coverage in the active employee plan.
- If you move outside of the Southern Health Provider Network Area for medical services, you must contact the Office of University Benefits to enroll in the Out-of-Area Plan. Otherwise, claims will be paid out-of-network.

If the employee has a spouse or dependents who are covered under the Health or Vision Plans, the employee and each covered spouse and/or dependent have independent election rights. COBRA law allows the employee and each covered spouse and/or dependent to choose coverage that is the same as the coverage that was in effect at the time of the Qualifying Event. If not all dependents and/or the spouse want to continue, do not include their names on the Enrollment Form. The employee's name must be included on the Enrollment Form's list of eligible persons if the employee wants coverage.

- The employee, spouse, and/or dependents have 60 days from the date their active coverage under the University of Virginia Health Plan or the Davis Vision Plan ends to apply for COBRA coverage.
- Postmark dates are used as submission dates for COBRA Enrollment Forms.
- Enrollees are allowed to delay the premium payment for up to forty-five days after they have dated the Enrollment Form. However, the COBRA Enrollment Form will not be processed and coverage in the University of Virginia Health Plan or the Davis Vision Plan reinstated until both the Enrollment Form **and** the Initial Premium payment have been received. The initial premium payment includes the first month's premium as well as premiums for any other month beyond the first that has begun when the initial payment is made.
- Any claims submitted for expenses incurred as of the continued coverage effective date will be denied until all premiums, which are due, have been paid.
- Reimbursement for prescriptions that have been filled before coverage is reinstated without presenting a valid ID card can be obtained from the same pharmacy within 30 days of the filled date. Reimbursement amounts may be less than the paid amount if the request is made by submitting a paper claim.

Future premiums are due on the first of each month thereafter, and should be mailed on or before the due date. If premiums are not received by the first of the month, claims will be put on hold until the premium is paid.

- Failure to pay premiums within 30 days of the due date **will** terminate participation under the University of Virginia Health Plan or the Davis Vision Plan. Postmark dates are used as premium payment dates.
- Premiums and benefits are subject to change based on the UVA Health Plan or the Davis Vision Plan.

UNIVERSITY OF VIRGINIA
2009 COBRA ELIGIBILITY AND ENROLLMENT – Continued

*This is important information about your COBRA rights and responsibilities.
Please be sure to read and understand all information.*

Continuation under the University of Virginia Health Plan or the Davis Vision Plan is based on eligibility. The Plan Administrator reserves the right to retroactively cancel coverage if it is determined that the Enrollee is not eligible. Also, please be aware that any break in coverage of more than sixty-three days may cause loss of coverage portability.

- If you are interested in enrolling in the COBRA plan, complete the attached Enrollment Form and submit it to the University Human Resources Office of University Benefits.
- When payment accompanies the Enrollment Form, reinstatement will take place within two weeks. Otherwise, reinstatement will not take place unless payment is received within 45 days of signing the Enrollment Form.

COBRA PREMIUMS Effective 1/1/09

*University of Virginia Health Plan
High Premium Program*

	Rate (Includes 2%)	Military LWOP Active Duty Employee Rate
Single	\$383.52	\$42
Single + Child	\$759.90	\$147
Single + Spouse	\$786.42	\$171
Family	\$1229.10	\$327

Low Premium Program

	Rate (Includes 2%)	Military LWOP Active Duty Employee Rate
Single	\$352.92	\$12
Single + Child	\$657.90	\$47
Single + Spouse	\$667.08	\$54
Family	\$1013.88	\$116

Davis Vision Plan

	Rate (Includes 2%)
Single	\$5.77
Single + Child	\$10.11
Single + Spouse	\$10.40
Family	\$16.18

Return COBRA Enrollment Forms and initial premium payments to: UHR Office of University Benefits, 914 Emmet Street, P.O. Box 400127, Charlottesville, VA 22904-4127. Make checks payable to UVA. Within two weeks of receipt of this form at UVA, you will receive information and monthly coupons from Chard Snyder, UVA's COBRA Administrator. Chard Snyder can be reached at 800-982-7715.

