

# NMTA HEALTH TRUST

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## Administrative Manual

## Key Contacts

For answers to questions about benefits issues — and for help with claims questions — contact the customer service department of the applicable insurance company. Telephone numbers are shown in the table below.

Benefit Plan	Insurance Company	Telephone Number / Website Address
Medical Plans Available	<b>Regence BlueShield</b>	(888) 370-6156 (toll-free) www.wa.regence.com www.myRegence.com or www.bluecares.com (nationwide provider directory)
Basic Life/AD&D Insurance	<b>LifeMap Assurance Company</b>	(800) 794-5390 (toll-free) www.lifemapco.com
Vision	<b>Regence BlueShield</b> <b>LifeMap Assurance Company</b>	(888) 370-6156 (toll-free) (800) 794-5390 (toll-free)
Dental	<b>Regence BlueShield</b> <b>LifeMap Assurance Company</b>	(888) 370-6156 (toll-free) (800) 756-4105 (toll-free)
Employee Assistance Program (EAP)	<b>Magellan Behavioral Health</b>	(800) 523-5668 (toll-free) www.magellanhealth.com

## Contacting EPK & Associates

You may also contact EPK & Associates anytime you have questions about your responsibilities or if you need help in working with the insurance companies. You may contact us as follows:

- by telephone at **(425) 641-7762 or (800) 545-7011 (toll-free)**. Our staff is available to talk with you during office hours from 7:00 am to 5:00 pm, Monday through Friday. If you call outside of office hours, please leave a message and we will call you the next business day
- by fax at **(425) 641-8114**
- by email at **admin@epkbenefits.com**
- by website at **www.epkbenefits.com**
- by mail at:

**EPK & Associates, Inc.**  
15375 SE 30th Place, Suite 380  
Bellevue, WA 98007

## Introduction

You have an important job as your company's representative for the NMTA Health Trust. You are the link between the employees in your company, the insurance companies that provide the benefit plans, and the Trust that sponsors the coverages.

EPK & Associates, the Trust contract administrator, has prepared this Administrative Manual to assist you. It's intended to:

- clarify your role as administrator of your company's health insurance plans
- provide detailed information about your responsibilities when specific events occur — including what you need to do when an employee first becomes eligible for coverage, how to make coverage changes, and what steps you need to take when an employee leaves the company
- help you understand the benefits offered through the Trust and how they work

This Administrative Manual is for use by your company's administrator — it is not intended for distribution to employees. It will be updated periodically as plans and administrative procedures change over time. Please insert all revised pages into the appropriate sections of your binder and destroy obsolete sections.

*This manual is provided as a tool to help company administrators in the administration of their NMTA Health Trust plans. It is not intended as a description of plan benefits, nor is it intended for distribution to employees.*

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## Roles & Responsibilities

The NMTA Health Trust is a non-profit, member owned and operated health insurance purchasing program. It's sponsored by the **Northwest Marine Trade Association** and directed by a Board of Trustees selected by the Northwest Marine Trade Association.

The purpose of the Trust is to allow participating employers to join together to purchase health care coverage for their employees. By purchasing this coverage as a large group, marine trade industry employers receive the advantages of:

- significantly lower health care insurance rates through increased purchasing power
- expanded health care plan options
- enhanced customer service — both for you and your employees

To ensure that the Trust can continue to offer these advantages, it's important that you, EPK & Associates and the insurance companies understand and fulfill the responsibilities outlined in this section.

### Your Role

As administrator of your company's NMTA Health plans, your key responsibility is to provide the following:

- **recordkeeping** — maintaining all records for employees in your company
- **communicating** — acting as a contact person for employee health care questions and concerns and working with the insurance companies — and EPK & Associates — to answer questions regarding benefits
- **processing** — initiating enrollment, changes and cancellations by providing the appropriate forms to EPK & Associates

### EPK & Associates' Role

EPK & Associates, Inc. is the contract administrator hired by the NMTA Health Trust Board of Trustees. As contract administrator, EPK & Associates acts as the Trust's agent in working with the health care insurance companies offering coverage through the Trust. Specific responsibilities include:

- preparing monthly billing statements for participating companies
- updating the billing system to reflect enrollment changes
- paying monthly premium costs to the applicable insurance companies on behalf of enrolled employees and their dependents
- assisting member companies with the day-to-day administration of their NMTA Health Trust programs
- administering the NMTA Health Trust program according to the insurance carriers contracts

To fulfill our responsibilities to the Trust and participating companies, EPK & Associates depends on complete, correct and timely information from you.

## Insurance Companies' Role

The insurance companies that currently offer health care plans through the Trust are listed under **Key Contacts** on the first page of this manual. Services provided by participating insurance companies generally include:

- interpreting plan provisions
- paying claims for covered services and supplies
- updating and distributing health care plan information within legally required time frames — including Summary Plan Descriptions (SPDs), Summary of Benefits and Coverage (SBCs), Glossary of Health Coverage and Medical Terms, and Summaries of Material Modification (SMMs)
- serving as a resource to you and other company representatives when you or the employees you represent have questions regarding benefits

## Employer Participation Agreement

Your ***Employer Participation Agreement*** is the legal contract under which you, EPK & Associates and the participating insurance companies administer the Trust insurance program for your company. In addition to information about your company, this agreement shows:

- the specific Medical, Dental, Vision and Life/AD&D insurance coverages that your company has chosen
- your company's definition of a full-time employee
- the probationary period selected by your company
- rehire policy
- part-time to full-time policy

**Since your *Employer Participation Agreement* is a binding contract, it's critical that your in-house benefit administration conforms to the provisions of the agreement and be uniformly applied to all employees.** Changes to the *Employer Participation Agreement* — except for deletion of dental and vision coverage — may be made only during the annual open enrollment period.

You should insert a copy of your company's current, completed *Employer Participation Agreement* for easy reference.

