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**IMPORTANT INFORMATION**  
**ABOUT COBRA CONTINUATION COVERAGE RIGHTS**  
**FOR PLATINUM AND PLATINUM PLUS PARTICIPANTS**

**1. What is COBRA Continuation Coverage?**

COBRA Continuation Coverage (“COBRA Coverage”) is a continuation of group health plan coverage required under federal law. This law requires that most group health plans (including this Fund) give “qualified beneficiaries” 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, as well as the employee’s covered spouse and children. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Domestic partners are not eligible for COBRA Coverage.

COBRA Coverage is the same health care coverage that the Fund gives to other Fund participants and dependents who are not receiving COBRA Coverage. Each qualified beneficiary who elects COBRA Coverage will have the same rights under the Fund as other Fund participants or dependents, including Open Enrollment and Special Enrollment Rights. COBRA Coverage does not include Death Benefits or Industry Vacation.

**2. How can you elect COBRA Coverage?**

To elect COBRA Coverage, you must complete the enclosed Election Form according to the directions on the form and mail it to the Fund Office before the Final Election Date shown on the first page of the Notice of Qualifying Event for COBRA Continuation Coverage (the “Election Notice”). Failure to do so will result in the loss of your right to elect COBRA Coverage through the Fund.

If you elect COBRA, you may choose either Core Benefits Only Coverage (which includes medical and prescription drug coverage) or Core Benefits Plus Coverage (which includes medical, prescription drug, dental and vision coverage).

If your Qualifying Event is the result of your disability or Workers’ Compensation Disability, you may be eligible to apply for an extension of your active Fund coverage. Please refer to the enclosed Loss of Eligibility form for a Disability Extension. NOTE: If your Loss of Eligibility Date changes for any reason (for instance, as a result of extended active coverage due to your disability), your Final Election Date will automatically change to 60 days following your new Loss of Eligibility Date. **You will not receive this notice again if your Loss of Eligibility Date changes. You will be responsible for returning the Election Form within the 60-day period following your new Loss of Eligibility Date if you wish to elect COBRA Coverage.**

Each qualified beneficiary has a separate right to elect COBRA Coverage. For example, the employee’s spouse may elect COBRA Coverage even if the employee does not. COBRA Coverage may be elected for only one, some, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA Coverage on behalf of any dependent children who are qualified beneficiaries. The employee or the employee’s spouse can elect COBRA Coverage on behalf of all of the qualified beneficiaries. In addition, each qualified beneficiary who elects COBRA Coverage need not choose the same level of coverage (i.e., Core Benefits Only vs. Core Benefits Plus Coverage).

If you reject COBRA Coverage before the end of the 60-day election period, you may change your mind as long as you submit a completed Election Form before the end of the 60-day period. However, if you change your mind after first rejecting COBRA Coverage, your COBRA Coverage will begin on the date you submit the completed Election Form.

**IMPORTANT: If you do not elect COBRA Coverage by the Final Election Date, you will lose all COBRA Coverage rights under the Fund.**

In considering whether to elect COBRA Coverage, 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 Fund coverage ends because of a Qualifying Event. You will also have the same Special Enrollment Right at the end of COBRA Coverage if you get COBRA Coverage for the maximum time available to you.

### **3. How long will COBRA Coverage last?**

If the loss of Fund coverage is due to the end of employment or reduction in hours of employment, COBRA Coverage can last up to a total of 18 months from the Qualifying Event Date.

If, however, the employee became entitled to Medicare less than 18 months **before** the Qualifying Event, COBRA Coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the Qualifying Event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Coverage for his spouse and children (who lost coverage as a result of the termination) can last up to 36 months after the date of Medicare entitlement. This COBRA Coverage period is available only if the covered employee becomes entitled to Medicare within 18 months **before** the termination or reduction in hours.

If the loss of coverage is due to an employee's death, divorce, or a dependent child ceasing to be a dependent under the terms of the Fund, COBRA Coverage can last up to a total of 36 months from the Qualifying Event Date.

### **4. How Does Extended Active Coverage Affect COBRA Coverage?**

The Fund may provide you with a period of extended active coverage after the Qualifying Event Date, depending on the circumstances. Your Maximum Period of COBRA Coverage (shown on the Election Notice) will be reduced by the number of months that you were covered under the Fund due to: (1) the normal runoff of eligibility; and/or (2) your receipt of extended active coverage due to disability. Payment for COBRA Coverage will not begin until after the extended active coverage period has been exhausted. *For example, if you are entitled to 18 months of COBRA Coverage, and you receive 6 months of extended active coverage due to disability, you will have to pay for only 12 months of COBRA Coverage.*

