Created on: March 21, 2008
Last Modified on: May 14, 2008

SR82183 Requirements
COBRA IDOC Text Changes

Objective:

The objective of this request is to change the text displayed on the COBRA employee documents (IDOCs). The text in the Instructions section needs to be updated for all COBRA IDOCs. In addition, the wording on the Retirement IDOC needs to be changed to be consistent with the retiree vision plan being offered effective 7/1/08. This change will impact the following employee documents:

- Separation
- Layoff
- Retirement
- Reduction of Hours
- Approved Leave without Pay

Project Type:

This involves modifications to existing PPS programs.

Requested by:

Health & Welfare Administration

Analyst:

Beth Burkart

Due Date(s):

The requested modifications are date mandated. Campuses should install as soon as possible after 5/1/08. Changes must be installed by 7/1/08 at the latest.

Background

Release 1701 (4/06) modified PPS to develop new IDOCs (employee documents) for the following COBRA qualifying events to provide the COBRA notification/application cover letter for COBRA Continuation:

1. Separation (for reasons other than gross misconduct)
2. Layoff
3. Retirement
4. Reduction of hours resulting in loss of coverage
5. Approved leave without pay

The Retirement COBRA IDOC contains specific language regarding vision coverage. Effective July 1, 2008, the University of California is offering a vision plan for the first time to retirees and their eligible family members. This new vision plan necessitates a change in the IDOC wording.

In addition, all COBRA IDOCs contain a set of instructions that the employee must follow to elect COBRA continuation coverage. Part of the instructional text needs to be changed.

Current Process:

Currently the note on the COBRA Retirement IDOC reflects the fact that vision coverage is not available to retirees.

Currently the instructions on all COBRA IDOCs indicate that the employee must send one month's premium to the health plan carrier. This is not the case at this time.

Proposed Process:

The text on the COBRA Retirement IDOC should be updated to reflect the new retiree vision plan being offered effective July 1, 2008.

The instructions on all COBRA IDOCs must be corrected to remove the reference to sending the premium to the health plan carrier.

Requirements

1.0 Retirement COBRA IDOC

The “Note” text on the Retirement COBRA IDOC should be changed as follows:

Old wording:

“Note: If you are eligible and have made arrangements to continue your UC-sponsored medical or dental coverage into retirement, and you are not enrolled in the vision plan or do not wish to continue your vision coverage under COBRA, please disregard this mailing. However, if you are enrolled in the vision plan and wish to continue your vision coverage under COBRA, use this form to apply. (Vision coverage through UC is not available to retirees.)”

New wording:

“Note: If you are eligible and have made arrangements to continue your UC medical, dental, or vision coverage into retirement, you are not eligible for COBRA.” See Attachment A.

2.0 All COBRA IDOCs

Step #5 in the Instructions section for all COBRA IDOCs should be changed as follows:

Old wording:

“Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month’s premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.”

New wording:

“Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.” See Attachment B.

Attachment A: Mockup showing New Note Text

DATE: 02/06/08
Page 1 of 3

UNIVERSITY OF CALIFORNIA
PAYROLL/PERSONNEL SYSTEM

TO: AARDVARK, FRANCIS
88 OAK ST.
OAKLAND CA, 94607

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Retirement on: 01/01/01

Note: If you are eligible and have made arrangements to continue your UC medical, dental, or vision coverage into retirement, you are not eligible for COBRA .

New Note Text

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date:

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below. Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries

Attachment B: Mockup showing New Instructions Step 5

Page 2 of 3

5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.

New Step 5 of instructions

6. Keep a copy of the form for your records.

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1. CURRENT COVERAGE AND DATE COVERAGE ENDS

The health plan(s) in which you are currently enrolled are indicated below.
None

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2. QUALIFIED BENEFICIARIES

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

* Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
* Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name		Birthdate	Sex	Relationship	Medical	Dental	Vision
FRANCIS AARDVARK SSN ( )	( )	01/01/60	F	Employee	No	No	No
SPOUSE EMPLOYEE039 SSN ( )	( )	01/01/61	M	Spouse	No	No	No

If you elect COBRA continuation coverage, your coverage will begin on:

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3. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.