## Eligibility

To be eligible for the NMTA Health Trust, your company must meet all of the following criteria:

- be a current, active member of the Northwest Marine Trade Association. Membership in the NMTA must be maintained each year to continue participation in the Trust
- be in the marine trade or related industry as its principal line of business
- be an active, income-generating business

## Eligible Plan Participants

If your company is eligible for and chooses to participate in the Trust benefit plans, all **active full-time** employees that meet the following requirements are eligible for coverage:

- work the number of hours per week — between 20 and 40 hours — specified in your *Employer Participation Agreement*
- have completed the probationary period that was in effect for your company on the employee's date of hire
- are paid on a regular basis through your payroll system and appear on your company's quarterly report of wages filed with the State Employment Security Department. In Washington, this is form 5208-B

The following dependents of eligible employees are also eligible to participate in the medical, dental and vision plans, as applicable to your company:

- legal spouse
- children — including natural, adopted and step children — under age 26
- domestic partners — the company must have adopted its own internal policy defining Domestic Partnership. A copy of the policy must be filed with EPK & Associates.
- state registered domestic partners — no internal Domestic Partner policy is required. All applications must include copy of State Domestic Partnership Registration.

## Probationary Period

The probationary period before coverage can begin is the zero to 2-month period specified on your *Employer Participation Agreement*. For employees who are hired or change to full-time status:

- on the 1st of a calendar month, that month will count toward the probationary period
- on the 2nd to 5th of a calendar month, that month can count toward the probationary period, as long as this is the company's uniform policy and is indicated on the employee's application
- after the 5th of a calendar month, the probationary period will begin on the first of the following month

If your company has a part-time to full-time policy on file with EPK, part-time capacity may also be counted toward the employee's probationary period following a change to eligible full-time status, as long as this policy is applied uniformly to all employees.

## Who Is Not Eligible

Individuals are not eligible to participate in the Trust plans offered through your company if they are:

- former active employees

- employees who have not completed your company's probationary period
- independent or sub-contractors
- retirees
- part-time employees (that is, who don't meet the hours worked per week requirement stated in your *Employer Participation Agreement*)
- inactive owners

The insurance companies may conduct periodic eligibility verification audits to ensure that your company is complying with eligibility requirements. The insurance companies are entitled to recover damages from you, your company, employees, any person to whom benefits were paid, or anyone else responsible for misleading the insurance company about an individual's eligibility for participation in the Trust plans.

## Rehired Employees

Upon rehire, employees who previously participated in the Trust plans have the same eligibility requirements as newly hired active full-time employees. The probationary period for a rehired employee may, however, be waived if your company has an approved Rehire policy.

Check your current Employer Participation Agreement to see if your company has an approved *Trust Rehire Policy*. If it does, review the maximum period of absence your company has selected for waiver of the probationary period.

## Eligibility During Leave of Absence

A participating employee who goes on an employer approved leave of absence with the intent to return to work can remain eligible for coverage for up to 90 calendar days of leave — as long as this policy is applied uniformly to all employees. The 90-day period starts on the first day of the month following the employee's last day of work.

The leave is considered a COBRA qualifying event and COBRA regulations apply to the continuation of coverage.

Employee's who are on a leave of absence for longer than 90 days — with the exception of leaves resulting from FMLA or injuries covered under Labor & Industries — will need to meet the same eligibility requirements that apply to new or, if applicable, rehired employees.

You must return a completed *Change Transmittal* form to EPK & Associates to cancel coverage for an employee who does not return to work from a leave of absence at the end of the 90-day period in which coverage was extended.

For more information about COBRA eligibility, see the **COBRA Continuation** section of this manual. You may also contact EPK & Associates for details about COBRA eligibility.

## Enrollment

The NMTA Trust is a group insurance program designed to provide coverage for participating companies with 2 or more full-time, eligible employees, including active owners.

Group plans require a specific percentage of all Eligible Employees/Subscribers to be covered on the plan. As a result, the requirements outlined below are strictly enforced.

- Companies with 2–5 eligible full-time employees: 100% participation (excluding approved waivers)
- Companies with 6 or more eligible full-time employees: 80% participation (excluding approved waivers)

**Approved Waivers:** Employees with Medicare, military, tribal, spouse, or other group coverage may elect to waive coverage and will not count against your company's participation requirement percentage.

Individual, Exchange Marketplace, Medicaid (DSHS, Apple Health, CHIP) will count against your company's participation requirement percentage.

Employees (or active owners) waiving coverage must sign a *Waiver of Insurance Form*. This form must be submitted to EPK & Associates, the Trust Administrator, to be kept on file as this form includes information on Federal HIPAA regulations and special enrollment rights.

To be covered when initially eligible, EPK & Associates must receive a completed *Employee/Subscriber Application* form within 15 days of the employee's eligibility date.

For companies that have waivers available, employees who are eligible and choose to waive coverage under the Trust plans must complete the *Employee Waiver of Insurance* form within 30 days of their initial eligibility.

Ensure that completed *Employee/Subscriber Application* forms are received by EPK & Associates **no later than the 15th of the calendar month following the date the employee's probationary period ends**. Employee's whose enrollment applications are received after this date may not be eligible to enroll for coverage until the next open enrollment period.

If you have employees who are waiving coverage, you must return completed *Employee Waiver of Insurance* forms to EPK & Associates **within 30 days following the completion of the employees' probationary periods**. Employees who do not have a form on file with EPK & Associates within this time frame may not be eligible to enroll for coverage until the next open enrollment period — even if they lose eligibility for other coverage during the year.

Sample *Employee/Subscriber Application* and *Employee Waiver of Insurance* forms are included in the **Sample Forms** section of this manual.

## Enrollment Changes During the Year

Enrollment changes may generally be made only during the annual open enrollment period. Under the following circumstances, however, you may make changes to employee coverage between open enrollment periods:

- If you acquire a dependent either through adoption, placement for adoption, birth of a child, or marriage or state registered domestic partnership, you and your dependents may apply for coverage prior to the next open enrollment date. The NMTA Health Trust Administrator must receive your application within 30 days of marriage or state registered domestic partnership, or within 60 days of birth, placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. Coverage for you and your dependents will begin retroactive to either the date of birth of a natural newborn, the date of

placement of an adoptive child, the date of assumption of total or partial legal obligation for support of a child in anticipation of adoption, in the case of marriage or state registered domestic partnership, on the first day of the month following the date of marriage or state registered domestic partnership, provided the application is received by the NMTA Health Trust Administrator within the parameters stated above.

