



1076 Franklin Street SE • Olympia, WA 98501-1346 • 360.753.4137 • 1.800.562.8981

awcnet.org

Continuation Coverage Rights Under COBRA

To: Municipal employees & family members covered on AWC-Trust sponsored health coverage
From: AWC Employee Benefits Trust
Subject: COBRA Health Care Continuation Coverage

This notification is being sent for your information only as an annual reminder of your COBRA rights and obligations. There has been no COBRA qualifying event to trigger this notice.

You and your covered family members may continue coverage under your health plan provided through the AWC Employee Benefit Trust ("AWC Trust") in certain instances when coverage would otherwise be lost. **When you first become covered by your health plan, this "Initial COBRA Notification" explains your rights and obligations should your employment end or certain other events occur which cause you to lose your medical coverage.** This notice is also sent to employees and retirees on an annual basis in order to remind you of your COBRA rights.

COBRA coverage will be the same as that provided to employees (or if you are on a retiree plan, retirees) and their covered family members, including domestic partners.

Rules for the continued coverage are provided by federal law – the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and its regulations. COBRA continuation coverage is continuation of Plan coverage when coverage would end because of a life event known as a "qualifying event." Under COBRA, you can continue medical coverage if you have any one of these qualifying events that causes you to lose to coverage under the Plan:

- Your employment terminates for any reason other than for gross misconduct. If you decide not to return to employment at your employer during FMLA leave, you will be offered COBRA at the earlier of the date your FMLA leave ends or the date you tell your employer that you will not return to work after the FMLA leave.
- You are no longer eligible for coverage due to reduced work hours.

Your covered family members can continue coverage if their coverage ends because of one of these qualifying events:

- One of the two qualifying events listed above;
- Your death;
- Legal separation, divorce, or termination of domestic partnership; or
- Your child is no longer eligible for coverage, due to age or loss of disability status.

Persons who are eligible to continue coverage under COBRA are called "qualified beneficiaries." You may change your coverage and add or cancel coverage for eligible family members (1) during any annual or other open enrollment period that is offered; and (2) during any special enrollment period applicable to your coverage.

When the qualifying event is the end of your employment, the reduction of hours of your employment, or your death, your employer will notify the AWC Trust of the qualifying event within 30 days of the event.

You must give notice of some qualifying events. You or a family member is responsible for notifying the AWC Trust of a qualifying event which is your legal separation, divorce, termination of domestic partnership or your dependent child ceasing to be eligible for coverage. Such notice must be provided in writing within 60 days of the qualifying event to the AWC Trust as provided in the "Notice Procedures" below.

Failure to furnish notice in accordance with these rules will result in a loss of coverage continuation rights that are otherwise available under COBRA.

How to apply and pay for COBRA

You must follow the steps below to apply and pay for COBRA continuation coverage.

Within 14 days after the AWC Trust receives notice of your qualifying event, a COBRA Enrollment Form will be mailed to the address listed on your employment record.

Complete the form and return it to the address on the form within 60 days of the later of (a) the date you are notified of the right to choose COBRA coverage; or (b) the date coverage would otherwise end. **IF YOU DO NOT SUBMIT A COMPLETED FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE.**

Send a check or money order for the required premium for the appropriate month(s) to the address on the enrollment form. The envelope must be postmarked within 45 days from the date COBRA is elected.

Payments are due each month on the due date listed on your billing statement, but must be postmarked no later than 31 days after the due date. You will receive premium-due billing statements each month, which will provide the address to which your payments must be mailed.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A spouse or domestic partner may elect, but not decline, COBRA continuation coverage on behalf of the other spouse or domestic partner. Either parent may elect or decline COBRA continuation coverage on behalf of their children, except that children who have reached the age of majority or who are otherwise considered adults under state law must decline COBRA continuation coverage on behalf of themselves.

Duration of COBRA coverage

COBRA continuation coverage is a temporary continuation of coverage. If coverage ends due to your termination of employment (other than for gross misconduct), or a reduction in hours, coverage may be continued for up to 18 months. If coverage ends due to any other qualifying event, coverage may be continued for up to 36 months beginning with the date coverage ended.

If you were originally only eligible for 18 months of COBRA, in the event of a disability (as defined under the applicable provisions of the Social Security Act) existing at the time of your termination or reduction in hours or existing within the first sixty days of COBRA continuation coverage, you and other family members on COBRA continuation are eligible for an additional 11 months of continuation coverage (for a total of 29 months). The disability must also last at least until the end of the initial 18-month period of COBRA continuation coverage. The person(s) wishing to receive the additional 11 months of coverage must notify the Claim Administrator in writing at the address below under "Notice Procedures" of the determination of disability by the Social Security Administration within 60 days of the later of (a) the date of the disability determination by the Social Security Administration; or (b) the date on which the qualifying event occurred that entitled you and/or your family members to receive COBRA continuation coverage with a maximum duration of 18 months.

However, such written notice must be furnished before the end of the first 18 months of COBRA continuation coverage. A copy of the Social Security determination must be included with the notice. If during the additional 11-month period it is determined that the person is no longer disabled under the Social Security Act, the right to continuation coverage ceases. The affected person must notify the AWC Trust in writing at the address below under "Notice Procedures" that the person is no longer disabled within 30 days of such determination.

Failure to furnish a written notice in accordance with the Plan rules and the Notice Procedures will result in a loss of coverage continuation rights that are otherwise available under COBRA.