If you receive extended active Fund coverage: (1) your Loss of Eligibility Date (shown on the Election Notice) will automatically change to the date the extended coverage ends; and (2) your Final Election Date will automatically change to sixty (60) days after your new Loss of Eligibility Date. **You will not receive a new Election Notice if your Loss of Eligibility Date changes. You will be responsible for returning the Election Form within the 60-day period following your new Loss of Eligibility Date if you wish to elect COBRA coverage. Please contact the Fund Office if you need assistance in determining your new Loss of Eligibility Date and COBRA Application Final Election Date.**

### **5. Can COBRA Coverage Terminate Early?**

Your COBRA Coverage will automatically terminate before the end of your Maximum Period of COBRA Coverage for any of the following reasons:

- If, after electing COBRA Coverage, a qualified beneficiary becomes covered under another group health plan (either as a participant or a dependent) that does not impose a pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. (NOTE: There are limitations on plans imposing a pre-existing condition exclusion, and such exclusions will become prohibited in 2014 under the Affordable Care Act, the specific prohibition date varying from plan to plan.)
- A qualified beneficiary's COBRA premium is not paid in full on time.
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA Coverage.
- During a disability extension period (which is described below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.
- The Fund no longer provides group health coverage.
- Your Employer stops making contributions to this Fund on behalf of its Active Employees and provides alternative group health coverage to those employees under another plan.

COBRA Coverage may also be terminated for any reason the Fund would terminate coverage of a Fund participant or dependent not receiving COBRA Coverage (such as fraud).

You must notify the Fund Office in writing within 30 days if, after electing COBRA Coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. In addition, if you were already entitled to Medicare before electing COBRA Coverage, you must notify the Fund Office of the date of your Medicare entitlement.

## **6. How can you extend the length of COBRA Coverage?**

Qualified beneficiaries who are receiving COBRA Coverage because of a Qualifying Event that is the reduction in hours or end of employment may be entitled to an extension if a qualified beneficiary is disabled or a second Qualifying Event occurs. You must notify the Fund Office in writing of a disability or a second Qualifying Event in order to qualify for the extension. **If you fail to provide timely written notice of a disability or second Qualifying Event, you will lose the right to extend your COBRA Coverage.**

### ***Disability***

An 11-month extension of COBRA Coverage may be available at an increased rate if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. Each qualified beneficiary who has elected COBRA Coverage will be entitled to the 11-month disability extension if one of them qualifies. The disability must have started at some time on or before the 60th day of COBRA Coverage and must last at least until the end of the initial 18-month period of COBRA Coverage.

To obtain this extension, you must notify the Fund Office in writing within 60 days after the date of the qualified beneficiary's disability determination under the SSA (or if the qualified beneficiary is already disabled, within 60 days after the date Fund coverage is lost due to the Qualifying Event), but before the end of the initial 18-month period of COBRA Coverage. Your written notice must include: (1) your name and social security number; (2) the name(s) and social security number(s) of your dependent(s); (3) your mailing address and phone number; (4) the mailing address(es) and phone number(s) of your dependent(s), if different from yours; (5) the date of the SSA's disability determination; and (6) a copy of the SSA determination letter. You must also notify the Fund Office in writing within 30 days after the date of a final determination under the SSA that the qualified beneficiary is no longer disabled. You must mail all written notices to the Fund Office at the address shown below under "Fund Contact Information." **If these procedures are not followed, the disability extension of COBRA Coverage will not be available.**

## *Second Qualifying Event*

An 18-month extension of COBRA Coverage (or, if you are receiving a disability extension, a 7-month extension of COBRA Coverage) will be available to spouses and/or dependent children who are receiving COBRA Coverage if a second Qualifying Event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA Coverage. The Maximum Period of COBRA Coverage available in the event of a second Qualifying Event is 36 months from the date of the original Qualifying Event. Such second Qualifying Events include the death of a covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. These events can be a second Qualifying Event only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first Qualifying Event had not occurred.

To obtain this extension, you must notify the Fund Office in writing within 60 days after the date of the second Qualifying Event. Your written notice must include: (1) your name and social security number; (2) the name(s) and social security number(s) of your dependent(s); (3) your mailing address and phone number; (4) the mailing address(es) and phone number(s) of your dependent(s), if different from yours; and (5) the date and nature of the second Qualifying Event. You may be asked to provide supporting documentation (such as a divorce decree) to the Fund Office. You must mail this written notice, along with any documentation, to the Fund Office at the address shown below under "Fund Contact Information." **If these procedures are not followed, the extension of COBRA Coverage due to a second Qualifying Event will not be available.**

### **7. How much does COBRA Coverage cost?**

Each qualified beneficiary will be required to pay the entire cost of COBRA Coverage. Under federal law, the amount a qualified beneficiary will be required to pay may not exceed 102% (or, in the case of an extension of COBRA Coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant who is not receiving COBRA Coverage. The required monthly payment for COBRA Coverage under the Fund is shown on the first page of the enclosed Election Notice. The Fund Office will advise you of any changes in the monthly COBRA rates.