- an employee may add coverage for him or herself and other eligible dependents if coverage under the Trust plans was waived due to other coverage that has been involuntarily lost. To qualify, the employee must:
  - have a *Employee Waiver of Insurance* form on file with EPK & Associates indicating that coverage was waived because of other coverage
  - request enrollment within 30 days of the date other coverage was lost
  - have lost the health insurance or other group health plan coverage because:
    - the health insurance was provided under COBRA, and the COBRA period was exhausted
    - the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage (including loss resulting from legal separation, divorce, death, termination of employment, or reduction in hours)
    - the coverage was non-COBRA coverage and employer contributions for the coverage were terminated. Under this provision, an employer's reduction (but not cessation) of contributions would not trigger a special enrollment right
- an employee may cancel coverage for dependents at the end of any month
- coverage cancels at the end of the month in which the participant and/or dependents are no longer eligible. See the **When Coverage Ends** section for more information
- changes in the employee's beneficiary for life insurance benefits may be made at any time. Similarly, changes or corrections to employee information — such as name, address, birth date or Social Security number — may be made at any time

To add coverage for an employee or eligible dependents, you must return a completed *Employee/Subscriber Application* form to EPK & Associates by the 15th day of the month in which coverage is to begin (except as described above). This form may also be used to change a beneficiary for Life insurance.

To cancel coverage for an employee and/or the employee's dependents, return a *Change Transmittal* form to EPK & Associates by the 15th of the month following the month in which coverage ended. This form may also be used to update/correct employee information.

EPK & Associates will confirm enrollment changes in writing. Report any discrepancies to EPK & Associates within seven days of receiving the confirmation.

If you don't receive a confirmation, call EPK & Associates immediately at **(425) 641-7762 or (800) 545-7011 (toll-free)**.

## When Coverage Starts

Coverage under the Trust plans begins on the contractual effective date — that is, the first of the month following completion of the employee’s probationary period— provided the following requirements are met:

- the employee enrolls within 15 days of the eligibility date\*
- the employee is employed on the date coverage is scheduled to start

Notify EPK & Associates within 15 days of the contractual effective date if an employee is not employed on that date.

**You must provide each employee and, if applicable, his or her enrolled spouse with a notice of his or her rights and obligations under COBRA when they first become covered under the NMTA Health Trust.** Keep in mind, this requirement also applies to spouses who are added to coverage at a later date. Notices must be mailed to the employee and spouse via first class mail.

A sample notice *Summary of Rights and Obligations Regarding Continuation of Group Health Plan Coverage* is included in the **COBRA** section of this manual.

\*Refer to the Enrollment section of this manual for information on special enrollment provisions.

## Monthly Payments

EPK & Associates sends detailed monthly billing statements for the coming month's premium to your company before the end of the month.

Checks for payments should be made out to the **NMTA/NMTA Trust** and returned to EPK & Associates.

Payments are due on the first day of the billed month.

If full payment is not received:

- by the 1st of the billed month, your account will be in delinquent status. This can result in a variety of coverage and claim payment problems that may affect your employees, their health care providers and the insurance carriers
- within 30 days of the payment due date, coverage will be canceled retroactively to the last day of the month for which full monthly payment was received. In this case, any partial monthly payments will be refunded and your company will not be eligible to reapply for participation in the Trust for at least 24 months

*For example:*

For coverage during the month of January:

- EPK mails billing statements to you on or about December 20-22
- Your payment is due to EPK & Associates by January 1
- Payment is in delinquent status if not received by January 1
- Participation in the Trust is canceled, retroactively to December 31, if payment is not received by January 31

Payments returned to EPK & Associates (for non-sufficient funds, stop payment, etc.) must be replaced with guaranteed funds (i.e., Cashier's check, money order, cash) before the expiration of the 30-day grace period. A \$20 fee will be assessed on all returned drafts.

## When Coverage Ends

Coverage under the Trust plans ends for an employee on the first day of the month following his or her last day of work, or loss of eligibility due to:

- change in status from full-time to part-time employment
- failure to pay required premiums
- termination of eligibility for the plans, for example, because your company is no longer eligible for the Trust
- termination of the plans

Coverage for enrolled dependents ends when the employee's coverage ends, or on the first day of the month following any of the following events:

- for a spouse, following divorce
- for children, when they no longer meet the definition of an eligible child. Health insurance coverage will also end for children if, as provided under applicable federal and state law, they are no longer covered under a court decree or administrative order requiring the employee to provide health care coverage
- termination of Domestic Partnership

All companies while in the Trust are COBRA eligible. Employees and/or their dependents may be eligible to extend health care coverage for a period of time by paying the cost of coverage. See the next section, **COBRA Continuation** for more information.

Return a completed *Change Transmittal* form to EPK & Associates within 15 days of the date an employee or enrolled dependent lose eligibility under the Trust plans. Keep in mind, provisions of the Trust do not allow retroactive cancellation of coverage.

You must provide an employee or dependent the following within 44 days of the date coverage is lost under the Trust plans:

- a *Notice of Right to Continue Group Health Insurance Coverage*
- a *Continuation Coverage Election* form

Samples of the *Notice to Continue Health Care Insurance Coverage* and the *Continuation Coverage Election* form are included in the **COBRA** section of this manual. For more information, see the **COBRA Continuation** section of this manual.

When COBRA coverage ends — employees and their dependents may be eligible to convert their Trust coverage to a group conversion plan. For more information, see *When You Are No Longer Eligible for Coverage* in the benefits booklet.

## COBRA Is An Employer Law

It is the responsibility of the employer to understand all the requirements of the federal COBRA law and fully comply with its requirements. The information contained in this manual, your benefits booklet, and model notifications is only intended to be a summary of COBRA administration rights and obligations, not a complete description of the law. Additional information can be found by contacting the U.S. Department of Labor directly or by visiting their web site at [www.dol.gov](http://www.dol.gov). Because of the importance of administering COBRA correctly—**we strongly encourage you to review COBRA and your company's COBRA administration requirements with your legal counsel.**

## Overview—Continuation of Group Health Insurance (COBRA)

When group health insurance coverage ends, the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires **eligible** employers to offer individuals who are losing coverage (known as qualified beneficiaries) the opportunity to purchase continued group health care coverage, including medical, dental and vision coverage if applicable, on a self-pay basis for a limited period of time. A “qualified beneficiary” is:

- an employee, spouse, domestic partner or dependent child who had coverage under a Trust health care plan on the day before the qualifying event that causes a loss of coverage under the Trust health care plan
- a child who is born or placed for adoption with a covered employee or qualified beneficiary, if the child is enrolled in a Trust health plan as described in the **Enrollment** section of this manual

Group health insurance continuation coverage (COBRA) is the same medical, dental and vision coverage as that provided under the Trust plan to active employees with similar family situations. If the Trust plan or the cost of the plan changes for active employees, then the coverage or cost will also change for participants continuing the group health plan under COBRA provisions. Life insurance and AD&D coverage are not considered group health plans and may not be continued under COBRA, but may be converted to individual policies.