**UNIVERSITY OF VIRGINIA
UVa HEALTH PLAN COBRA ENROLLMENT FORM - 2009**

1) PERSON ENROLLING:

Name: _____

Address*: _____

City: _____

State Zip: _____

E-mail Address: _____

Phone: _____

ID # of Active Employee if Different from name above:

Name of Active Employee if Different from above:

**Failure to request enrollment in the out-of-area plan when you move to an address outside the SHS Provider Network will result in health claims being paid out-of-network. Contact UVA's Office of University Benefits to enroll.*

2) QUALIFYING EVENT:

Qualifying Event Date: _____ / _____ / _____
(Example: termination date, divorce date)

COBRA Effective Date: _____ / _____ / _____
(First day of the month following qualifying event date)

Reason for Termination of Active Employee Insurance: _____

3) MEDICAL/DENTAL PLAN DESCRIPTION:

UVa HEALTH PLAN: (Choose Election)
(You must choose the same health program in which you were enrolled as an active employee or eligible dependent.)

	High Premium Program	Low Premium Program
Single		
Single & Child		
Single & Spouse		
Family		

4) PERSONS TO BE COVERED IN MEDICAL/DENTAL PLAN:

Include yourself - Only persons previously covered by the UVa Health Plan are eligible for coverage.

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

5) STATEMENT OF UNDERSTANDING AND ELECTION: I hereby request enrollment for continuation of the health benefits for myself and eligible qualified dependents I have listed on this form, and I agree to pay the premium as required. I understand that continuation of coverage will terminate, after this election, under several circumstances, including: the date I or a continued dependent become covered under another group health plan or become entitled to Medicare, **when my premium payment is not received timely**, or the date on which the employer's group health plan ends. I also understand that any break in continued coverage of more than sixty-three days may cause loss of coverage "portability".

Signature of Enrollee

Date

COBRA Continuation coverage will be initiated upon receipt of Initial Premium Payment which must include premiums for all retroactive months as well as the current month's premium.

COBRA ENROLLMENT 2009 – CONTINUED

UNIVERSITY OF VIRGINIA
DAVIS VISION COBRA ENROLLMENT FORM – 2009

1) DAVIS VISION PLAN DESCRIPTION:

DAVIS VISION PLAN: Choose Election below and fill out section 1 (Person Enrolling) and section 2 (Qualifying Event) on the front side of this page.

Employee Only _____ Employee & Child _____ Employee & Spouse _____ Family _____

2) PERSONS TO BE COVERED IN VISION PLAN:

Include yourself – Only persons previously covered by the Davis Vision Plan are eligible for coverage.

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

Last Name First Name M

Date of Birth: ____/____/____ Gender: _____ Soc. Sec#: _____

3) STATEMENT OF UNDERSTANDING AND ELECTION: I hereby request enrollment for continuation of the vision benefits for myself and eligible qualified dependents I have listed on this form, and I agree to pay the premium as required. I understand that continuation of coverage will terminate, after this election, under several circumstances, including: **when my premium payment is not received timely**, or the date on which the employer's group vision plan ends.

Signature of Enrollee

Date

COBRA Continuation coverage will be initiated upon receipt of Initial Premium Payment which must include premiums for all retroactive months as well as the current month's premium.

UNIVERSITY OF VIRGINIA
FSA MEDICAL COBRA ENROLLMENT FORM - 2009

1) Flexible Spending Account MEDICAL: Choose Election below and fill out section 1 (Person Enrolling) and section 2 (Qualifying Event) on the front side of this page.

I wish to continue my FSA Medical care account under my COBRA rights: YES _____ NO _____

You have the right to continue participation in the Flexible Spending Account for up to 18 months. In order to continue your FSA participation, you must pay your monthly contribution and monthly fee, both of which were previously paid through payroll deduction. In addition, you will be charged a 2% administrative fee to provide this benefit continuation.

Signature of Enrollee

Date