

INITIAL COBRA NOTICE

TO: All Employees Covered Under the Plan and Their Covered Spouses

FROM: The Ideal Group

RE: Continuation Coverage Requirements for Health Plans

On April 7, 1986, a Federal law was enacted [Public Law 99-272, Title X] requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This Notice is intended to inform you in a summary fashion of your rights and obligations under the continuation coverage provisions of the law. (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to read this Notice carefully.)

If you are an employee of the Employer and covered by the Employer's group health plan (called "the plan" in this Notice), you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee and you are covered by the plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the plan for *any* of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with the Employer;
3. Divorce or legal separation from your spouse;
4. Your spouse becomes entitled to Medicare.

In the case of a covered dependent child of an employee, he or she has the right to choose continuation coverage if group health coverage under the plan is lost for *any* of the following five reasons:

1. The death of the employee;
2. The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with the Employer;
3. The employee's divorce or legal separation;
4. The employee becomes entitled to Medicare;
5. The dependent ceases to be a "dependent child" under the plan.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, of a legal separation, or of a child losing dependent status under the plan, within 60 days of the event. Failure to meet this notice requirement results in loss of continuation coverage rights. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment, or Medicare entitlement. (Similar rights may apply to certain retirees, spouses, and dependent children if the Employer commences a bankruptcy proceeding and these individuals lose coverage.)

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.

Effective January 1, 1997, children born to, or placed for adoption with, a covered employee during a continuation coverage period also have the right to elect COBRA continuation coverage.

If you do not choose continuation coverage, your group health coverage will end.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is generally 18 months. This 18 months may be extended for affected individuals to 36 months from the termination or reduction in hours of employment if other events (i.e., the employee's death, divorce, legal separation, or Medicare entitlement) occur during the original 18 month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made an individual eligible to elect coverage.

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) at any time during the first 60 days of COBRA continuation coverage. To benefit from this extension, you must notify the Plan Administrator of that determination within 60 days of the date of the determination and before the end of the original 18 month period. If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, these non-disabled family members are also entitled to the extension of the COBRA continuation coverage period from 18 to 29 months. A greater premium amount applies to the 11-month extension period. The affected individual(s) also must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

The law provides that your continuation coverage will be cut short for *any* of the following five reasons:

1. The Employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. After the date of your continuation coverage election, you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have. If the exclusions or limitations for pre-existing conditions in the other group health plan would not apply to you (or would be satisfied by you) due to the requirements enacted by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), then the Plan may terminate your COBRA continuation coverage. The HIPAA rules become effective in plan years beginning on or after July 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements);
4. You become entitled to Medicare; or
5. You extended coverage for up to 29 months due to disability and there has been a final determination that the disabled individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you must pay all of the cost of your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the 18, 29, or 36 month continuation coverage period, you are allowed to enroll in an individual conversion health plan if otherwise provided under the plan.

If there are any changes to your marital status, your or your spouse's address(es), or the dependent status of any of your children under the plan, please notify the Plan Administrator immediately.

Please note that this Notice is merely a summary of a very complicated federal law. In the event of any inconsistency between this Notice and federal law, federal law will control. Also, please note that this Notice is not intended to inform you about any details of the plan. You should refer to your copy of the plan's Summary Plan Description, or request a copy of it or of the plan's governing document, for such details.

Important Notice from *The Ideal Group* about Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Blue Cross Blue Shield of Michigan Prescription Plan** for 2010 and prescription drug coverage available since January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decision about your prescription drug coverage.

1. Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare.
 2. **The Ideal Group** has determined that the prescription drug coverage offered by the **Blue Cross Blue Shield of Michigan Prescription Plan for 2010** is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
 3. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.
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You may have heard about Medicare's prescription drug coverage, and wondered how it would affect you. **The Ideal Group** has determined that your prescription drug coverage with **Blue Cross Blue Shield of Michigan Prescription Plan** is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide enroll in Medicare coverage.

Each year, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

If you do decide to enroll in a Medicare prescription drug plan and drop your **Blue Cross Blue Shield of Michigan Prescription Plan prescription drug coverage, be aware that you may not be able to get this coverage back.**

If you drop your coverage with **Blue Cross Blue Shield of Michigan Prescription Plan** and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare you current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with **Blue Cross Blue Shield of Michigan Prescription Plan** and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You 2007" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

*Visit www.medicare.gov for personalized help.

*Call your State Health Insurance Assistance Program (see your copy of the Medicare & you handbook for their telephone number)

*Call 1-800-MEDICARE (1-800-633-4227). TY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778)

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	04/20/2010
Name of Company/Sender:	The Ideal Group
Contact-Position/Office:	Human Resources Department
Address:	2525 Clark Street Detroit, MI 48209
Phone Number:	(313) 849-0000

The Health Insurance Portability and Accountability Act (HIPAA)

Fact Sheet from the U.S. Department of Labor Employee Benefits Security Administration – December 2004

The Health Insurance Portability and Accountability Act (HIPAA) offers protection for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions)
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law

Preexisting Condition Exclusions

- The law defines a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage)
- Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date
- Under HIPAA, a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more, thereby reducing or eliminating the 12-month exclusion period (18 months for late enrollees)

Creditable Coverage

- Includes prior coverage under a group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends
- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents
- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights. A new model certificate is available on EBSA's Web site
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence – like pay stubs, explanation of benefits, letters from a doctor – if you cannot get a certificate.