## Overview of COBRA Qualifying Events

A COBRA qualifying event occurs when one of the events listed in the COBRA statute causes the covered employee, or the spouse, domestic partner or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

**Qualifying Events For Covered Employee**—If you are the covered employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage *if* you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

**Qualifying Events For Covered Spouse or Domestic Partner**—If you are the *covered* spouse or domestic partner of an employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage for yourself *if* you lose group health coverage because of any of the following reasons:

1. A termination of your spouse's or domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse's or domestic partner's hours of employment;
2. Employee becomes entitled to Medicare;
3. The death of your spouse or domestic partner;
4. Final divorce from your spouse;
5. Termination of domestic partnership.

**Qualifying Events For Covered Dependent Children**—If you are the *covered* dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself *if* you lose group health coverage because of any of the following reasons:

1. A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment;
2. Parent-employee becomes entitled to Medicare;
3. The death of the parent-employee;
4. Parent's final divorce;
5. Termination of domestic partnership or;
6. You cease to be eligible for coverage as a "dependent child" under the terms of the health plan.

The length of continuation coverage is determined by the actual event. If the event is a termination of employment or a reduction of hours on the part of the employee, then qualified beneficiaries are eligible to continue coverage in general for a maximum period of 18 months. If the event is the death of the employee, final divorce, termination of domestic partnership, or a dependent child ceasing to be eligible as a dependent under the terms of the plan, then qualified beneficiaries are eligible to continue coverage in general for a maximum time period of 36 months.

## Qualifying Events—Employer Responsibilities

It is the responsibility of the employer to know when the following qualifying events occur. These qualifying events include, termination of employment, reduction of hours and death of the employee.

## Qualifying Events—Employee/Qualified Beneficiary Responsibilities

It is the responsibility of the covered employee, spouse, domestic partner, dependent, or representative of the qualified beneficiary to notify the Employer Plan Administrator of a final divorce, termination of domestic partnership or a dependent child ceasing to be a dependent child under the terms of the group health plan. Notification of these events **must be made within 60 days of the date of the event or from the date of loss of coverage**. Notification must be made in accordance with the reasonable notification procedures that have been established by the plan administrator. These notification procedures must be described in detail in the initial “general” notification that is provided by the employer upon commencement of coverage under the plan. A failure to notify the plan within the required timelines will cause continuation coverage rights to be forfeited.

## Employer COBRA Notification Requirements

You have the responsibility of providing **three** required COBRA notifications to plan participants. The first being provided when coverage under the plan commences, the second when a COBRA qualifying event actually occurs, and third if a determination is made that continuation coverage is not available. If you would like these notices in Word format, please contact EPK & Associates, Inc.

### 1. Initial “General” COBRA Notification

**You** are required to provide each *covered* employee and *covered* spouse or domestic partner with written notification of their rights and obligations under COBRA when they first become covered under the Trust health care plans or within 90 days of the start of that coverage. For more information on when coverage under the plan commences, see **When Coverage Starts** in this manual.

**Single Notice Rule:** You may satisfy the requirement to provide notice to a covered employee and the covered employee’s spouse or domestic partner by furnishing a single notice addressed to both the covered employee and the covered employee’s spouse or domestic partner, if, on the basis of the most recent information available to you, the spouse or domestic partner resides at the same location as the covered employee. **If a covered spouse lives at a different address or if the spouse’s or domestic partner’s coverage under the plan commences after the date on which the covered employee’s coverage commences, then a separate notice would have to be provided to the covered spouse or domestic partner at that time.** For example, if a single employee marries and adds the new spouse to the group health plan according to health care plan rules, then an initial general notice must be sent to the covered spouse at that time.

**Model Notice.** Contained in this section is a model notice that is intended to assist you in discharging the notice obligations of this section. The model reflects US Department of Labor notification requirements. In order to use the model notice, you must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted.

**Reasonable Employee/Qualified Beneficiary Notification Procedures.** As stated above, it is the responsibility of the qualified beneficiary to notify the plan administrator of a final divorce or if a covered dependent child is ceasing to be eligible for coverage under the terms of the plan. **Failure to provide notice within the required time frame of 60 days will result in loss of eligibility for group health insurance continuation coverage.** However, it is your responsibility in the Initial “General” COBRA Notification to establish reasonable procedures for the qualified beneficiary to follow when making this notification. At a minimum, your reasonable procedures should specify the individual or entity designated to receive such notices; specify the means by which notice may be given; and describe the information concerning the qualifying event that you deem necessary in order to provide continuation coverage.

## 2. COBRA “Election” Notification—“Notice of Right to Continue Group Health Insurance Coverage”

**You** are required to provide each *covered* employee, *covered* spouse or domestic partner, and *covered* dependent with written notification of their rights to elect to continue and pay for their group health insurance continuation coverage when a qualifying event occurs.

**Timing:** A COBRA election notice shall be provided to *each* qualified beneficiary not later than 44 days after the date of the qualifying event, or, if the loss of coverage date is being used as the qualifying event date, then not later than 44 days from the loss of coverage date.

**Special notice rule:** The notice shall be furnished to each qualified beneficiary or individual, except that an administrator may provide notice to a covered employee, the covered employee’s spouse or domestic partner, and each qualified beneficiary who is the dependent child of a covered employee by furnishing a single notice addressed to both the covered employee and the covered employee’s spouse or domestic partner, if, on the basis of the most recent information available to you, the covered employee’s spouse or domestic partner and dependent child(ren) reside at the same location as the covered employee.

