FRESNO STATE
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COBRA QUALIFYING EVENT (ELECTION) NOTICE

Date: _____

Name: _____
Covered Employee, Spouse, Registered Domestic Partner and/or Dependent Children

From: California State University, Fresno
Human Resources Office

This notice contains important information about your right to continue your group health care coverage in medical, dental, vision, health care reimbursement account (HCRA) plans (collectively, the "Plan") as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace at **www.HealthCare.gov** or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that may costs less than COBRA continuation coverage.** In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

Additionally, there may be other coverage options for you and your family. You may qualify for a special enrollment opportunity for another group health plan for which you are eligible for as a dependent (spouse's/ domestic partner's plan). Although the plan generally does not accept late enrollees, you may be eligible to enroll within 30 days due to your loss of coverage.

Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should complete the enclosed COBRA Coverage Election form and submit the form to Human Resources. Additional information about payments for COBRA continuation coverage(s) will be mailed to you based on your election to enroll.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on _____ due to:

☐ End of employment (18 months)
☐ Death of employee (36 months)
☐ Loss of dependent child status (36 months)
☐ Reduction in hours of employment (18 months)
☐ Divorce or legal separation or Annulment (36 months)
☐ Dissolution of Registered Domestic Partnership (36 months)

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to **18 or 36, whichever applies** for the following qualified beneficiaries specified below:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Registered Domestic Partner or Former Registered Domestic Partner
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of Coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on _____ and can last until _____.
You may elect any of the following checked options for COBRA continuation coverage:

☐ CalPERS Health Coverage: _____
☐ CSU Vision Coverage (VSP)
☐ CSU Dental Coverage: _____
☐ Health Care Reimbursement Account (HCRA) Plan

If you have any questions about your rights to COBRA continuation coverage, you should contact ***California State University, Fresno, 5150 N. Maple Avenue, Joyal Adm. Room 211, Fresno, CA 93740;(559) 278-2032***.

COBRA COVERAGE ELECTION FORM

Print Employee Name: _____ People Soft #_____

Print Cobra Enrollee Name:_____ Telephone: _____

Address/City/Zip: _____

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to CSU. Under federal law, you must have 60 days after the date of this qualifying event (election) notice to decide whether you want to elect COBRA coverage under the Plan.

Mail or hand deliver the completed Election Form to: **California State University, Fresno, Human Resources, Joyal Administration 211, 5150 North Maple Avenue, M/S JA71, Fresno, CA 93740-8026 559.278.2032.** This Election Form must be completed in writing and returned by mail or hand delivered to the address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail.

If you do not submit a completed Election Form within 60 days from the date on this notice, you will lose your right to elect COBRA coverage. If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

☐ **I (We) decline enrollment in all COBRA coverages.**

☐ **I (We) elect COBRA coverage for medical, dental vision plan and/or the HCRA plan**. (Collectively, the Plan) as indicated below (you may elect one or more group health coverages under "Coverage elected"):

COBRA Medical Plan Options- Check Plan Selected				
☐ **Anthem Blue Cross Select (HMO)**	☐ **Anthem Blue Cross Traditional (HMO)**	☐ **Blue Shield - Access (HMO)***	☐ **Blue Shield – NetValue (HMO)***	☐ **Kaiser (HMO)***
☐ **PERSChoice (PPO)**	☐ **PERS Select (PPO)**	☐ **PERS Care (PPO)**	☐ **PORAC – (PPO)**	☐ **United Healthcare (HMO)**

Name	**Date of Birth**	**Relationship to Employee**	**SSN (or other identifier)**	**Coverage elected**
_____	_____	_____	_____	□ medical □ dental □ vision
_____	_____	_____	_____	□ medical □ dental □ vision
_____	_____	_____	_____	□ medical □ dental □ vision
_____	_____	_____	_____	□ medical □ dental □ vision
_____	_____	_____	_____	□ medical □ dental □ vision
_____	_____	_____	_____	□ medical □ dental □ vision

All qualified beneficiaries who were covered under the HCRA will be covered together for HCRA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate HCRA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact Human Resources.

MEDICARE

Is the covered employee, spouse, domestic partner, or any dependent child entitled to Medicare Part A, Part B or both? □ Yes □ No
If yes, name and date of entitlement (shown on Medicare card): _____.

If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting this *Election Form*, immediately notify Human Resources and the applicable dental and vision carriers/COBRA administrators of the date of your Medicare entitlement at the addresses shown below.

HCRA Participant

If you lose your eligibility to participate in the Health Care Reimbursement Account for any reason during the plan year (i.e., retire, terminate, etc.), you may continue to make contributions on an after-tax basis to your account under the CSU's Continuation of Coverage guidelines. You must have a positive account balance at the time you separate. If you choose not to continue contributions under COBRA, the funds you have already contributed to your account will not be available for reimbursement of expenses you incur after the date you are no longer eligible.

☐ I (we) have received and read this entire COBRA Qualifying Event (Election) Notice, including the information regarding "Electing COBRA under the HCRA". I (we) understand that the use-it-or-lose-it rule will continue to apply to the HCRA coverage, if elected, so any unused amounts will be forfeited at the end of the Plan year (December 31). I (we) also understand that no HCRA coverage will be available for subsequent years. _____ Initials

_____ _____

Cobra Enrollee Signature Date