If you are a spouse, a domestic partner, or a Dependent child and you were originally only eligible for 18 months of COBRA continuation, and during the first eighteen (18) months, one of the four following events happens which would also have caused you to lose coverage, you are eligible for an additional 18 months of continuation coverage (for a total of 36 months): death of the Employee; divorce, legal separation, or termination of domestic partnership of the Employee; or the Dependent child ceasing to be eligible as a Dependent under the Benefit. You or a family member is responsible for notifying the AWC Trust in writing at the address below under "Notice Procedures" of such an event within 60 days of its occurrence. Reasonable documentation of the second qualifying event must be included with the notice. For example, if the second qualifying event is your death, a certified copy of the death certificate must be included. If it is your divorce, a copy of the final divorce decree must be included. **Failure to furnish written notice in accordance with these rules will result in a loss of coverage continuation rights that are otherwise available under COBRA.**

COBRA may also be elected, for the remainder of the parents' own continuation coverage, for any Dependent child born to, placed for adoption with or adopted by an employee or former employee during the period of COBRA continuation coverage. When a family member becomes eligible for continuation coverage when or after an employee becomes entitled to Medicare, the family member is entitled to continuation for a period of no less than 36 months from the date the employee became entitled to Medicare.

COBRA coverage will terminate if your employer terminates group coverage on all its employees (or if you are on retiree coverage, for all of its retirees) or if the recipient becomes covered under Medicare or covered under a new group health plan after the COBRA election (as long as the recipient is not subject to a pre-existing condition limitation in the other group plan). You must notify the AWC Trust in writing at the address listed below under "Notice Procedures" if you become entitled to Medicare or become covered under other group health plan within 30 days of such entitlement or coverage. However, your COBRA coverage will not be terminated based on the fact that you had other group coverage (including Medicare) in place prior to electing COBRA. Non-payment of premiums will also terminate coverage at the end of a 31-day grace period. Following the termination of continuation coverage, no further benefits will be payable unless eligible charges were actually incurred prior to the date continuation coverage terminates.

Special considerations in deciding whether to elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA 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 preexisting condition exclusions if you do not get COBRA 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) with 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end the COBRA coverage if you get COBRA coverage for the maximum time available to you.

Cost of COBRA coverage

You pay the full premium cost of COBRA coverage, plus a 2% administrative fee, as permitted by law. For any COBRA member who has extended COBRA eligibility for 11 months due to a disability, the cost of the extended coverage will be 150% of the full premium cost.



AWC Employee Benefit Trust
 1076 Franklin Street SE
 Olympia, WA 98501

PRESORT STD
 U.S. POSTAGE
 PAID
 OLYMPIA, WA
 PERMIT NO. 201



*****AUTO**ALL FOR AADC 990
 TIFFANY ROGERS 14195 55
 PO BOX 194
 ASOTIN WA 99402-0194

Address changes

In order to protect your family's rights, you should keep your employer and the AWC Trust informed in writing of any changes in the address or marital status or domestic partnership of family members. You should also keep a copy for your records of any notices you send to the AWC Trust, your employer, or anyone else concerning COBRA.

This notice may not describe all information concerning your continuation rights under federal law. More complete information regarding such rights is available by contacting the AWC Trust.

COBRA Notice Procedures

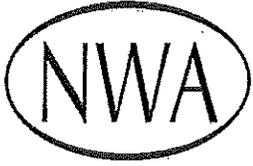
Any notice that you provide must be *in writing* to the AWC Trust as described below: Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice addressed as follows:

<p>Mail to: AWC Employee Benefit Trust c/o Northwest Administrators P.O. Box 84303 Seattle, WA 98124</p>	<p>Hand-deliver to: AWC Employee Benefit Trust 1076 Franklin Street SE Olympia, WA 98501</p>
OR	
<p>Fax to: AWC Employee Benefit Trust c/o Northwest Administrators (206-926-2699)</p>	<p>AWC Employee Benefit Trust c/o Northwest Administrators 2323 Eastlake Avenue East Seattle, WA 98102</p>

If mailed, your notice must be postmarked no later than the last day of the required notice period. In addition to the information required by the Plan for the notice, all notices you provide must state:

- The name of the Plan,
- The name and address of the employee or former employee,
- The name(s) and address(es) of the qualified beneficiary(ies), and
- The Qualifying Event and the date it happened.

If the qualifying event is a divorce, legal separation, or termination of domestic partnership, your notice must include a copy of the divorce decree, legal separation agreement, or similar document.



ASSOCIATION OF WASHINGTON CITIES
 c/o Northwest Administrators, Inc.
 2323 Eastlake Avenue East
 Seattle, WA 98102-3393
 (206) 726-3285 Fax (206) 926-2699



**COBRA NOTICE TO ADMINISTRATOR
 (SPOUSE/DEPENDENTS)**

INSTRUCTIONS TO SPOUSE/DEPENDENT: In order to maintain your rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you or a family member must inform the Plan Administrator if your health plan coverage ends as a result of a divorce, legal separation, or if a child loses dependent status under the terms of the group health plan. You must inform us within 60 days of the date the event occurs, (or if later, within 60 days of the date on which coverage would end under the plan because of the event) in order to be eligible for continued COBRA coverage.

If one of the Qualifying Events described above occurs, please complete this form and send it to Northwest Administrators at the address shown above.

COBRA qualifying event:	
<input type="checkbox"/> Divorce or Legal Separation	
<input type="checkbox"/> Child has lost "Dependent Child" status under the plan	

Date of qualifying event:	Date coverage ends:

Name of spouse (if applicable): _____	Date of birth: _____
Name of dependent (if applicable): _____	Date of birth: _____
Current Address: _____	
City: _____	State: _____ Zip Code: _____
Telephone No.: _____	Social Security No.: _____

Name of employee: _____	Social Security No.: _____
Employer name: _____	

Signature of spouse, dependent or family member	
_____	_____
(Signature)	(Date)