The notice shall be written in a manner calculated to be understood by the average plan participant and should clearly identify each qualified beneficiary who is recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event.

**Model notice.** Contained in this section is a model notice that is intended to assist you in discharging the notice obligations of this section. Use of the model notice is not mandatory. The model reflects US Department of Labor notification requirements. In order to use the model notice, you must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted.

## 3. Notice of Unavailability of Continuation Coverage

In the event you are not notified of a final divorce, termination of domestic partnership or a dependent child ceasing to be a dependent child under the terms of the group health plan within the 60 days as required by plan and COBRA rule, a determination can be made that the individual is not entitled to continuation coverage because of their failure to follow the reasonable notification procedures. If continuation coverage is not going to be offered, you shall provide to the individual an explanation as to why the individual is not entitled to elect continuation coverage. Notice shall be furnished in the same time period that would apply if you had determined the individual was entitled to elect continuation coverage.

# Employer COBRA Qualifying Event Notification Procedures

Once you have determined a qualifying event has occurred, the following steps must be taken.

## 1. Termination of Health Insurance—Retroactive Reinstatement

**You** are *required* to cancel coverage of a qualified beneficiary from active group coverage by providing to EPK & Associates a completed *Change Transmittal* form. If a qualified beneficiary has a claim that occurs after the loss of coverage date, it will not be considered an eligible expense and will be denied payment. However, if the qualified beneficiary elects **and pays** for continuation coverage in the appropriate time periods, then their group health insurance under the Trust will be reactivated by EPK & Associates back to the loss of coverage date. Any valid claims will be released for payment as long as the former employer has also paid their group's current amount due.

## 2. COBRA Election Notice Procedures

As described in the ***Employer COBRA Notification Requirements*** section, you are required to provide each qualified beneficiary within 44 days of a qualifying event:

- *COBRA Election Notice—Notice of Right To Continue Group Health Insurance Coverage (Model COBRA Continuation Coverage Election Notice)*
- *Continuation Coverage (COBRA) Election form*

A model *Notice of Right To Continue Group Health Insurance Coverage and Continuation Coverage Election* form are included in this section. If a qualified beneficiary wishes to elect to continue their group health insurance, the *Continuation Coverage Election* form is sent directly by the qualified beneficiary to EPK & Associates for processing.

Mail the notice and election form to the qualified beneficiary's last known address via first class mail, certified mail or certificate of mailing. If a qualified beneficiary lives at a different address than the covered employee, for example; because of a divorce, termination of domestic partnership or a dependent ceasing to be a dependent, then the notice is to be sent to that address.

Failure to send the notice within the 44-day COBRA notification period can have severe consequences for your firm. Additionally, failure by an employer to timely provide a COBRA notice does not terminate a qualified beneficiary's right to continuation of group health coverage. However, such a failure will eliminate any obligation on the part of the Trust and/or its insurance carriers to provide this continuation coverage under the plan. This effectively means that the firm will self-fund any claims the qualified beneficiary incurs.

### 3. Employer Administration Fundamentals

To insure that the employer properly administers their responsibilities under COBRA and to prevent against errors, it is recommended by federal regulators that the employer take the following administration steps.

- Establish Written COBRA Standard Operating Procedures (SOPS)
- Document all notifications (who, what, where, why, and how)
- Train all personnel involved in administration of COBRA
- Establish an audit system to insure all notices were sent in a timely manner
- Periodically review all COBRA notifications to insure they are updated in a timely manner

## COBRA Election Period

A qualified beneficiary must elect continuation of group health insurance coverage by returning a completed and **signed** *Continuation Coverage Election* form to EPK & Associates within 60 days after the later of:

- the date he or she is sent the *Notice of Right to Continue Group Health Insurance Coverage* (as long as that notice is sent within the required timeframe), or
- the date coverage under the Trust health plan ends

Elections are deemed made on the date the Election Form is sent to EPK & Associates. If a qualified beneficiary fails to elect continuation coverage during the 60-day election period, he or she will no longer be eligible to continue their group health insurance coverage. **No late COBRA elections will be accepted.**

**Example:** An unmarried employee without children who is receiving coverage under a Trust health plan voluntarily terminates employment on January 1, 2004. The *Notice of Right To Continue Group Health Insurance Coverage* is sent by you on January 15, 2004, but coverage under the Trust does not end until January 31, 2004. In this example, the qualified beneficiary would have 60 days to elect continuation coverage from January 31, 2004 since this is the later of the two dates. However, if you did not send the *Notice of Right To Continue Group Health Insurance Coverage* until February 5, 2004, then the qualified beneficiary would have 60 days from February 5, 2004 since February 5th is now the later of the two dates.

## Duration of Continued Group Health Insurance

### How Long will Continuation Last?

In the case of loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, final divorce, termination of domestic partnership or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if 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).

## Group Health Insurance “COBRA” Payments

Qualified beneficiaries who elect to continue their group health insurance must pay the full cost of the group health insurance coverage, plus a 2% administration fee. All payments are made by the qualified beneficiary directly to EPK & Associates.

For current continuation coverage rates, contact EPK & Associates at (425) 641-7762 or (800) 545-7011 (toll-free).

Once a qualified beneficiary elects continuation coverage by sending the election form to EPK & Associates, they must pay their initial continuation coverage payment within 45 days of the date they elected continuation coverage. This payment is to cover the initial rate months - the period from the date coverage under the Trust plans ends through the 45th day after coverage is elected. If payment is not made within this 45-day period, then rights to continuation coverage are lost and any claims occurring after the loss of coverage date will remain unpaid.

After this initial payment, monthly payments are due on the first of each month for that month's coverage. Checks for payments should be made out to the “**NMTA/NMTA Trust**” and sent to:

NMTA Health Trust  
c/o EPK & Associates, Inc.  
15375 SE 30th Pl, #380  
Bellevue, WA 98007

The qualified beneficiary has a 30-day grace period following the monthly due date in which to make full payments. Delinquent notices are not provided to the qualified beneficiary. If payments are not postmarked within the grace period, coverage will be canceled retroactively to the last day of the month for which full monthly payment was made.