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates.
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption

Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Employee Benefits Security Administration by visiting www.dol.gov/ebsa or call 1-866-444-EBSA (3272). For TTY, call 1-877-889-5627.

Notice to Employees of Rights under FMLA

Your Rights under the Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks unpaid, job protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least 12 months and 1,250 hours, separate periods of employment count toward the total as long as the break in service is no longer than seven years (unless the longer break was caused by military service or there was a written agreement with the employer) and if there are at least 50 employees within 75 miles.

Reasons for Taking Leave: Unpaid leave must be granted for any of the following reasons:

- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son, daughter or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.
- Up to 12 weeks of leave for certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status, in support of a contingency operation. “Qualifying Exigency Leave” includes: Short Notice Deployment, Military Events and related activities, child care and school activities, financial and legal arrangements, counseling, rest and recuperation, post deployment activities.
- Up to 26 weeks of leave in a single 12-month period to care for a covered service member recovering from a serious injury or illness incurred in the line of duty on active duty. Eligible employees are entitled to a combined total of up to 26 weeks of all types of FMLA leave during the single 12-month period.

Serious Health Condition definition:

- A serious health condition requires incapacity for more than three calendar days plus “two visits to a health – care provider”. There must be two visits to a health care provider within 30 days of the beginning of the period of incapacity. The first visit to a health care provider must occur within seven days of the first day of incapacity, and for chronic serious health conditions, the employee must visit a health care provider at least twice per year.

Advance Notice and Medical Certification: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable”
- Unexpected FMLA leave notice must be given to the Employer as per the normal and customary call-in procedure, absent unusual circumstances. Example: if employees must report an absence before the start of their shift.
- An employer may require medical certification to support a request for leave because of a serious health condition, the employer may have contact with an employee’s health care provider, however; an employee’s direct supervisor is prohibited from having any contact with the employee’s health care provider.
- An employer may require a Fitness for Duty certification before the employee may return to work. The employer may require the certification to specifically address whether the employee can perform the essential functions of his/her job.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan”
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Notice:

- When an employee requests an FMLA leave, the employer must **(1) respond within five business days (2) advise the employee whether he or she is eligible (3) provide at least one reason if the leave is denied, (4) discuss arrangements for payment of health insurance premiums, (5) discuss the use of concurrent paid leave.**

Unlawful Acts by Employers: FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under the FMLA.
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division by visiting www.dol.gov/esa/whd/fmla or call the Wage-Hour Office help line at 1-866-4USWAGE (1-866-487-9243).

Notice Regarding the Women's Health and Cancer Rights Act of 1998

Under federal law, the WHCRA notice provided upon enrollment in the plan must state that for the covered worker or family member who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedema.

These benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan coverage.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Employee Benefits Security Administration by visiting www.dol.gov/ebsa or call 1-866-444-EBSA (3272). For TTY, call 1-877-889-5627.

Newborns and Mothers Health Protection Act

This notification is a requirement of the act. If you have any questions you may contact your Plan Administrator or your health Blue Cross Blue Shield of Michigan Prescription Plan directly.

Group health plans and health insurance issuers offering group health insurance coverage may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Michelle's Law

Michelle's Law extends Group Health Benefit Plan Eligibility for Dependent Students on a Medically Necessary Leave of Absence. Most group health plans currently permit participation of a dependent child over the age of 18 only if that child is enrolled at an institution of higher education on a full time basis. Michelle's Law requires such a group plan to extend coverage of a dependent child who loses full-time student status due to serious illness or injury.

There are two important definitions central to this law. *Dependent Child* mean a dependent child of a plan participant who is enrolled under the terms of a group health benefit plan based on his/her student status before the first day of the medically necessary leave of absence. *Medically Necessary Leave of Absence* means a leave of absence: **(1)** *of a dependent child from a post-secondary educational institution or any other change in enrollment that begins while the child is suffering from a serious illness or injury;* **(2)** *which is medically necessary;* and **(3)** *which causes the dependent child to lose student status under the terms of the group health benefit plan.*

The 4 requirements with respect to the administration of this extended coverage are:

- 1) **Doctor's Certification:** A doctor's written certification of the medical necessity of the leave of absence is required for continued participation in a group health benefit plan.
- 2) **Coverage Requirement:** Michelle's Law will prohibit a health benefit group plan from terminating coverage of a dependent child who is on medically necessary leave of absence before the date that is the earlier of: (1) year after the first day of the leave of absence; or (2) the date coverage would otherwise terminate (in the absence of the leave) under the terms of the group health benefit plan. For example, the dependent ages out.
- 3) **Continuity Requirement:** A dependent child on a medically necessary leave of absence is entitled to receive the same group health benefits as other dependents that are eligible and covered under the plan based on their student status. Further, any change in coverage under a group health benefit plan that occurs while a dependent child on a medically necessary leave of absence will be applicable to the remaining period of that leave without interruption.
- 4) **Notice Requirement:** A group health benefit plan will be required to include a notice of the terms of Michelle's Law along with any notice requiring certification of student status to plan participants.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Employee Benefits Security Administration by visiting www.dol.gov/ebsa or call 1-866-444-EBSA (3272). For TTY, call 1-877-889-5627.



We are the agency that coordinated your company's benefit program. We are not your insurance company or legal counsel. We support your company's Plan Administrator / H.R. Department with enrollment assistance and supplies. If you have questions regarding the preceding information, please contact your plan administrator or the government agencies listed.

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5435 Corporate Drive, Suite 250 ▲ Troy, Michigan 48098 ▲ Phone: 248-633-2952 ▲ Fax: 248-530-0043