### **8. When and how must payment for COBRA Coverage be made?**

#### *First payment for COBRA Coverage*

If you elect COBRA Coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA Coverage no later than 45 days after the date you submit your Election Form to the Fund Office. (This is the date your Election Form is postmarked.) **If you do not make your first payment for COBRA Coverage in full by the end of this 45-day period, you will lose all COBRA Coverage rights under the Fund.**

Your first payment must cover all calendar months between your Loss of Eligibility Date and the calendar month ending immediately before the date the first payment is made. COBRA Coverage will not be effective and no claims will be paid until the Fund Office receives payment. If you pay immediately, you will assure early reinstatement of coverage and minimize claim delays.

You are responsible for making sure the amount of your first payment is correct. If the first payment is not made in the correct amount before the end of this 45-day period, your right to COBRA Coverage will be lost. You may call the COBRA Coordinators at the Fund Office at 714-220-2297, 562-408-2715 or 877-284-2320, Extension 441 to confirm the correct amount of your first payment.

### *Monthly payments for COBRA Coverage*

After you make your first payment for COBRA Coverage, you will be required to make monthly payments for each subsequent month of COBRA Coverage. Each monthly COBRA payment is due on the first day of the month of coverage. (For example, payment for COBRA Coverage in January would be due on January 1.) If you make a monthly payment on or before the first day of the month to which it applies, your COBRA Coverage under the Fund will continue for that month without any break. **The Fund Office will not send statements to you for your COBRA Coverage. It is your responsibility to pay your COBRA premiums on time.**

### *Grace periods for monthly payments*

Although monthly payments are due on the first day of each month of COBRA Coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Fund will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

**If you fail to make a monthly payment in full before the end of the grace period for that month, your COBRA Coverage will terminate as of the last day of the month for which a timely payment was made, and you will lose all rights to COBRA Coverage under the Fund.**

The initial payment for COBRA Coverage may be made by check, cash or credit card. Make checks payable to "UFCW Benefit Fund," and mail to the Fund Office at the following address:

COBRA Department  
UFCW Unions and Food Employers Benefit Fund  
P.O. Box 6010  
Cypress, CA 90630-0010

**You will receive coupons for subsequent payments.**

## **9. More information about individuals who may be qualified beneficiaries**

### *Children born to or placed for adoption with the covered employee during a COBRA Coverage period*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA Coverage is considered to be a qualified beneficiary, provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA Coverage for himself or herself. The child's COBRA Coverage begins when the child is enrolled in the Fund, whether through Special Enrollment or Open Enrollment, and it lasts for as long as COBRA Coverage lasts for other family members of the employee. To be enrolled in the Fund, the child must satisfy the otherwise applicable Fund eligibility requirements (for example, regarding age).

### *Alternate recipients under QMCSOs*

A child of the covered employee who is receiving Fund coverage pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Fund Office during the covered employee's period of employment is entitled to the same rights to elect COBRA Coverage as an eligible dependent child of the covered employee.



## **10. For more information**

This notice does not fully describe COBRA Coverage or other rights under the Fund. More information about COBRA Coverage and your rights under the Fund is available in your Summary Plan Description or from the Fund Office.

If you have any questions concerning the information in this notice or your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact the COBRA Coordinators at the Fund Office at: COBRA Department, UFCW Unions and Food Employers Benefit Fund, P.O. Box 6010, Cypress, CA 90630-0010, 714-220-2297, 562-408-2715 or 877-284-2320, Extension 441.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 888-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

## **11. Keep the Fund Office informed of address changes**

To protect your rights and those of your family, you should keep the Fund Office informed of any changes in your address and telephone number and the addresses and telephone numbers of family members. You should also keep a copy of any notices you send to the Fund Office, for your records.

## **12. Fund Contact Information**

COBRA Department UFCW Unions and Food Employers Benefit Fund  
P.O. Box 6010  
Cypress, CA 90630-0010  
714-220-2297, 562-408-2715 or 877-284-2320, Extension 441

### **Participating Union Locals**

***UFCW Local 8***  
***Bakersfield*** – 661-391-5773 or 661-391-5770

***UFCW Local 135***  
***San Diego*** – 619-298-7772

***UFCW Local 324***  
***Buena Park***  
800-244-8329 or 714-995-4601

***UFCW Local 770***  
***Los Angeles (Main Office)***  
213-487-7070 or 800-832-9770  
***Arroyo Grande*** – 805-481-5666  
***Camarillo*** – 805-383-3300  
***Harbor City*** – 310-784-5340  
***Huntington Park*** – 310-923-1510  
***Newhall*** – 661-259-9900  
***Santa Barbara*** – 805-681-0770

***UFCW Local 1167***  
***Bloomington*** – 909-877-1110

***UFCW Local 1428***  
***Claremont*** – 909-626-6800

***UFCW Local 1442***  
***Inglewood*** – 310-322-8329