**Note: Once canceled, continuation coverage can not be reinstated.**

## EPK & Associates' Responsibilities

EPK & Associates takes the responsibility for the following continuation coverage related duties for your firm:

- Once the qualified beneficiary elects to continue, process the Continuation Coverage Election form
- Denying late COBRA elections and communicating with qualified beneficiary
- Providing monthly billing statements to continuation coverage participants (not required by law)
- Processing and collecting COBRA payments
- Forwarding eligibility and enrollment information to the applicable insurance companies
- Reinstating group health insurance coverage
- Answering all qualified beneficiary written and telephone inquiries
- Terminating continuation coverage when applicable
- Notifying qualified beneficiaries of termination of coverage
- Notification of premium changes
- Notification of plan changes
- Processing open enrollment changes
- Notifying qualified beneficiaries of conversion rights upon expiration of coverage
- Processing second qualifying events
- Administering continuation coverage disability extensions
- Notification of early COBRA termination

## When COBRA Coverage Ends

Please refer to the benefits booklet for information on cancellation of COBRA coverage.

Please see the ***When You Are No Longer Eligible For Coverage*** section in the benefits booklet for information on conversion plans available when your COBRA continuation ends.

**Warning: this is a model of the notice that the employer must provide to qualified beneficiaries who become covered. This notice must be adapted to the specific circumstances of the employer. Neither the NMTA Health Trust Program nor EPK & Associates, Inc. represents or warrants that the notice satisfies the requirements of COBRA. The employer should consult with its employee benefits counsel before using this model as the basis for its own notice.**

*This is a model notice to be typed on your company letterhead*

## **MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS**

### **\*\* CONTINUATION COVERAGE RIGHTS UNDER COBRA \*\***

#### **Introduction**

You are receiving this notice because you have recently become covered under the NMTA Health Trust Program. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the 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. 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. 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.

The Plan Administrator is *[enter name, address and telephone number of Group]*. The Plan Administrator is responsible for administering COBRA continuation coverage.

#### **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 this notice. 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, domestic partners 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.

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

- (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 or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- (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 becoming entitled to Medicare,
- (5) You become divorced from your spouse, or
- (6) Termination of domestic partnership.

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

- (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 becoming entitled to Medicare,
- (5) The parents become divorced,
- (6) The employee and domestic partner's termination of domestic partnership or,
- (7) The child stops being eligible for coverage under the plan as a "dependent child."

For dependent qualifying events (divorce of the employee and spouse, termination of domestic partnership the employee and domestic partner, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: *[Enter name and address of group]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, whether it should be in writing, etc.]*

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment, reduction of the employee's hours of employment or employee becoming entitled to Medicare, COBRA continuation coverage lasts for up to 18 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 at any time during the first 60 days of COBRA continuation coverage and you notify the Trust Administrator (EPK & Associates, Inc.) in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Trust Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. A copy of the determination letter from the Social Security Administration **must** be sent with the written notice. This notice should be sent to:

EPK & Associates, Inc.  
15375 SE 30<sup>th</sup> Pl, Suite 380  
Bellevue, WA 98007

### ***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 or domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse or domestic partner and dependent children if the former employee dies, gets divorced or termination of domestic partnership. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Trust Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to EPK & Associates, Inc. at the address above in writing.

### **If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact EPK & Associates, Inc. at 1-800-545-7011, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep Your Plan Informed of Address Changes**

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

**Warning:** this is a model of the notice that the employer must provide to qualified beneficiaries who are entitled to elect COBRA coverage. This notice must be adapted to the specific circumstances of the employer. Neither the NMTA Health Trust Program nor EPK & Associates, Inc. represents or warrants that the notice satisfies the requirements of COBRA. The employer should consult with its employee benefits counsel before using this model as the basis for its own notice.

***Please note: an Election Form cannot be processed until we receive the initial premium payment. In addition, all claims including prescription drug benefits, occurring after the loss of coverage will be held in pending status. Once full payment has been received, and the former employer has paid their monthly premium, the Election Form will be processed and the benefits all eligible claims will be released for payment according to the terms of the health insurance contract.***

*This is a model notice to be printed on your company letterhead*

## MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

[Enter date of notice]

Dear [enter name of employee, spouse, dependent children, as appropriate]:

This notice contains important information about your right to continue your health care coverage in the NMTA Health Trust as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Please read the information contained in this notice very carefully.

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage, you should contact the Trust Administrator, EPK & Associates, 15375 SE 30<sup>th</sup> Place #380, Bellevue, WA 98007, 1-800-545-7011.

If you do not elect to continue your health care coverage by completing the enclosed Election Form and returning it to the Trust Administrator, your coverage under the Plan will end on [enter date] due to:

- End of employment
- Death of employee
- Reduction in hours of employment
- Divorce
- Loss of dependent coverage

Each of the following persons is entitled to elect to continue health care coverage under the Plan:

- Employee – [enter name]
- Spouse (or former spouse of employee) – [enter name]
- Dependent children – [enter name(s)]

Because of the event checked above that will end your coverage under the Plan, you (and/or, as appropriate, your spouse, domestic partner and dependent children) are entitled to continue your health care coverage for up to **[enter 18 or 36, as appropriate]** months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on the first of the month following your loss of coverage and can last until **[enter date]**.

Your continuation coverage will cost: **[enter amount each qualified beneficiary would be required to pay for each option per month of coverage and any other permitted coverage periods]**.

**IMPORTANT – To elect continuation coverage you MUST complete the enclosed Election Form and return it with payment to:**

NMTA Health Trust  
15375 SE 30<sup>th</sup> Place #380  
Bellevue, WA 98007

The completed Election Form must be postmarked by **[enter date]**. If you do not submit a completed Election Form by this date, you will lose your right to elect continuation coverage. Important information about your rights is provided to you on the following pages.

***Please note: an Election Form cannot be processed until we receive the initial premium payment. In addition, all claims including prescription drug benefits, occurring after the loss of coverage will be held in pending status. Once full payment has been received, and the former employer has paid their monthly premium, the Election Form will be processed and the benefits all eligible claims will be released for payment according to the terms of the health insurance contract.***

There may be other coverage options for you and your family. The Affordable Health care law allows you to buy coverage through the Health Insurance Marketplace. 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. For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov). For the state of Washington you should go to [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org)

## **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 covered under the group health plan, a covered employee’s spouse, a covered employee’s domestic partner and 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. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's Summary Plan Description (SPD), which can be obtained from EPK & Associates, 15375 SE 30<sup>th</sup> Place #380, Bellevue, WA 98007, 1-800-545-7011.

### **How Long Will Continuation Last?**

In the case of loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, final divorce, termination of domestic partnership or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan, if a covered employee enrolls in Medicare, or if 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 participant or beneficiary not receiving continuation coverage (such as fraud).

### **How Can You Extend the Length of Continuation Coverage Beyond 18 Months?**

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify EPK & Associates in writing of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability (including a copy of the Social Security determination letter) or second qualifying event may affect the right to extend the period of continuation of coverage.

#### ***Disability***

An 11-month extension of coverage may be available, beyond the original 18 months, if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify EPK & Associates of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify EPK & Associates of that fact within 30 days of SSA's determination. A copy of the determination should accompany this notice.

#### ***Second Qualifying Event***

An 18-month extension of coverage will be available to spouses, domestic partners 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 include the death of a covered employee, divorce from the covered employee, termination of domestic partnership, or a

dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify EPK & Associates within 60 days after a second qualifying event occurs.

### **How Can You Elect Continuation Coverage?**

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse or domestic partner may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage within 60 days of the loss of coverage or date of notice, whichever is later. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

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 pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get 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 Continuation Coverage Cost?**

Each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary will be required to pay may not exceed 102 percent of the cost of 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 continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

### **When and How Must Payment for Continuation Coverage Be Made?**

#### ***First Payment for Continuation Coverage***

If you elect continuation coverage, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this *entire* period. You may contact EPK & Associates at 1-800-545-7011 to confirm the correct amount of your first payment.

***Please note: an Election Form cannot be processed until we receive the initial premium payment. In addition, all claims including prescription drug benefits, occurring***

*after the loss of coverage will be held in pending status. Once full payment has been received, and the former employer has paid their monthly premium, the Election Form will be processed and the benefits all eligible claims will be released for payment according to the terms of the health insurance contract.*

Your first payment for continuation coverage should be sent to:

NMTA Health Trust  
15375 SE 30<sup>th</sup> Place #380  
Bellevue, WA 98007

### ***Periodic Payments for Continuation Coverage***

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are **due on the first of every month**. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of delinquent payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

NMTA Health Trust  
15375 SE 30<sup>th</sup> Place #380  
Bellevue, WA 98007

### ***Grace Periods for Periodic Payments***

Although periodic payments are due on the first of every month, you will be given a grace period of 30 days 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 or postmarked before the end of the grace period for that payment.

However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be pended as of the due date and then retroactively advanced (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is pended may be denied and may have to be resubmitted once your eligibility is advanced.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, by providing proof of insurability and applying within 31 days of your loss of coverage. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you.

### **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. You can get a copy of your Summary Plan Description from EPK & Associates, 15375 SE 30<sup>th</sup> Place #380, Bellevue, WA 98007.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact 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](http://www.dol.gov/ebsa).

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Trust Administrator informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to the Trust Administrators.

# NMTA HEALTH INSURANCE TRUST

## Continuation Coverage (COBRA) Election Form

### A. Employee / Employer Information:

Employee Name: \_\_\_\_\_  
(Please print - last name, first name, middle initial)

(Former) Employer: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Employer Group #: \_\_\_\_\_

Employee Social Security #: \_\_\_\_\_

For Disabled and/or Over age 65 applicants:  
Is applicant "entitled" to Medicare benefits? Yes No  
If "Yes", indicate date of Medicare Entitlement: \_\_\_\_\_

### B. Qualifying Event / Type of Coverage:

1. Indicate which QUALIFYING EVENT caused applicant's Loss of Coverage:
- a.  Termination of employment/reduction in hours
  - b.  Death of Employee
  - c.  Divorce
  - d.  Employee becoming eligible for Medicare
  - e.  Dependent Child no longer eligible
  - f.  Other (explain) \_\_\_\_\_

4. Indicate type of Continuation Coverage requested:  
Continue coverage for (check only one box):
- a.  Employee Only
  - b.  Dependent(s) Only
  - c.  Employees & Dependents

2. Date of Qualifying Event: \_\_\_\_\_

Note: Life and AD&D insurance coverages are not included under Continuation Coverage.

3. Last date of coverage \_\_\_\_\_

### C. Applicant Information:

(Applicant is Employee unless B.4.b "Dependent Only" Continuation Coverage is elected)

1. Applicant's Name: \_\_\_\_\_  
(Please print - last name, first name, middle initial)

2. Social Security #: \_\_\_\_\_

3. Address: \_\_\_\_\_

4. Applicant's Birthdate: \_\_\_\_\_

(City) (State) (Zip)

5. Telephone #: \_\_\_\_\_

(Monthly billing statement and all correspondence will be sent to this address)

6. List all Dependents for whom Continuation Coverage is elected: (continue on additional page if necessary)

Name of Dependent	Date of Birth	Relationship to Employee
_____	_____	_____
_____	_____	_____
_____	_____	_____

### D. Terms and Conditions: Note: application will not be processed until payment is received

I elect Continuation Coverage on the applicant and dependents (if any) listed above in accordance with the Continuation Coverage terms and conditions listed on the back of this form. I agree to make retroactive rate payment within 45 days of the date of this election for all months outstanding since my employer sponsored coverage ended. I agree to make future rate payments in full within the time frames specified on the back of this form. I have read, understand and agree to the Continuation Coverage provisions set forth on the back of this form:

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Return this Form and Payment To:  
NMTA Trust c/o EPK & Associates, Inc.  
15375 SE 30th PL. #380; Bellevue, WA 98007

Administrator's Use Only  
COBRA No: \_\_\_\_\_ Cov. \_\_\_\_\_  
Effective Date: \_\_\_\_\_

## NMTA HEALTH TRUST Continuation Coverage (COBRA) Terms and Conditions for Participation

1. You are eligible for COBRA Continuation Coverage only if (1) the Employer is a current participant in the NMTA Health Insurance Trust program and (2) the Employer has certified it is subject to the Continuation Coverage law.
2. To elect Continuation Coverage, you must complete and submit this Continuation Coverage Election Form to the Trust Administrator within 60 days after the day coverage terminated, or, if later the day your Employer gave you this Continuation Coverage Election Form (provided the Employer met their 44 day COBRA notification requirement). If the Employer does not meet the 44 day notification requirement described above, this Election Form must be received, or postmarked, within 104 days from the later of the COBRA qualifying event or the date coverage under the plan terminates. If your Election Form is not received within the 104 day period Continuation Coverage will not be provided through the NMTA Trust program.
3. You must submit your first Continuation Coverage rate payment within 45 days after the date you elect Continuation Coverage on the Election Form. Your first retroactive rate payment must be for the full amount necessary to cover the initial rate months. The "initial rate months" are the months that end on or before the 45th day after the date of the Continuation Coverage election. After the first rate payment, rate payments are due on the first day of each month for that month's Continuation Coverage, and must be paid in full within 30 days after the first day of the month. If you fail to make full payment within the required time periods, Continuation Coverage terminates retroactively to the last day of the month for which full timely payment has been made, and will NOT be reinstated.
4. The rate for Continuation Coverage is 102% of the rate charged to similarly situated individuals covered under the Former Employer's group plan. Rates are subject to change at least annually. Rates are also subject to change in the event of a benefit change elected by the Former Employer. COBRA participants are eligible only for the same NMTA Medical, Dental and Vision benefits selected by the Former Employer.
5. If the employee's spouse, domestic partner or dependent child loses plan coverage because of the employee's death, divorce, or termination of Domestic Partnership, the dependent child loses plan coverage because he or she ceases to be a dependent under the plan, the maximum coverage period (for spouse, domestic partner and dependent child) is 3 years from the first day of the month following the qualifying event. If the employee, spouse, domestic partner or dependent child loses plan coverage because of a termination, reduction in hours of the employee's employment or employee becomes entitled to Medicare, the maximum continuation coverage period (for the employee, spouse or dependent child) is 18 months from the first day of the month following the termination or reduction in hours of employment. There are two exceptions:
  - If an employee or family member is disabled at any time during the first 60 days after the termination or reduction in hours of employment, the maximum coverage period for the disabled individual and the family members who elect Continuation Coverage is 29 months from the first day of the month following termination or reduction in hours. The disability that extends the 18 month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the NMTA Trust Administrator within the 18-month coverage period and within 60 days after the date of the determination.
  - If a second qualifying event that gives rise to a 36 month maximum coverage period occurs (for example, the employee dies, divorces, termination of domestic partnership or a child ceases to be an eligible dependent) within the 18-month or 29-month coverage period, the maximum coverage period for the spouse, domestic partner and dependent child becomes 3 years from the first day of the month following termination or reduction in hours of employment.
6. Continuation Coverage automatically terminates (even before the end of the maximum coverage period) when any one of the following 6 events occur:
  - The Former Employer no longer provides a medical, dental or vision plan through the NMTA Health Insurance Trust (as the case may be) to any of its employees;
  - The full rate payment for Continuation Coverage is not timely paid.
  - You (employee, spouse, domestic partner or dependent child) become covered under another group health plan .
  - You (employee, spouse, domestic partner or dependent child) become entitled to Medicare benefits (applies only to person entitled to Medicare).
  - If you became entitled to a 29-month maximum coverage period, but then there is a final determination under Title II or Title XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled. However, Continuation Coverage will not end until the month that begins more than 30 days after the determination.
  - An event occurs that permits termination of coverage under the NMTA Trust for cause.
7. Your application cannot be processed until we receive your initial premium payment. In addition, all claims including prescription drug benefits, occurring after your loss of coverage will be held in pending status. Once full payment has been received, and your former employer has paid their monthly premium, all eligible claims will be released for payment according to the terms of the health insurance contract.

NMTA Health Trust—c/o EPK & Associates, Inc.—15375 SE 30th Pl. #380 Bellevue, WA 98007—Phone 1-800-545-7011

# Sample Forms



# NMTA Health Trust

## Change Transmittal Form

### I. INSTRUCTIONS:

Use this form to: a) Cancel employee coverage; b) Cancel dependent coverage, or c) Update insurance information. For coverage cancellation, the NMTA Administrator must receive this form within 15 days of a participant's last day of coverage. **Do not use this form to add employees and/or dependents to your plan.** The NMTA Employee/Subscriber Application Form, signed by the employee, is required to add new employees and/or dependents to your plan.

**Please submit all forms to:** NMTA Health Trust  
**Attn: EPK & Associates, Inc.**  
**15375 SE 30<sup>th</sup> Pl Suite 380**  
**Bellevue WA 98007**

### II. CANCEL EMPLOYEE COVERAGE *(Note: This also cancels dependent coverage, if applicable.)*

To cancel employees from your plan, please provide the information noted below. Coverage will cease at the end of the month in which the participant is no longer eligible or leaves the firm. Assuming timely notification, "cancellation date" will be the first of the month following the employee's loss of eligibility. Contract provisions prohibit retroactive cancellation of coverage.

Name of Employee	Social Security Number	Cancellation Date	Reason for Cancellation

### III. CANCEL DEPENDENT COVERAGE ONLY

*To cancel an employee's dependent(s) from your plan, please provide the information noted below.*

Name of Employee	Social Security Number	Dependent's Name	Cancellation Date

### IV. CHANGE INSURANCE INFORMATION *(Name change, correct birthdate, correct SSN, etc.)*

Name of Employee	Social Security Number	Description of Change

### V. GENERAL INFORMATION

**Name of Employer:** \_\_\_\_\_ **Employer Number:** \_\_\_\_\_

The person signing this form below acknowledges and affirms:

1. The employee(s) or dependent(s) listed above have not paid premium to the employer after the effective date of the cancellation request, and
2. The employee(s) or dependent(s) listed above have no expectation of coverage after the effective date of the cancellation request

Employer's Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Administered by: EPK & Associates, Inc.  
 15375 SE 30<sup>th</sup> Place – Suite 380 - Bellevue, WA 98007

Phone Number (Toll Free) 1-800-545-7011 or (425) 641-7762  
 FAX Number: (425) 641 – 8114 email address: admin@epkbenefits.com  
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